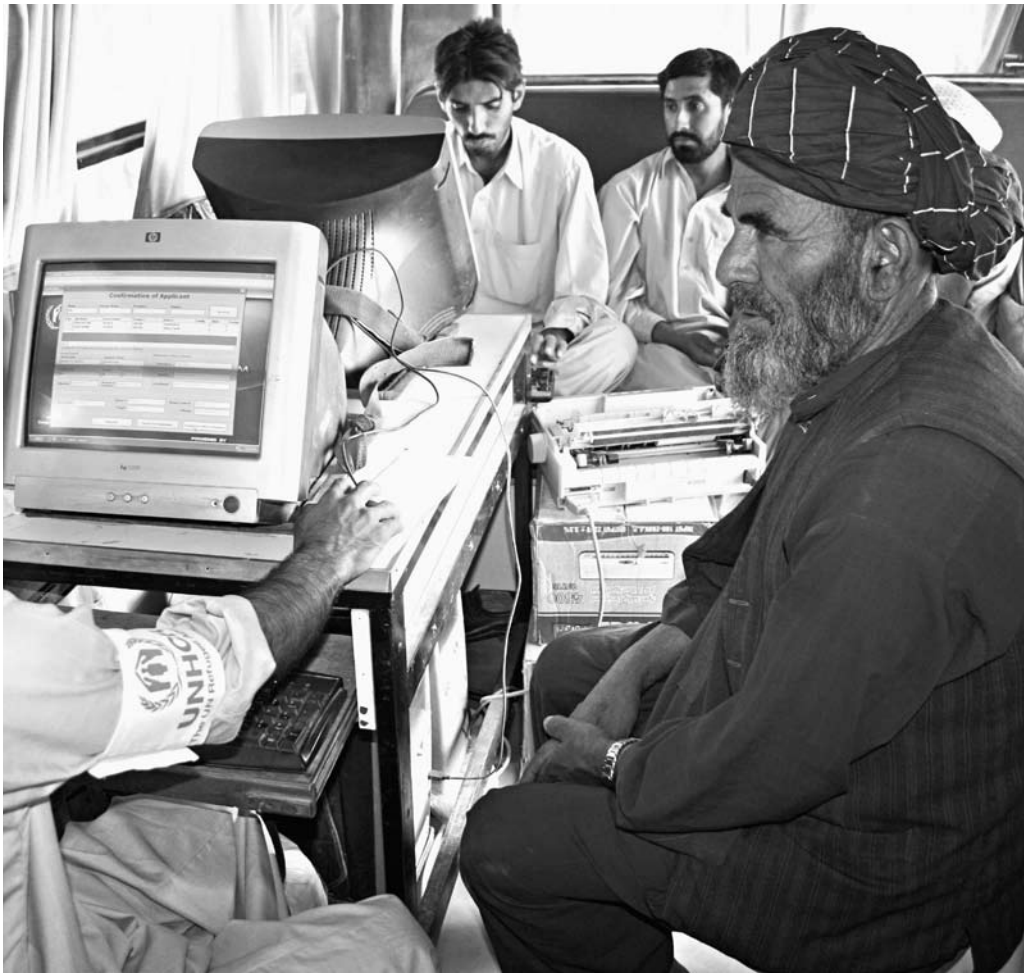
10

Population estimation and registration



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Situation

Refugee emergencies are characterized by a mobile population, often with rapidly fluctuating numbers. While it may be difficult to collect exact information on the total number and composition of the population, every effort should be made to obtain individual information, progressively through phases, to better assist the population.

Objectives

- To obtain working figures on the population of concern, including a breakdown of the population by age, sex, and groups with specific needs.
- To obtain detailed individual information on the population of concern which will help to better identify protection needs and to deliver more appropriate assistance.

Principles of response

- If refugees are still on the move, the influx is rapid or there are concerns for general security, an estimation of the population should be conducted to obtain working figures until the situation stabilizes and is conducive for registration.
- Registration is the primary responsibility of the refugee hosting government; however, in an emergency situation, UNHCR may be called upon to conduct the registration on their behalf. It is essential to involve the government from the early stages of registration planning.
- Knowing the size and profile of the refugee population is essential for an efficient and cost-effective operation and is at the core of UNHCR's protection mandate. Refugee registration will serve as the basis for various standards and indicator reporting.
- Involvement and understanding by the refugees (women and men) themselves is essential to the success of registration.
- The information collected will be important in planning for the care and maintenance in the country of asylum, as well as for voluntary repatriation and reintegration in the country of origin.
- Individual registration is the standard and the ultimate goal. Where this is not immediately possible, it can be achieved progressively in stages, starting with a household level registration. At each phase of the registration process, it is crucial to computerize the information as soon as possible to facilitate programme delivery and beneficiary analysis.
- Continuous registration and verification is the norm. Information needs will change through the course of time and the first registration should not necessarily attempt to collect all the information at once.

Action

- Use population estimation techniques only if the situation is not conducive for a more thorough registration or during the initial days of an influx.
- Conduct a household registration as early as possible.
- Plan towards an individual registration, keeping the population and partners (government, WFP and the NGO community) informed.
- Identify resources which will be required for a full registration.
- Define the protection and operational strategy,[1] and consult the Regional Registration Officers and HQ in planning for an individual registration exercise as soon as feasible.

[1] *See: How to Register, Manage Population Data and Issue Documentation process. (Registration Handbook –2006).*

Introduction

- Knowing how many refugees there are and who they are is fundamental for planning and managing an efficient operation. It is also essential for public information and fund raising.
- Successful registration needs good planning, careful implementation and consistent monitoring. Individual population records need to be continuously updated to ensure that registration data reflects the actual situation at all times.
- To plan and manage an efficient operation, it is critical to know the size and the profile of the refugee population. It is also important to have good baseline data to ensure that you are meeting minimum standards.[1] An accurate enumeration is therefore an essential component of any assessment.

1. Chapter II, 8(f) of the UNHCR Statute states that the High Commissioner shall provide for the protection of refugees by "obtaining from Governments information concerning the number and condition of refugees in their territories." It must be made clear to the authorities that an assistance operation cannot be carried out without this information.

2. Executive Committee Conclusion No. 91 of 2001 (Appendix A) sets the standards for the registration of persons of concern to UNHCR and acknowledges "the importance of registration as a tool of protection, including protection against refoulement, protection against forcible recruitment, protection of access to basic rights, family reunification of refugees and identification of those in need of special assistance, and as a means to enable the quantification and assessment of needs and to implement appropriate durable solutions." It also recommends that refugees should be registered on an individual basis.

Although individual registration is the standard to be achieved within the first 3 months of an influx[3], this should not be an automatic response at the start of an emergency.

3. Although every effort should be made to create the conditions in which registration can be achieved, there may be situations in which registration activities may be inappropriate or not feasible. Situations in which registration should be delayed include:

- **Populations that are still moving**: If refugees have not yet reached a destination, whether temporary or final, registration can be difficult to organize and manage. In addition, registration formalities might compromise the flight to safety, part of the population may be missed in the registration activities, and there is a risk of multiple enrollments.
- **Proximity to borders**: Registration may have to be avoided for security reasons or to avoid mixing the refugee population with armed elements moving back and forth across the border. There may also be mixing with the local population living on both sides of the borders.
- **Security problems**: Under no circumstances should registration activities be carried out if they are deemed to be or become detrimental to the safety and security of refugees or to the security of staff.
- **Saving lives is a high priority**: Saving lives is more important than registering people. In circumstances where staff must concentrate on other priorities, registration may not be

[2] For example, if the population figure is higher than reality, the crude mortality rate when calculated will be low or below critical but in reality there may be more than e.g. 1 death per 10,000 person per day.

3 As agreed with WFP under the joint UNHCR and WFP Memorandum of Understanding (July 2002).

carried out. This is often the case in the first few weeks of an emergency when the level of trauma amongst arriving refugees is high, or where the response by UNHCR or its partners is not fully implemented.

4. Where formal registration is not possible, efforts should concentrate on population estimates, rate of influx, general characteristics of the population and information on origin and destination. There are a number of methods for population estimation which do not require a formal registration. In circumstances where minimal conditions for operation do not exist, these methods may be preferable as an initial first response.

5 . Information compiled through a registration process is required to support a wide range of activities. The same set of core data is used for different purposes, although most also require specific additional information and variations in the registration steps. These may include:

- Issuance of identity documents
- Refugee status determination
- Planning and targeting of assistance (food, shelter) and services (health, water)
- Issuance of documents providing access to services (ration cards, health cards)
- Identification of beneficiaries with specific needs
- Voluntary repatriation
- Resettlement
- Local integration

6. The most practical time to register refugees is when they arrive at a reception/ transit centre or site for settlement. Registration is often carried out in conjunction with health screening. Transferring refugees to a new site also provides an opportunity for registration.

7. Discrepancies may arise over time between official figures and the estimates of those working closest to the refugees. Unless these discrepancies are swiftly resolved, major problems will follow. Small discrepancies are likely, given the difficulties in enumeration and registration. Large ones can be avoided by timely action to verify numbers through the various methods set out in this chapter. The key point for registration is that it is not a one-off exercise – it is a continuous process that is incorporated in the day to day activities of the operation.

8. **For detailed information on registration and population estimation techniques, refer to UNHCR Handbook for Registration (2006) and UNHCR/WFP Joint Assessment Guidelines – First Edition (June 2004).**

Population estimates

- Population estimation techniques should be used when basic ground conditions are not conducive for a registration. For example, during the very initial phase when refugees are still on the move, the influx is rapid and any activity would create a bottleneck for the delivery of essential assistance or there are concerns for general security.
- For most methods of population estimation, it is important to understand the community structure of the beneficiary population. It may be necessary to employ several methods of estimation to obtain a better estimate.
- Estimates should be updated regularly until the situation stabilizes and is conducive for registration.
- The estimates should be obtained in close cooperation with the Government, WFP and other partners on the ground.

Introduction

9. The following methods can be used to estimate the population:

i. Counting
ii. Administrative records
iii. Lists compiled by refugee leaders and/or outreach teams
iv. Extrapolation including the use of aerial photographs and satellite imagery

10. Understanding the community structure of the beneficiary population is important for most methods of population estimation – for example, living arrangements and the average number in a family group.

11. Annex 1 provides a format for reporting population estimates as part of an overall situation report. Estimates should be updated regularly and the methodology should be determined jointly with other key partners who are affected, e.g. WFP who will deliver food based on the estimated numbers.

Counting

12. If there are easily identified entry or transit points during a refugee influx (e.g. bridges or transportation sites), daily counts of the number of people passing through these points can give a reasonable estimate of the refugee population. Sufficient staff should be immediately positioned at bridges and other critical points to provide 24-hour coverage. These staff members should be provided with counters to aid counting and with simple recording and reporting forms. See Annex 2 a.

Administrative records

13. Local authorities or volunteers at the refugee site may collect population data on the refugees. If possible, national census and other population data should be obtained from the country of origin as a means of cross-checking the host area data.

Lists compiled by refugee leaders

14. Lists of names can be compiled by refugee leaders and verified through a process agreed with the refugee community. If this method is taken, it is essential to harmonize the information collected at all locations for easy comparison. See Annex 3 for the minimum information to be collected.

To ensure that the population estimates are as accurate and as fair as possible, it is particularly important to understand the community structure.

15. The normal community structure and hierarchy in a society are often disrupted during exodus and new leaders can emerge who were not necessarily leaders in the country of origin. It is essential to understand the role, motives and effectiveness of the new leadership. Community services and field staff can help in this. Initial records compiled by refugee leaders may eliminate the need for immediate registration; however the information provided should be randomly checked and verified and regularly updated. Once the situation stabilizes, the registration should be streamlined into the regular activity.

16. The lists can also be useful in identifying refugees with specific needs who require special assistance. Community services staff and health outreach teams should visit such individuals and families to confirm the accuracy of lists provided by the leaders. This method can also be used in non-camp spontaneous settlement situations, and/ or populations on the move (nomadic).

Extrapolation

17. Population estimates can also be obtained by calculating the total area of the camp, then counting shelters in a fraction of the camp, from which the population of the whole camp can be extrapolated. Alternatively, aerial photograph or satellite images may be used to count the number of shelters.

18. In all scenarios, it must be accompanied by a ground survey to establish the average family size per shelter and the percentage of empty shelters.

19. The total surface area of the camp can be determined in a number of ways. Below are some examples on how it can be determined:

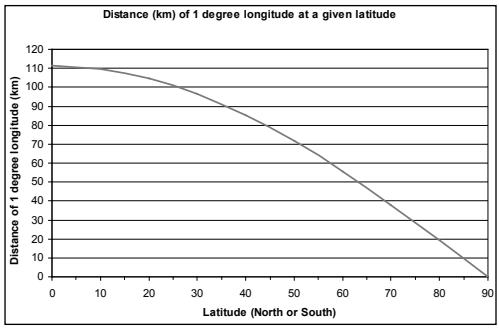
Area calculation based on measurement made with a Global Positioning System (GPS) receiver. GPS uses satellites to establish and indicate the latitude and longitude of its current position. The device does not work under heavy forest cover or in deep narrow valleys because it needs an unobstructed sightline to several satellites. It is important to note in which coordinate system the GPS receiver is displaying the positions. UNHCR uses WGS84 in latitude and longitude as standard, the format of the coordinates being degrees (°) minutes (‘) and seconds (“), dd mm ss.. This should normally be the setting for any GPS receiver at all times. Due to the accuracy of the GPS, it is not recommenced to measure areas below 200m x 200m. The table below indicates the error in percentage that a GPS might give on a square area assuming the accuracy is +/- 10m:

Area	Maximum error on surface calculation
100m x100m	+/- 20%
200m x 200m	+/- 10%
300m x 300m	+/- 7%

a) Automatic area calculation using a GPS. Many GPS receivers have a function to calculate an area from measurements made while walking the perimeter of the area. It is important to slowly follow the perimeter of the area to be measured and to make sure that the track does not cross itself since that would make the calculated area incorrect. Consult the handbook for the GPS receiver for exact instructions on how to calculate an area automatically.

b) Area calculation based on points measured with GPS. If the GPS has no function for calculating the area, it can be used to measure all break points on the perimeter enclosing the camp. Any simple GPS receiver can be used to measure the points, for example the Thuraya phones that have a built in GPS. The more irregular the camp’s shape, the more perimeter points will be needed. Once the break points have been measured the area can be calculated.

The lines of latitude are parallel and evenly spaced with approximately 111 km for one degree latitude. The distance which a degree of longitude represents on the ground varies with the latitude. This is because lines of longitude converge at the poles and thereby make the distance represented by one degree of longitude smaller moving away from equator towards the North and South poles. It is necessary to know the distance which one degree represents at the exact location of the camp, for example by determining it with help of a map of the area, if it is sufficiently large scale. The length of a degree at any given latitude can be found in the graph below.



Many GPS receivers have a function for selecting the format in which the positions are being displayed. To avoid the calculation of the length of a degree, the positions can be displayed and recorded in a metric system directly. A very common metric system is the coordinate system Universal Transverse Mercator (UTM). There are 36 different UTM zones and each UTM zone is six degrees of longitude wide. Either the GPS receiver detects the actual zone by itself or it has to be entered.

Once the camp perimeter points have been measured, the surface area of the camp can be calculated in the following ways:

i. The perimeter's breakpoints can be marked on paper which has scaled gridlines by using the Y-axis to represent longitude and the X-axis to represent latitude. A line is drawn joining these points. Counting the scaled squares inside the perimeter will give the total area. Make sure that the correct scale factor for the length of a degree is being used.

ii. Geographical Information Systems (GIS) can automatically map and calculate an area based on the perimeter points measured with GPS. Technical assistance for setting up this software can be obtained from Field Information and Coordination Support Section, (FICSS) at HQ (hqmap@unhcr.org).

iii. FICSS can also assist in calculating the area for the measured points. Communicate the perimeter coordinates to FICSS at HQ (hqmap@unhcr.org).

iv. Calculation from an existing map: If there is a map of the camp, the surface area of the camp can be estimated by overlaying scaled gridlines on the map, and adding up the number of the squares falling within the camp's boundaries.

Area estimation: The estimated area can be calculated by using the average length and average width of the camp and other necessary measurements depending on the shape of the camp. The length and width can be measured with a GPS receiver, by pacing, or by using a wheel meter or measurement tape (if the camp is small), or by driving (if the camp is large), using the trip meter to estimate distance.

Once the surface area has been established, select a minimum of three sample areas within the camp, each representing about one thirtieth of the total camp area. For example, if the total surface area of the camp is 600,000 sq. m, then each sample area should be 20,000 sq. m. Any variation of length or width which yields 20,000 sq. m could be used for the sample sections. The normal GPS is not sufficiently accurate for use in measuring the size of the sample area and conventional means of measuring should be used instead.

20. Count the number of family shelters occupied in each of the three sample sections. Obtain a figure for the average number of shelters per section (i.e. – in 20,000 sq. metres). Then multiply by 30 to extrapolate this over the entire camp.

For example, if 3 sample sections have 120, 134, and 150 occupied shelters respectively, then the average number of shelters in a sample section will be (120 + 134 + 145) / 3 = 133. Thus the total number of occupied shelters in the 600,000 sq. metres camp will be 133 x 30 = 3,990 shelters.

21. Determine average family size per occupied shelter to estimate the total population. For example, if the average family size per shelter is 5, then the total population is 5 x 3,990 = 19,950.

22. Alternatively, aerial photographs (or sometimes videos of a camp) or satellite image can be used to count the number of family shelters. Depending on the topography, a picture from a nearby hill, tower or tall building may be sufficient. In addition to professional aerial photography or satellite images, photographs taken, for example, from a UNHCR plane can be used for estimation. It is important to define an appropriate scale for the photography. This will depend, in part, on the size of the camps. High altitude flights produce fewer photographs to handle and interpret, but it will be more difficult to distinguish the shelters. Note, however, that flying over the site may require the permission of the authorities.

23. Once the number of shelters is counted on the photo, it can be multiplied

by the average family size per shelter to obtain an estimated total population. If the ground survey indicated that there are some percentages of empty shelters, ensure that this is factored into the shelter calculation.

24. The results of aerial surveys or satellite images can be integrated within the GIS from which maps can then be produced. This is also true for the GPS coordinates collected during the surface calculation. The coordinates can be a base to create camp maps.

TIP: If there are various estimates floating around, a quick count of all children under five years old in the camp or in a section of the camp (that can then be extrapolated for the camp) can be used to cross-check the various estimates. For most developing countries, the percentage of under 5 year-old range between 15- 20% of the population.

Registration

- Registration provides the more detailed information needed for the efficient management of an assistance operation.
- Registration is carried out over several phases.
- Individual registration should be the final goal and should also be continuously updated, including deregistration of those no longer of concern, to avoid becoming irrelevant.

Introduction

25. For effective protection and assistance delivery, individual and demographic information obtained through registration is imperative. Information requirements will change during different phases of an operation (emergency, care and maintenance, VolRep); therefore, the initial registration should be followed by continuous verification of information and additional information collection to ensure up-to-date information.

26. There are 3 levels of registration which are determined by the amount of information collected. Level 1 is household registration which should take place immediately upon arrival of the refugees. Level 2 is individual registration required for prima facie caseload/camp management or voluntary repatriation which should be achieved within 3 months from the influx. Level 3 is individual registration required for status determination, local integration and resettlement. The information below relates mainly to initial registration at the time of an influx. For further details, refer to the registration handbook.

Registration is not a one-off exercise. Individual and continuous registration is the UNHCR standard for registration.

27. In order to cope with large numbers, normally household registration is conducted immediately, followed by individual registration according to the immediate needs of the population and the time and staff available to carry out the task. In some situations, the operation may go directly into individual registration. Registration should only be carried out when:

i. the safety of the staff and of the refugees can be assured;
ii. the refugees and other stakeholders accept the process;
iii. the key partners can supply personnel to help carry out the registration; and
iv there are sufficient quantities of registration materials and other equipment, including logistical support and communications.

28. There are 4 main phases in registration, regardless of whether you conduct a household registration or an individual registration. In all stages, staff training and full understanding of the process involved is essential for the success of the exercise. The 4 main phases in registration are:

i. assessing and determining the registration strategy;

ii. collecting information and issuing registration cards;
iii. computerization; and
iv. Verification and updating.

29. The 'ideal' in registration is to work as closely as possible with the refugee population and its leadership, especially refugee women, to ensure their concerns are noted, promoting community responsibility and participation in all stages of the process. Whilst this may not always be possible initially, it should be a major objective for both registration and camp management.

30. Formal registration requires considerable time and personnel resources and needs the active involvement of key partners to supply the necessary personnel. Key partners include government, other UN agencies, NGOs and the authorities responsible for security. See Excel sheet in the CD-ROM which helps to give an idea for registration staffing and equipment requirement; however, this will change depending on the operating environment. Case by case support is provided by the Senior (Regional) Registration Officers covering the country who can advise on the best methodology for a particular situation. List of country coverage is attached as Annex 4.

Standard UNHCR registration materials

31. Standard materials for registration are stockpiled at Headquarters and are sufficient to register 300,000 refugees. The materials include standard cards and forms, wristbands, fixing tokens, etc. These materials are included as part of a refugee registration package. Please refere to the catalogue of Emergency Response Resources which has further details of these resources and how to obtain them.

Registration phases

Phase 1: *Assessing and determining the registration strategy*

32. This is the initial step to determine the registration methodology based on estimated or existing planning figures. It is crucial to review the available information and to build on it rather than start everything from scratch.

33. Designate a focal point to take responsibility for planning and executing the registration. A pilot registration in a small camp can help identify potential difficulties. Planning should be a joint exercise with the concerned partners, including refugees. Staff training, including basic protection training may be required at this stage. Ensure that the necessary staffing, equipment, supplies, security, telecommunications, vehicles and logistical support will be available on the date of the exercise. Decide on the level of information to be collected on a control sheet or registration form, and ensure planning includes procedures for data entry computerization.

34. At the same time as planning, there should be an intensive information campaign aimed at the refugee population at large (not just the leaders) informing the refugees of the procedures and benefits of registration. Special arrangements should be made to cater to the needs of those who are unable to spend time in queues and under the hot sun for example, such as older persons and those with disabilities.

Phase 2: *Collecting information and issuing registration cards*

35. Registration should be conducted on a "fixed" population. This means that the size of the group on whom more detailed information will be collected needs to be temporarily frozen. Without some kind of "fixing", registration will become a revolving door, open to escalating distortion and abuse.

36. Depending on the situation and the availability of previous lists, the "fixing" can be done in different ways. Tradition-

ally, it was done using tokens and wristbands. (See Annex 5) It must be done rapidly (preferably within a few hours, maximum one day) to avoid multiple and/or bogus registration. While the population may be given only short notice of when this will take place, it is necessary to ensure that they understand what is happening. This method is best used when absolutely no prior information exists for the population.

37. In situations where an initial "large influx" has stabilized to a steady trickle of hundreds, fixing tokens or wristbands can be issued at entry/transit points. This would "fix" a population and indicate who needs to be registered at the camp in the following days. (See Annex 2 b)

38. Alternatively, when you have a control sheet or an existing assistance list (such as food list) compiled by an NGO working with the refugee population, this list can be used as a "fixing" tool. The accuracy of the list should be verified by random sampling and a review of the process used to compile the list. Those who are not on the list need to be interviewed and verified to determine whether they are persons of UNHCR's concern. Another method is to conduct a tent to tent (or shelter to shelter) verification to create a list of refugees who would be registered.

39. In a scenario where there is a manageable rate of new arrivals to a camp, the registration can take place upon arrival. The "fixing" element of the registration may be the convoys arriving from the border (or foot arrivals in the transit area of the camp) and through allocating tent/shelter plots in the camp. In this situation, the families are allocated a fixed tent/shelter in the camp and fully registered. The operation can go straight into continuous registration/verification, by using the camp address as a verification tool.

40. In planning for this phase, it is essential to pay attention to the flow of people coming in for registration. Security incidents may occur if there are bottlenecks or long waiting periods, disorganised procedures, and large numbers of beneficiaries exposed to extreme conditions (heat, cold, sandstorm, etc.). See Annex 6 for a sample site set-up. Communication with the beneficiary population is essential to ensure that they are fully aware of the procedure and what it entails.

41. Below are 2 levels of information collection and entitlement card issuance – depending on the operating environment.

a) Collecting limited information on control sheets and issuing temporary family cards

42. Collecting information and issuing temporary family cards should be carried out immediately after the "fixing" and preferably, before any food or NFI distribution. Usually there will be no time to collect detailed information immediately, yet assistance should be distributed urgently and basic demographic data is needed. The first step therefore is to exchange the fixing token or wristband (if used) for a temporary family card (see Annex 7) to all heads of family, and collect limited information on control sheets (see Annex 8). In most instances this information will be limited to the names of the head of family, family size, age and sex breakdown of the family members and the number of the temporary family card, with an indication of any immediately visible vulnerable family members.

43. The control sheet can be used as a beneficiary list until the information is computerized to create distribution lists.

b) Completing registration forms and distributing ration cards

44. The second step is to record detailed information about the families on registration forms (see Annex 9) and to issue longer-term ration cards (the standard UNHCR card lasts about one year or 24 to 36 distributions). When it is done after the issue of temporary family cards it

can be spread over a longer period of time, with a cut-off date for the validity of the temporary cards.

45. For operations without assistance delivery or where refugees have been accepted in the local communities (spontaneous settlements), the individual registration should still be undertaken for protection and eventual durable solutions.

The registration form constitutes the core document of a UNHCR registration and will provide the basis for future reference, analysis, verification and updating of information.

46. This step provides a verifiable link between the identity of persons of concern and the very simple forms needed for processing large numbers of people for assistance distribution. The two-step process of information collecting is normally used because the second step can take considerable time, and registration information is needed in the interim for commodity distribution.

47. One key aspect to registration is the use of standard codes. This is essential in order to obtain data which is easily comparable and analysable. Further, it facilitates the collection and input of data. It is particularly important to have personnel who speak the language of the refugees and to ensure there is a common transliteration between alphabets, particularly for names. See Annex 10 for parts of the standard code list. The full list is in the CD-ROM.

Phase 3: *Computerization*

48. Computerization must start immediately when any form of entitlement card (temporary family card or ration card) has been issued. Any assistance delivery must use a combination of an entitlement card and a beneficiary list.

49. Data can be entered on-site by trained data-entry clerks or by outsourcing to an off-site specialized data entry company. If a data entry company is hired, it is essential that they sign a confidentiality declaration. The data should be computerized as soon as possible and not more than a few months after being collected on the registration forms or control sheet, otherwise it will be outdated and unusable.

50. Refugee data is normally processed using *proGres* (UNHCR standard registration software). *ProGres* is a holistic registration and case management tool which can be used during an emergency phase to record personal bio-data, to capture individual photos, and to create beneficiary lists. If the emergency is taking place in a remote location with very basic infrastructure, it is possible to record the data in Excel with a view to migrate to *proGres* at a later stage. See Excel sheets and user guide in the attached CD-ROM. Operations are advised to migrate their registration data to *proGres* as soon as the situation stabilizes.

If the Excel option is selected, it is strongly recommended to use the sheets attached in the CD-ROM. Any modification should be done in consultation with FICSS and *proGres* Support to ensure the data can be migrated to *proGres*.

51. Country specific advice on the best registration method or process for the situation can be obtained from either the Senior Regional Registration Officers covering the country or from FICSS (**hqcs00**@unhcr.org) in HQ. Technical support on *proGres* can be obtained from *proGres* Support Desk (**hqprosup**@unhcr.org).

Phase 4: *Verification and updating*

52. Registration information must be updated as the population changes with births, deaths and population movements. It is important to deregister and close cases when the persons are no longer of concern. There should be a procedure to do this from the start and it should be documented in the Standard Operating Procedure to ensure consistent practice. This

is especially important during the emergency phase when there is a high turnover of staff.

53. Registration and verification should not be a one-off exercise conducted once every year. The registered numbers and information should be continuously cross-checked with other available information, for example, births and deaths can be monitored through the health services, and population movements monitored through any of the methods for population estimation described above. Verification can also be conducted during food distribution, house to house visits by community services/community health workers, through school enrolment etc. The method of reporting back field findings should be agreed as early as possible at the onset of an emergency to ensure that most up-to-date information is available centrally. In order to facilitate the verification process, shelters should be given an address (block/ community/individual shelter number) which will be linked to the individual family registration information. Assistance to set up "Continuous Registration Process" is available with FICSS and the Regional Registration Officers.

A situation where various agencies maintain their own lists which are not shared or sharable should be avoided.

54. Entitlement documents (such as ration cards) and identity documents (such as attestation letters or ID cards) are 2 distinct documents which should not be mixed in use. Identity documents confirm the status of the persons of concern whereas entitlement documents confirm that a person or family is entitled to a specific assistance. For example, being a refugee does not automatically imply that a person is entitled to a certain type of assistance. Both documents can acquire monetary value, depending on the context. To ensure the refugees are not using other people's documents or forged documents there should be a system to check the documents, for example random verification at food distribution points.

It is important to emphasize the difference between entitlement documents and identity documents. This means that the total population of concern to UNHCR (with identity documents) can be higher than the number of beneficiaries (with entitlement documents).

Key references

Handbook for Registration, UNHCR, Geneva, 2006.

UNHCR/ WFP Joint Assessment Guidelines, First Edition (June 2004).

Annex 1: Emergency statistical report (to be included in the emergency situation reports)

Period: From _____ to _____

Type/status of population: _____

Origin of the population: _____

Main source of information is □ Government □ UNHCR □ NGO

Main basis of the information is □ Registration □ Estimate

Current location	Pop. at start of period	Increase			Decreases			Pop. at end of period Total	% of total 0 – 4 years old*	% of total who are female *
		New arrival	New born	Other	Spont. depart	Death	Other			

* Percentage as per end of period. Estimate, if statistics are not available.

Annex 2a: Sample counting form

Location name: _____ Date: _____

Start time: _____ End time: _____

Name of supervisor: _____ Signature: _____

Name of clerk	Serial # of manual counter *	Number counted	Signature
TOTAL			

*** The serial number is solely used to keep track of the equipment.**

Annex 2 b: Sample form to count issued wristbands/fixing tokens at entry points

Location name: _____ Date: _____

Start time: _____ End time: _____

Name of supervisor: _____ Signature: _____

Name of clerk	Serial # of Wristbands/ Fixing Tokens issued		Signature
	From	To	
TOTAL of wristbands/ tokens issued			

Annex 3: Minimum information to be collected

The information listed below is the minimum information to be collected if a list is to be maintained by community leaders. The information can be collected in a ledger book or notebooks provided to the block leaders (if the camp is organized). As indicated earlier, it is essential that the leaders are made fully aware that this is a temporary measure and that verification will take place as soon as the opportunity arises.

- Name (first/ given and family name), of head(s) of household
- Sex
- Age/ date of birth
- Relationship to the head(s) of family
- Marital status
- Place of origin
- Date of arrival
- Family size
- Ration card number
- Camp address
- Specific needs groups

Annex 4:

List of countries covered by Senior Registration Officers

(as per IOM/ FOM No. 91/2003/ Rev. 1 Human Resources management procedures relating to Regional Global posts effective 1 January 2004)

Name (based in)	Countries covered
Ms. Maureen Mc Brien (Nairobi)	Burundi, Djibouti, DRC, Eritrea, Ethiopia, Kenya, ROC, Rwanda, Somalia, Sudan, Tanzania, Uganda
Mr. Koffi Adossi (Accra)	Benin, Burkina Faso, Cameroon, Cape Verde, CAR, Chad, Cote d'Ivoire, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria, Sao Tome & Principe, Senegal, Sierra Leone, Togo
Mr. Nasir Fernandes (Cairo)	Afghanistan*, Algeria, Bahrain*, Egypt, Iran*, Iraq, Israel, Jordan, Kazakhstan*, Kuwait, Kyrgyzstan*, Lebanon, Libya, Mauritania*, Morocco, Pakistan*, Saudi Arabia, Syria, Tunisia, Tajikistan*, Turkmenistan*, UAE, Uzbekistan*, Western Sahara*, Yemen
To be determined (Pretoria)	Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, Zimbabwe
Ms. Sakura Atsumi (HQ) Mr. Christian Oxenboll (HQ)	All other countries in the world

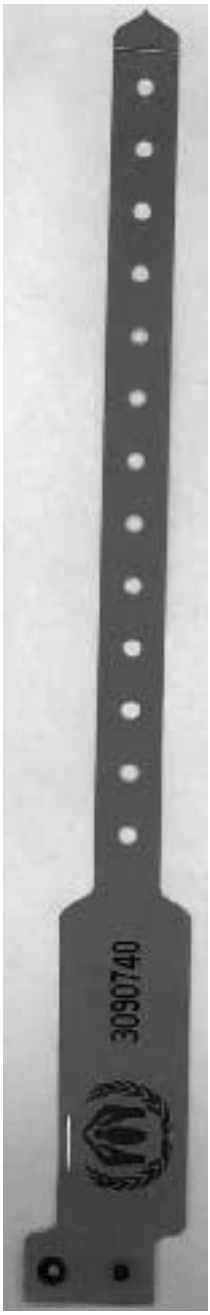
Note:

• Countries added after the issuance of the IOM/ FOM No. 91/2003/ Rev. 1 is indicated with an asterisk (*).

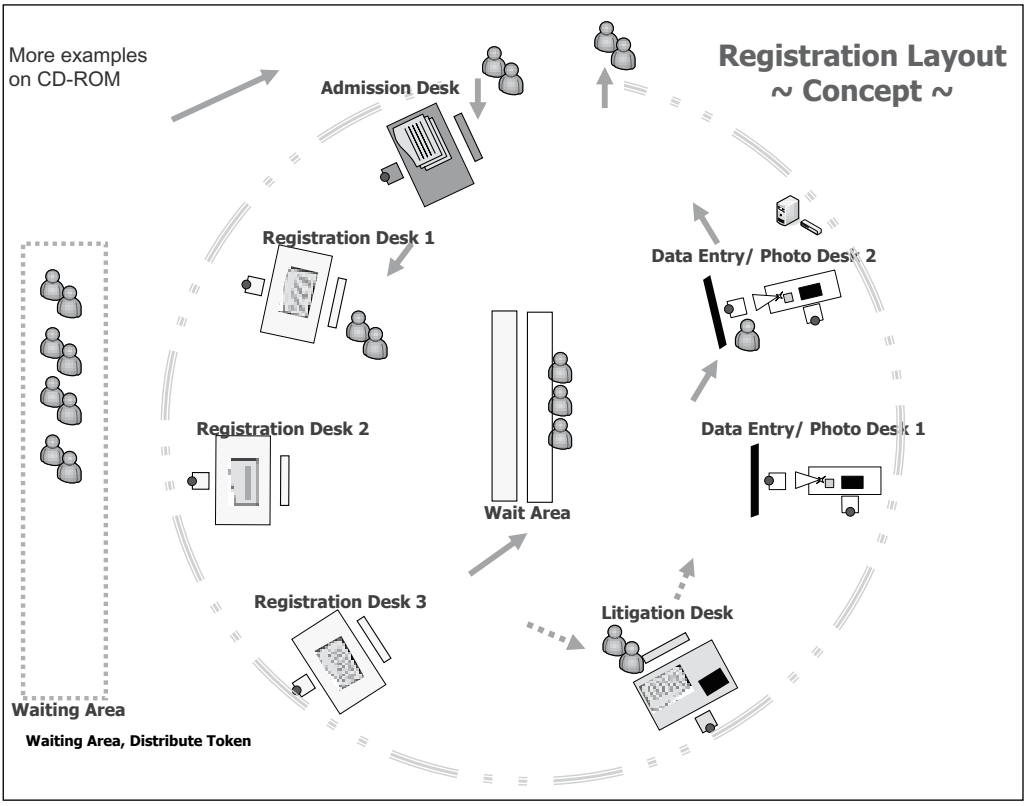
Annex 5: Sample fixing token and wristbands

Fixing token in 3 colours

Wrist band in 4 colours

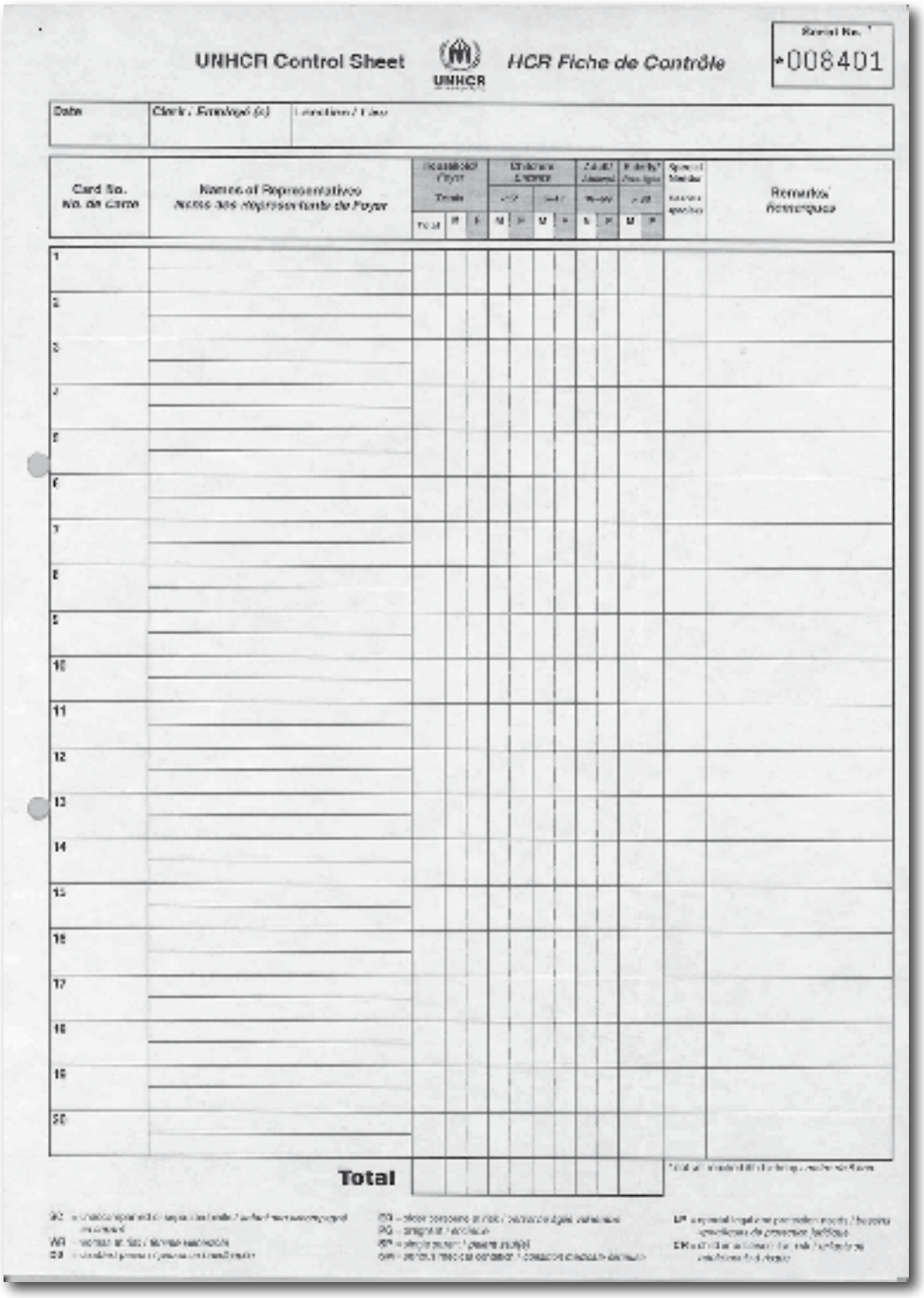


Annex 6: Registration layout - concept



Annex 7: Sample family card

Annex 8: Sample control sheet



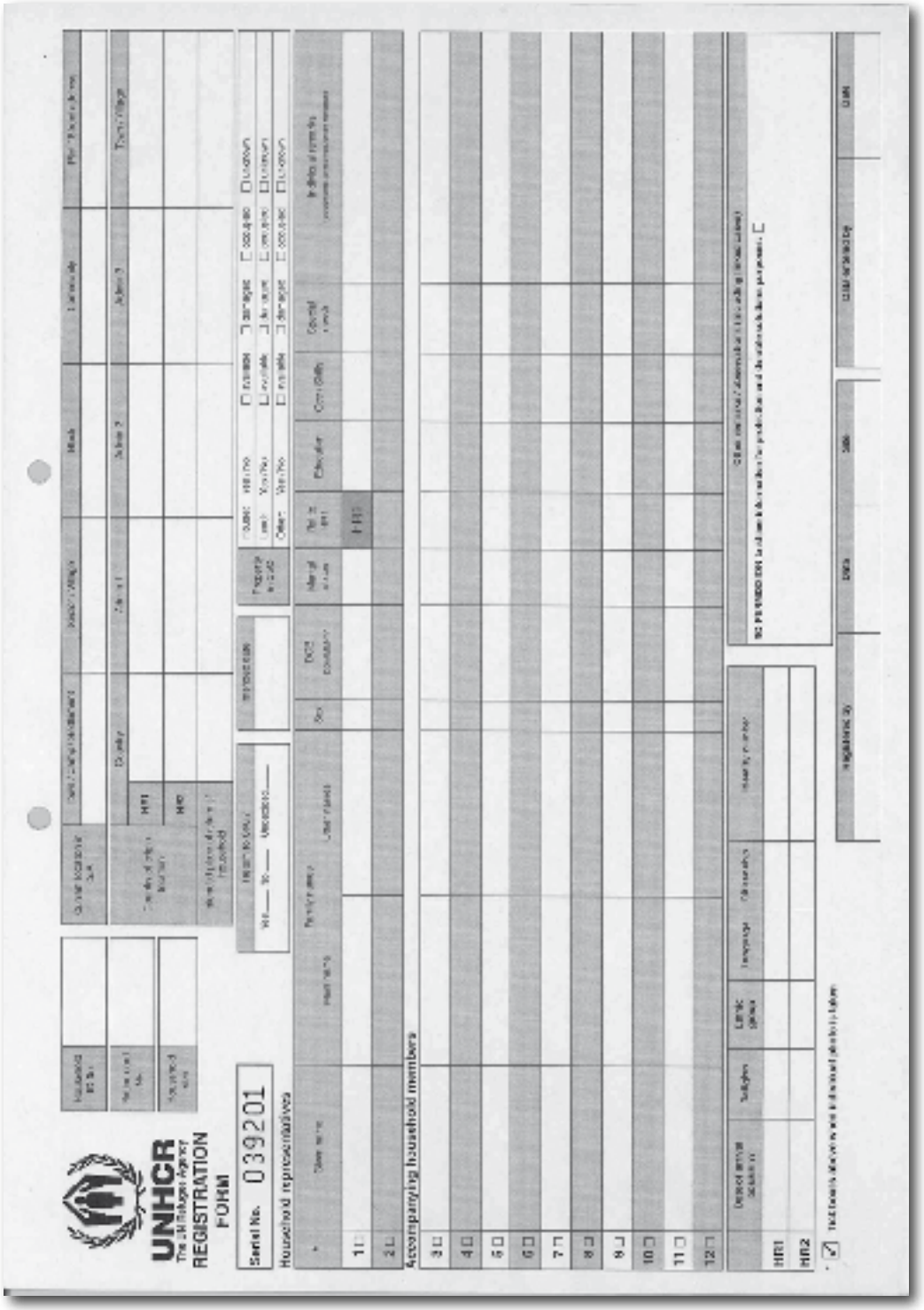
UNHCR Control Sheet — HCR Fiche de Contrôle

Serial No. *008401

Date	Clerk / Employé (e)	Location / Lieu

Card No. No. de carte	Name of Representative Nom du représentant de Foyer	Household Foyer — Total	Children / Enfants — <12 M	Children / Enfants — <12 F	Children / Enfants — >=12 M	Children / Enfants — >=12 F	Adults / Adultes — M	Adults / Adultes — F	Elderly* / Personnes âgées — M	Elderly* / Personnes âgées — F	Special Medical Besoins spéciaux	Remarks Remarques
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
Total												

Annex 9: Sample registration form



Annex 10: Sample codes

Age	Year
1	2004
2	2003
3	2002
4	2001
5	2000
6	1999
7	1998
8	1997
9	1996
10	1995
11	1994
12	1993
13	1992
14	1991
15	1990
16	1989
17	1988
18	1987
19	1986
20	1985
21	1984
22	1983
23	1982
24	1981
25	1980
26	1979
27	1978
28	1977
29	1976
30	1975
31	1974
32	1973
33	1972
34	1971
35	1970
36	1969
37	1968
38	1967
39	1966
40	1965
41	1964
42	1963
43	1962
44	1961
45	1960
46	1959
47	1958
48	1957
49	1956
50	1955
51	1954
52	1953
53	1952
54	1951
55	1950
56	1949
57	1948
58	1947
59	1946
60	1945

This year is:

2005

Age	Year
61	1944
62	1943
63	1942
64	1941
65	1940
66	1939
67	1938
68	1937
69	1936
70	1935
71	1934
72	1933
73	1932
74	1931
75	1930
76	1929
77	1928
78	1927
79	1926
80	1925
81	1924
82	1923
83	1922
84	1921
85	1920
86	1919
87	1918
88	1917
89	1916
90	1915

Month	Abv.
January	Jan
February	Feb
March	Mar
April	Apr
May	May
June	Jun
July	Jul
August	Aug
September	Sep
October	Oct
November	Nov
December	Dec

Marital Status	Code
Married/Common Law	MA
Single	SN
Widowed	WD
Separated	SR
Divorced	DV
Engaged	EG

Relationship	Code
Household Representative	HR1
Wife	WIF
Husband	HUS
Son	SON
Daughter	DAU
Household Representative 2	HR2
Brother	SBM
Sister	SBF
Father	PRM
Mother	PRF
Grandfather	GPM
Grandmother	GPF
Grandson	GCM
Granddaughter	GCF
Uncle	UNC
Aunt	ANT
Nephew	NEP
Niece	NCE
Cousin - male	COM
Cousin (female)	COF
Father-in-law	PLM
Mother-in-law	PLF
Son-in-law	CLM
Daughter-in-law	CLF
In-law (male)	ILM
In-law (female)	ILF
Step-father	SPM
Step-mother	SPF
Step-son	SCM
Step-daughter	SCF
No blood relation (male)	NRM
No blood relation (female)	NRF

Status	Code
Asylum seeker	ASR
Internally displaced person	IDP
Not of concern	NOC
Returnee (returned refugee)	RTR
Refugee	REF
Legal Basis	**Code**
Other/unknown (inc. human status)	HumSt
1951 Convention	51Con
UNHCR mandate	HCMan
Not applicable	N/A
OAU - 1969 Convention	OAU69
Complementary protection	CmPro
Temporary protection	TP

Occupation	Code
Accountant	2411
Agronomist	2213
Artist	2452
Athlete	3475
Baker	7412
Basket weavers	7424
Blacksmith	7221
Builder	7121
Building labourer	9313
Butcher	7411
Car drivers	8322
Carpenter	7124
Carrier	9150
Cattle breeder	6121
Civil servant	1120
Computer expert	2130
Cook	5122
Craftsman	7330
Doctor	2221
Domestic helper	9131
Electrician	7241
Engineer	2140
Farm labourer	9211
Farmer	6111
Fisherman	6152
Guard	9152
Hairdresser	5141
Housewife	5121
Hunter	6154
Journalist	2451
Labourer	4131
Lawyer	2421
Mason	7122
Mechanic	7231
Media	3472
Merchant	3415
Military	0110
Miner	7111
None	NE
Nurse	2230
Plumber	7136
Police officer	5162
Political	1141
Potters	7320
Religious	2460
School teacher - Primary	2331
School teacher - Secondary	2320
Secretary	4115
Shepherd	6120
Shoe maker	7442
Shopkeeper/ Small business	1319
Social Worker	2446
Street food seller	9111
Student	0001
Tailor	7433
TBA/ midwifes	3232
Traditional healer	3241
Traditional leaders	1130
Weavers	7432
Well technician	8113

Education	Code
Primary 1	1
Primary 2	2
Primary 3	3
Primary 4	4
Primary 5	5
Primary 6	6
Primary 7	7
Primary 8	8
Secondary/ Vocational/ Agricultural 1	9
Secondary/ Vocational/ Agricultural 2	10
Secondary/ Vocational/ Agricultural 3	11
Vocational/ Agricultural 4	12
Vocational/ Agricultural 5	13
Technical or Vocational school finished	TC
University	UG
Post University/ Doctor	PG
Informal education	IN
No education	NE
No data	U

Special Needs	Code	Detail
Blind	DS	BD
Deaf and/or Mute	DS	DF
Mentally Disabled (Moderate)	DS	MM
Mentally Disabled (Severe)	DS	MS
Physically Disabled (Moderate)	DS	PM
Physically Disabled (Severe)	DS	PS
Unaccompanied elderly	ER	UR
Single Parent	SP	PT
Unaccompanied minor	SC	UM
Separated Child	SC	SC
Woman at risk	WR	UW

Annex 11: Sample budget, registration staffing and equipment requirement calculation sheet in Excel

XXXXXX Verification / Registration Xxx-Xxx 2005

Total population	14 128
Total households	5 620

Planning Worksheet

Operational Assumptions

1. User pre-populated or blank registration form for the interview
2. Data Entry on site will be kept to minimum bio data and photo
3. Rest of the data entry (comments etc) will be completed in the office

7 hours/day of operational hours

If one interviewer is able to verify/ collect data for **20** households/ day = **50 individuals/day**

(21) minuites/household

and a data entry person takes pictures of **101 Individuals/day**

Interview/ basic data entry / photo capture will finish in **28,1** working days

I. Human Resources

	Staff HCR	Staff à recruter	Cout unit par jour (USD)	Cout Total par jour	Nbre de jrs prestes	Cout total de l'operation en $ US
Superviseur(HCR)	1					
Controleur foule		1	20	20	28	$560
Enregistreurs	5	5	20	100	28	$2 800
Personnel de Protection(HCR)	1					
Bureau controle/Reception(HCR)	1					
Administrateur de la base de donnes	1					
Agents de Saisie(staff HCR)	0	5	30	150	28	$4 200
Assistant de Photo						
Agents Feuille de controle						
Carte de ration(HCR)						
Chargé de la logistique						
Electricien		1	25	25	30	$750
Autorites locales		4	20	80	28	$2 240
Cdt Police		1	20	20	28	$560
Policier(agent securité)		2	10	20	28	$560
S/Total	**9**	**19**				**$11 670**

NB: Les staff du HCR sont responsible de la logistique, cartes de ration et les autres aspects administratives. If faut ajouter le DSA pour les staff en mission (de Bangui)

II.Materiel

		Qte	PrixUnit		
Fournitures de Bureau/consommables					
a. Formulaires d'enregistrement (virges ou pre-populated)		6000	Stock		
b. Bic Bleu		20	Stock		
c. Marqueurs		5	Stock		
d. Classeurs à levrier		10	Stock		
e. Perforateur			Stock		
f. Perforateur carte			Stock		
g. Papier duplicateur			Stock		
h. Agraffeuse		4	Stock		
i. Agraffes		2	Stock		
j. Farde chemise		10	Stock		
S/Total					**$0**
Furnitures Informatiques					
a. Ordinateurs (x6)	new laptops ->	5	1500		$7 500
b. Imprimante (x1)		1 Imprimante	Stock ?		
c. Switched hub 8/16 port (x2)	One spare?	1	33		$33
d. UPSs (x1)		1(Existe)	stock?		
e. WebCams/Tripods (x5)	PROFILE stock ->	5(existent)	stock		
f. Cables RJ 45		10(à fabriquer)	Stock		
g. Draps (mieux Fonds Blancs durs)/		10m	1		$10
S/Total					**$7 543**
Materiel electronique					
a. Groupe 1KVA (x1)		1 generateur	Stock?		
b. Rlx cables de 2,5mm		100 m			
c. Prises avec terres					
d. Chevilles					$1 000
e. Reglette avec tubes de 40 watt					
f. Rallonges electriques					
g. Domino					
S/Total					**$1 000**
Carburant					
a. Gasoil vehicule		600 litres de GO	2		$1 200
b. Essence groupe electrogene		50 litres	5		$300
c.Huile moteur Groupe Electrogene		2 litres	10		$50
S/Total					**$1 550**
Autres materiels					
Megaphone		2	Stock?		
Ciseaux		5 pieces	Stock		
S/Total					**$0**
Imprevus(10%)					**$2 176**
Grand Total					**$23 939**

2001 Executive Committee of the UNHCR Programme (52nd Session)

Conclusion No. 91 (LII)
REGISTRATION OF REFUGEES AND ASYLUM-SEEKERS

The Executive Committee,

Recalling its Conclusion No. 22 (XXXII) on the protection of asylum-seekers in situations of large-scale influx, Conclusion No. 35 (XXXV) on identity documents for refugees, Conclusion No. 39 (XXXVI) and Conclusion No. 64 (XLI) on refugee women and international protection, as well as Conclusion No. 73 (XLIV) on refugee protection and sexual violence;

Noting also that the 1951 Convention relating to the Status of Refugees in article 27, calls on States Parties to issue identity papers to refugees;

Mindful of the importance accorded to registration in the independent evaluation of UNHCR's emergency preparedness and response to the Kosovo crisis;

Welcoming the discussion which took place on registration in the context of the Global Consultations on International Protection;

(a) *Acknowledges* the importance of registration as a tool of protection, including protection against *refoulement*, protection against forcible recruitment, protection of access to basic rights, family reunification of refugees and identification of those in need of special assistance, and as a means to enable the quantification and assessment of needs and to implement appropriate durable solutions;

(b) *Recommends* that the registration of refugees and asylum-seekers should be guided by the following basic considerations:

(i) Registration should be a continuing process to record essential information at the time of initial displacement, as well as any subsequent demographic and other changes in the refugee population (such as births, deaths, new arrivals, departures, cessation, naturalization, etc.);

(ii) The registration process should abide by the fundamental principles of confidentiality;

(iii) The registration process should to the extent possible be easily accessible, and take place in a safe and secure location;

(iv) Registration should be conducted in a non-intimidating, non-threatening and impartial manner, with due respect for the safety and dignity of refugees;

(v) Personnel conducting the registration, including, where necessary, refugees and asylum-seekers, should be adequately trained, should include a sufficient number of female staff and should have clear instructions on the procedures and requirements for registration, including the need for confidentiality of information collected; special measures should be taken to ensure the integrity of the registration process;

(vi) In principle, refugees should be registered on an individual basis with the following basic information being recorded: identity document and number, photograph, name, sex, date of birth (or age), marital status, special protection and assistance needs, level of education, occupation (skills), household (family) size and composition, date of arrival, current location and place of origin;

(c) *Encourages* States and UNHCR, on the basis of existing expertise, to develop further and implement registration guidelines to ensure the quality and comparability of registered data, especially regarding special needs, occupational skills and level of education;

(d) *Also encourages* States and UNHCR to introduce new techniques and tools to enhance the identification and documentation of refugees and asylum-seekers, including biometrics features, and to share these with a view towards developing a more standardized worldwide registration system;

(e) *Acknowledges* the importance to the international community, particularly States, UNHCR and other relevant organizations, of sharing statistical data;

(f) *Recognizes* the confidential nature of personal data and the need to continue to protect confidentiality; also recognizes that the appropriate sharing of some personal data in line with data protection principles can assist States to combat fraud, to address irregular movements of refugees and asylum-seekers, and to identify those not entitled to international protection under the 1951 Convention and/or 1967 Protocol;

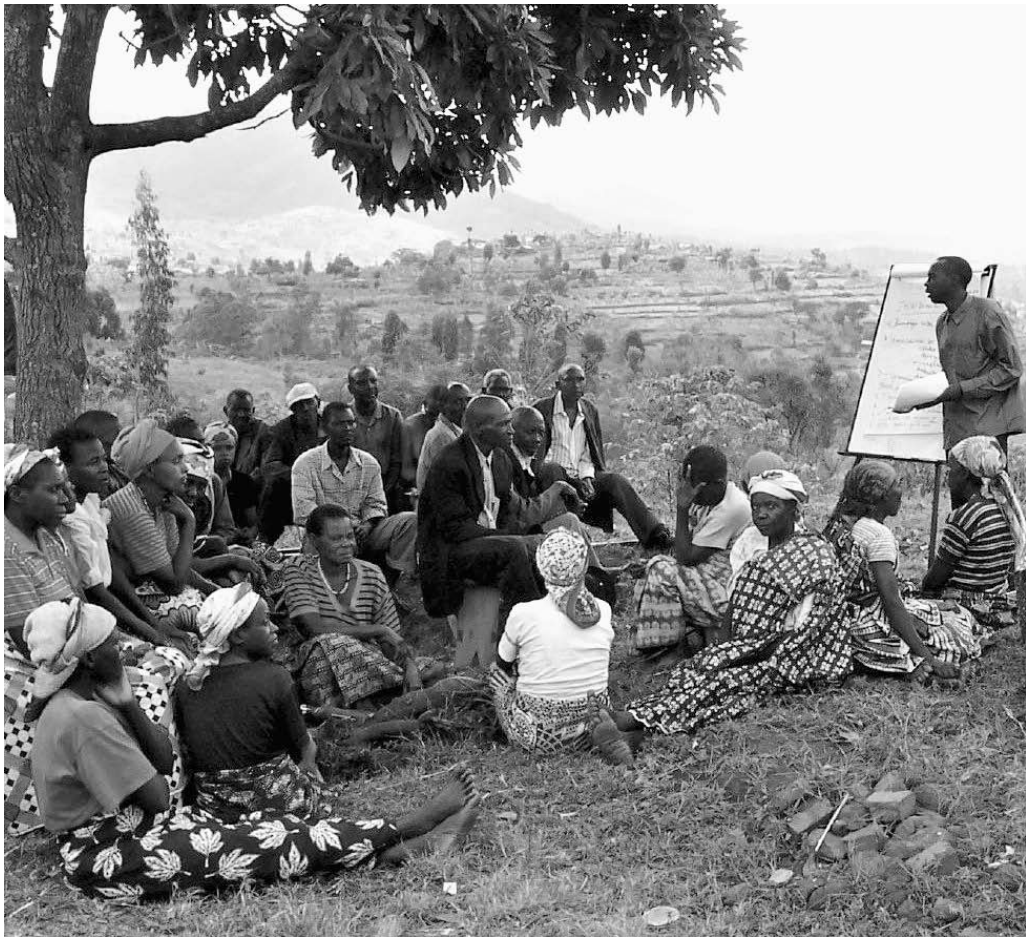
(g) *Requests* States, which have not yet done so, to take all necessary measures to register and document refugees and asylum-seekers on their territory as quickly as possible upon their arrival, bearing in mind the resources available, and where appropriate to seek the support and co-operation of UNHCR;

(h) *Emphasizes* the critical role of material, financial, technical and human resources in assisting host countries in registering and documenting refugees and asylum-seekers, particularly developing countries confronted with large-scale influxes and protracted refugee situations.

10 Population estimation and registration

11

A community-based approach and community services



CONTENTS **Paragraph** **Page**

Introduction

A community-based approach and community services[1]

1. UNHCR's strategy for reinforcing a community development approach[2] emphasizes that all persons of concern should be considered as resourceful and active partners. A community-based approach is an inclusive partnership strategy, a process, and a way of working with persons of concern that recognizes their individual and collective capacities and resources and builds on these to ensure their protection. The approach seeks to understand the community's concerns, capacities, and priorities and to engage women, men, girls, and boys of all ages and diverse backgrounds as partners in protection and programming. In an emergency, the role of UNHCR is to recognize the resilience of the community members, work with them as equal partners in designing, implementing and evaluating protection and assistance responses and strengthen their capacity to build solutions for the future.

Situation

2. Conflict, war, persecution and displacement are devastating for individuals, families and communities. People often lose their livelihoods, their land, their property and belongings and their entire way of living. Displaced women and men are forced to live in makeshift emergency shelter, overcrowded camps and centres while struggling to protect their dependents, particularly young children and those with specific needs such as persons with disabilities and unaccompanied older persons. Adolescent boys and girls are uprooted and find themselves suddenly without the familiar structures of school and home and often face serious protection risks such as military recruitment and exploitation. Women and girls are particularly affected. Sexual and gender based violence is frequently present during conflict and continues into the emergency setting. Much can be done to improve the protection of women, girls, boys and men through the manner in which an emergency is responded to by the emergency team.

3 .Normal and traditional community structures, which may have regulated community well-being, may have broken down. Social and psychological problems are created and exacerbated. New response mechanisms will emerge possibly with new leadership structures, which may or may not be representative of all members of the community. Negative coping mechanisms might also arise as people struggle to meet basic needs. Developing a community-based approach and providing community based services in an emergency requires a full understanding of these community dynamics, the economic, legal, social and political context, as well as the roles of women, girls, boys and men and the power relations between them and between different majority and minority groups.

Objectives

4. During the emergency phase, UNHCR and partner multi-functional teams[3] should work to:

- Implement a community-based approach, including participatory assessment, in the emergency operation to ensure that the follow up phase supports communities to regain control of their lives as quickly as possible.

[1] *The manual Community-Based Approach in UNHCR Operation, will provide details on community-based approach and different techniques for its implementation.*

[2] *Standing committee meeting document Reinforcing a Community Development Approach, 15 February 2001.*

[3] *A multifunctional team is, at a minimum, composed of protection, programme, and community service staff. Ideally, it should include female and male staff, both national and international and of different levels and government and non-government partners.*

- Support the re-establishment and/or development of refugee community-based structures which are representative of the population from an age, gender and diversity perspective and respect international legal standards.
- Provide and support opportunities that are community based to explore livelihoods for men and women with the purpose of gaining food security and earning incomes to meet other basic living standards.
- Provide targeted community-based services for those groups with specific needs and ensure regular monitoring and follow up to identify protection risks and assistance gaps.
- Establish an effective community services system for community-based activities.

Principles in an emergency response

5. Work in partnership and adopt a multi-functional team approach: An effective UNHCR emergency team needs to ensure that protection, programme, community services, field, technical staff and others coordinate closely and adopt complementary working methods, sharing information and agreeing on common goals. Such an approach requires mutual understanding and respect of the complementarity of different functions combined with a respectful attitude to the women, men, girls and boys of concern and a commitment to work with them as partners. A multifunctional team approach includes partnership with government organizations, UN agencies, implementing and operational national and international non-governmental organizations to ensure a multi-lateral ownership for refugee protection. A multifunctional team is, at a minimum, composed of protection, programme, and community service staff and should include female and male staff.

6. Participation and transparency: The first step to setting up a community-based approach is for multifunctional teams to undertake participatory assessment by holding separate discussions with women, men, girls, and boys, including adolescents, in order to gather accurate information on the specific protection risks they face and the underlying causes of those risks, to identify their capacities and resources, and to hear their proposed solutions.[4] Participatory assessment helps to mobilize communities to take collective action to enhance their own protection and encourages individual, family and community self-esteem.[5] The findings from the participatory assessments should be analysed from an age, gender and diversity perspective and be used to define the protection strategy and the emergency operations plan. Teams must also take steps to share the outcomes of the findings, to understand and verify the analysis and planning decisions with the community, as well as work with the different members to evaluate the impact of service delivery early on in the emergency and correct mistakes in a timely fashion. Information, particularly in an emergency, must be disseminated in different manners to reach all people in the community.

7. Equality and non-discrimination: The UNHCR code of conduct states that **"**From the outset of an emergency, refugees and other people of concern to UNHCR must be treated equally and with respect and dignity regardless of race, sex, religion, colour, national or ethnic origin, language, marital status, sexual orientation, age, socio-economic status, disability, political conviction, or any other distinguishing feature".[6] This requires staff to ensure that they take steps to dialogue with persons from different backgrounds and not only

[4] Please refer to the UNHCR Tool for Participatory Assessment in Operations, UNHCR, 2006.
[5] The manual on Community-based Approach provides details on principles as well as techniques in community participation.
[6] UNHCR's Code of Conduct, Commitment Number 1.

focus on leaders, who are often traditionally male. This is particularly important in an emergency. Leaders might be selective in providing and distributing information. This can result in inequitable assistance distribution and serious oversights in terms of protection risks, for example in the case of unaccompanied and separated children, child headed households, young adolescent girls or older persons on their own.

Key Actions to be undertaken using a multi-functional team approach

Implement a community-based approach, including participatory assessment, in the emergency operation to ensure that the follow-up phase supports communities to regain control of their lives as quickly as possible.

8. The implementation of a community-based approach means placing refugee women, men, girls and boys of diverse backgrounds at the centre of decision making for how protection and assistance will be provided at the outset of the emergency phase. This will ensure that protection strategies and the delivery of assistance are adapted to the specific culture, traditions and structures of the refugee community. This approach will enable each community to participate directly in the decisions affecting their future, to regain control of their lives and support their empowerment. A community-based approach seeks to build trust and mutual respect between UNHCR, its implementing partners and the people of concern. In order to facilitate and promote participation and decision-making as well as to obtain a good understanding of the dynamics within the community, the delivery of services must be developed and monitored together with the different members. A constant information exchange should be maintained between the community and service providers on the quality of the services and to monitor that all groups, particularly those with specific needs and those who might be excluded traditionally such as single women, are benefiting from the assistance. Refugees need to know that they should contribute to the decisions, what they can expect, what our limitations might be, the time frame for assistance and based on this information, participate in decisions to prioritize the assistance and its delivery.

Principles of empowerment

9. Awareness raising and critical analysis of the situation: Awareness raising with women and men of concern is a process of critical analysis of their situation and their roles and contributions in resolving protection risks and exercising their rights. The impact of emergency activities should be analysed carefully with both women and men to ensure that they promote empowerment and gender equality and that solutions are identified.

10. Meaningful participation: Participation[7] refers to the full and equal involvement of men and women of all ages and backgrounds in all decision-making processes and activities in the public and private spheres that affect their lives and the life of their community. As women are traditionally disadvantaged and excluded this often requires taking positive action to support women's access to decision-making processes, especially in emergencies.

11. Mobilization: Mobilization is the process of bringing men and women together to discuss common problems and establishing community responses with the support of the humanitarian workers. This can lead to the formation of women's groups, organizations, and networks, and

7 The themes of participation and equal rights in decision-making runs through CEDAW, which refers to the right of women to participate in the political and public spheres, have access to and use of resources, inherit property, to participate in recreation, sports, and all aspects of cultural life, to participate in all community activities, and in decision-making in relation to marriage and family life.

to public lobbying for the recognition of women and men' rights.

12. Access and control: Access and control refer to the opportunities and rights available to women and men to be able to have access to or have control over services, resources, and the distribution of benefits. In the context of an emergency, problems of access and control can have devastating consequences on those excluded and lead to heightened protection risks. Staff need to monitor closely who has access to and control of services that are established. If any excluded groups are identified, such as minority groups, or unaccompanied and separated children, staff will need to work with the community and aid workers to change any discriminatory patterns through empowerment and improved service delivery.

Actions

13. Obtain a good understanding of the operational context through a review of documents and reports on the social, cultural, economic and legal context, including the position of women and gender roles.

- Undertake initial participatory assessments with women, men, girls and boys of diverse backgrounds by engaging in informal discussions with as many different focus groups as possible.
- Find out who does what by sex and age, i.e. what activities do women and girls undertake and where? What activities do men and boys undertake and where? Who controls resources in the community? Who takes decisions?

  Consider the specific needs of particular groups such as older persons living alone, persons with disabilities and child headed households and discuss with the community how they are being cared for and protected?
- Systematize the information to build a picture of the population profile, those most at risk, the overall context, the roles assumed by women, girls, boys and men, and the background and diversity of the people of concern as well as the host population. Incorporate findings into the emergency programme and work with the programme officer to ensure these aspects are budgeted
- Identify relevant key actors such as local authorities (in particular Ministries for social welfare/services, family, gender, etc.), religious leaders, traditional leaders, teachers, political leaders, landowners, implementing and operational partners, or other important stakeholders and make sure that their opinions are reviewed with community members (women and men) and taken into consideration.
- Together with the community, identify and assess resources within the community, such as skills, equipment, tools or existing social projects and initiatives.
- Follow up with regular participatory assessments[8] because in an emergency, the situation is often rapidly changing as people might move from one place to another, the security situation may change and new people can arrive etc. These changes are likely to affect the environment, the relation to the host population and the power balance within the refugee community.
- Keep a continual dialogue with women, men, girls and boys to build trust and confidence and to ensure active participation in planning, implementation and monitoring of service delivery.

[8] *In an emergency the participatory assessment might need to be slightly adjusted. If not all the steps within the tool can be used, parts can be used as a basis. Please see Chapter 5 for more information.*

- Mobilize the community to form organizations and claim their rights by:
  - meeting with them regularly and making sure specific information campaigns are held for women and those who cannot leave their homes;
  - visiting schools and health centres to exchange information;
  - informing people of the assistance programmes;
  - informing people who will do what amongst the agencies;
  - informing people how their views have been reflected in any actions taken and then reviewing the effectiveness of the decisions taken; and
  - Supporting the development of appropriate community management structures, including mechanisms to ensure the meaningful participation of women, children and groups with specific needs.
- Discuss with the community the overall goals of the operation, as well as constraints based on finance, duration of support and personnel.
- Adapt activities to the time and availability of persons of concern.
- Keep a focus on the long-term sustainability and impact of the operation and provide protection and assistance with the aim of self-help and self-reliance.
- Coordinate with local authorities and host communities to set up a framework for peaceful partnership between the refugee/IDP community and the host population.
- Ensure coordination with other agencies to draw their focus to refugee hosted areas in order to support the host community to cope with the influx of refugees.

Support the re-establishment and/or development of refugee community-based structures which are representative of the population from an age, gender and diversity perspective and respect international legal standards

14. Every community has its own system and mechanisms to solve problems. In an emergency situation it is vital to seek to enhance and improve existing positive coping mechanisms which may include family relationships, mutual assistance among neighbours, local, social and economic organizations, community leaders, religious institutions and practices, traditional ceremonies, festivals and traditional healers.

15. Assistance should be channelled in a way that enhances already existing structures and mobilizes resources within the community. It is however important to recognize that existing structures and systems are not necessarily fair and do not always respect human rights, particularly women's rights and children's rights. The arrival of humanitarian assistance can exacerbate discriminatory practices like the exclusion of minority groups from accessing services, resources and decision–making processes and lead to heightened protection risks. It is therefore vital that community structures are analysed in this light and strengthened to ensure fair representation of the community and that they enable meaningful participation of women, adolescents and groups with specific needs.

Communities, culture, tradition and rights

The universality of human rights is often challenged by members of the community on the grounds that local culture and tradition should take precedence. Some UNHCR staff have resisted taking action to promote and protect, for example, the rights of women and girls on the grounds that it would interfere with local culture.

Cultural beliefs are not homogenous and cultures are not static; they are continually being renewed and reshaped.[9] Cultural change is shaped by many factors, particularly conflict and displacement. Change also results from deliberate efforts to influence values through revisions of law or government policy.

International law provides that States are obliged to take measures to modify cultural patterns of conduct with the aim of eliminating customary and other practices that are based on the superiority or inferiority of either sex or on stereotyped roles for women and men.[10] When a tradition or practice is considered by the relevant organ of the United Nations to be directly contrary to an international human rights instrument or standard, UNHCR staff will be guided by the applicable human rights instrument or standard.[11]

Actions:

- Establish good relations with the community to understand the dynamics and social interactions in order to identify the support structures already existing in the community before and after displacement.
- Reactivate and support traditional community management structures and coping mechanisms if they respect human rights and are representative, if not, work with them to promote human rights.
- Support community members to set criteria for leadership and arrange for representatives to be selected by the community and respect principles of democracy.
- Coordinate with agencies on how to work with leaders representing the interests of the displaced community.
- Analyse, with the community, priorities for action and work with them in distributing roles and responsibilities.
- Monitor that women, adolescents girls and boys and groups with specific needs participate in decision making systems for the distribution of food, basic goods and registration.
- Ensure equal participation of women, men of all ages and backgrounds in sectors such as food, health, shelter, education, environment, water and sanitation.
- Ensure constant monitoring of how the assistance is being provided including distribution of food and NFIs (non food items) in order to identify abuse of power, corruption and discrimination.
- Support refugees own initiatives and the creation of cultural, social economic activities and/or religious centres and events. Involve the host population where appropriate.

Women's participation/ empowerment[12]

16. In most refugee and displacement contexts, the roles and responsibilities of men and women change because of the impact of conflict on family and community structures. For example, women may become the breadwinners and men could

[9] *Adapted from Addressing Cultural Relativism in Relation to Gender Equality and Women's Rights: An Approach by CIDA, contained in Gender Training Kit on Refugee Protection, UNHCR, 2002, pp. 175–180.*

[10] *CEDAW, Article 5; DEVAW, Article 4; General Comment No. 28, Equality of rights between men and women (Article 3), 2000, para. 5.*

[11] *For guidance see UNHCR, Code of Conduct and Explanatory Notes, Core Values and Guiding Principles, p. 4.*

[12] *Part adapted from UNHCR Handbook for Protection of Women and Girls.*

get involved in childcare. Displacement can be an empowering or disempowering experience for women. Every day, displaced women actively challenge their traditional gender roles that hinder their participation in the political, economic, and social realms. Displacement in an emergency generally has a higher number of women and children. The inclusion of women in community structures, camp management, economic life, and peace negotiations widens the range of choices available to women, provides them with discretion over their futures, and enhances the quality of their lives and those of their families and communities.

Participatory assessments and an analysis of the findings from a gender perspective are essential for gender mainstreaming. The power relations between women and men and how they impact on women's participation in decision-making, access and control of resources and physical security must be well understood. When violations of women's and girls' rights and inequalities between women and men are identified in an operation, UNHCR programmes must seek to address these through sustainable targeted action.

Key actions

- Ensure that structured dialogue includes a substantial number of displaced women and girls from the outset of the emergency to enable a holistic understanding of the problems.
- Have female staff with a community services background on the emergency team to ensure easy access to displaced women and girls.
- Analyse with women and girls the protection risks that they in particular face and ensure that the operational design considers these risks as well as the delivery of assistance to support them in carrying out their activities, such as sanitary materials, sufficient domestic items and support for dependents (cf section on protection and on prevention of and response to sexual and gender-based violence [SGBV]).
- Work with partners to guarantee women's representation on all decision making structures such as shelter design and layout, NFIs, food and security.
- Ensure individual registration and documentation, including women in polygamous marriages.
- Together with women, decide who will receive the family ration cards.
- Provide female to female medical services so that women will not face barriers to accessing health support.
- Provide conditions/space and time for women's groups to meet, discuss common problems and advise collective strategies and share their experiences and ideas.
- Provide information and awareness to staff and people of concern on the UN Security Council Resolution 1325 on Women, Peace and Security.
- Implement brief sessions, including capacity development in leadership skills for women and on conflict resolution and peace building.
- Raise awareness and promote women's participation in peace negotiations and political governance.
- Promote men's participation in activities that reinforce women's empowerment.

Children's participation

17. Child participation is integral to a rights- and community-based approach. The core purpose of children's participation is to empower them as individuals and members of civil society, giving them the opportunity to influence the actions and decisions that affect their lives.[13]

[13] *This is the draft definition used by Save the Children Alliance as reproduced in Save the Children Sweden, Creating an Enabling Environment: Capacity-building in children's participation, Save the Children Sweden, Vietnam, 2002–2004, pp. 15–16.*

18. The consequences of displacement and the loss of their normal social and cultural environment are devastating for children. Girls may be particularly affected as they are required to assume more adult responsibilities, including domestic chores and caring for younger children, and may not be able to go to school. Many girls suffer sexual exploitation and violence during flight. Further abuse often takes place in displacement for both girls and boys. Children who are unaccompanied and separated or children who are heads-of-households with younger siblings are at particular risk of social marginalization and isolation, and are often overlooked within conflict-affected populations.[14] More information on children at risk is covered under groups and individuals with specific needs.

19. Therefore, ensuring the meaningful participation of girls and boys, in particular adolescent girls, in decisions and activities that affect their lives is essential. Participation will help children to have some structure to their lives, and will enable them to take action to improve their circumstances and their future. Participation also enhances their protection. As girls and boys are given the opportunity to express their views, in safety and in confidence, protection problems and solutions can be identified. Participation is also essential as it helps operations to address the problems faced by girls and boys, as well as build on their resources and capacities. Participation is also a right that can lead to the access and enjoyment of other fundamental rights, including the right to education. Children participate to different degrees; but the deeper the level of participation, the more children are able to influence what happens to them and the greater the opportunity for personal development and empowerment.

Key actions:

- Be sensitive to gender, culture ethics and the power relations within the community between adults and children and between girls and boys.
- Set up informal focus groups with girls and boys to discuss their main concerns in the emergency and to understand how they are coping with the situation.
- Ensure a safe environment where they feel secure enough to discuss their needs.
- Explain the purpose of emergency support and seek their ideas on what should be done and how protection and assistance should be provided.
- Identify experts in child interviewing techniques to support/undertake focus group discussions and follow up actions.
- A sympathetic and imaginative approach to interviewing children is very important and best conducted by carefully trained refugees; if possible by someone the child already knows and trusts. If an interview has to take place through an interpreter, the interpreter must be well briefed, with his or her role limited to direct translation, and must not be allowed to break personal contact between interviewer and child. Children may react very differently. The presence of the child's friend(s) at the interview reassures the child but may also yield important information. Any accompanying adults or persons who brought the child forward should also be interviewed.
- Use simple language and creative activities to facilitate participation among children
- Provide feedback on how their concerns will be addressed.

14 See Adolescent Girls Affected by Armed Conflict: Why Should we Care, a fact sheet issued by the Gender and Peace Working Group of the Canadian Peace-building Coordination Unit and the Women's Commission for Refugee Women and Children.

Provide and support opportunities that are community-based to explore livelihoods for men and women with the purpose of gaining food security and earning incomes to meet other basic living standards.

20. Many individuals in the emergency context are pre-occupied with fulfilling the basic needs of their family members, including finding ways to re-establish their livelihoods even if they are displaced. The process of taking actions to explore livelihood opportunities will provide women and men an avenue to address psycho-social stresses and insecurities by identifying solutions to take control over their lives and gradually gain back their self-confidence. Therefore any initiatives aiming at re-establishing livelihoods should be supported by UNHCR or partners.

Key actions:

- Through focus group discussion with groups of men and women of different age groups, identify the various skills and capacities that they possess. Prepare a roster with names, skills, age and sex. This roster can include doctors, nurses, teachers, water engineers, public heath workers, community workers and social workers, interpreters, water engineers, construction workers, other trades persons, administrators etc, so that NGOs and UN agencies can call upon the professionals and skilled persons to assist with the relief activities.
- Identify informal livelihood skills and capacities people may have and support those which the community consider feasible as well as identify local markets.
- Since women often play multiple roles, ensure that they are not overburdened with additional tasks linked to re-establishing livelihoods. However, if found relevant, do provide them opportunities through organizing group meetings to express their fears and insecurities due to loss of livelihood and their plans to address them and ways in which UNHCR and other partners can support them in implementing these plans.
- Provide literacy training and conduct awareness raising workshops on the entitlements of the displaced persons and on their rights and responsibilities. This may be appropriate for women and adolescent boys and girls. Provide training on women's leadership skills that includes participation in decision-making in community structures, peace building and peace negotiations.
- Co-ordinate with colleagues and NGOs working on environment concerns to introduce fuel efficient stoves.
- Identify local organizations and women's groups and partner with them to support the possibilities with displaced communities to implement their plans for re-establishing their livelihoods so as to address gaps in their living standards.

Provide targeted community based services for groups with specific needs and ensure regular monitoring and follow up to identify protection risks and assistance gaps.

21. In every emergency there will be refugee groups or individuals facing heightened protection risks because of their specific needs, including individuals with trauma related problems. In stable situations, most communities respond to these needs through traditional community structures. Therefore it is important that assistance is community based, focusing on building the community's capacity to meet their needs and, if possible, within the care of their families or neighbours. In an emergency, groups or individuals with specific needs may be unintentionally ignored or excluded, leading to further problems. It is therefore vital to ensure that groups or individuals with specific

needs are not overlooked and/or discriminated and that protection and assistance are provided based on their concerns and needs. (see chapter 18 for information on survivors of SGBV).

Groups with Specific Needs

The following groups are generally considered to need more attention in an emergency than other members of the community, based on their specific needs. However, it is important to remember that this might not be the case for all persons within that group or that these may change according to the context and over time. Rather than targeting labelled groups of people with a standard package of assistance it is essential that an assessment is done to analyse the protection risks facing individuals or groups with specific needs to identify those at heightened risk and the nature of the assistance they are likely to need..

This list is not exhaustive and it is important to not limit the scope of assistance to only these groups, but to ensure that all persons with specific needs in a particular community receive appropriate protection and assistance according to their needs as expressed by themselves:

Girls and boys at risk
Child-headed household
Separated child
Unaccompanied child
Child associated with fighting forces
Victim/survivor of violence

Important medical/health condition
Serious medical condition – chronic illness
Psychosocial needs
Serious medical condition – other
Persons living with HIV/AIDS

Special legal or physical protection need
Survivor of torture/violence in asylum
At risk of deportation
Urgent need of physical protection
Minority group member
Other individual or group excluded or marginalized from the community

Women at risk
Woman associated with fighting forces
Female headed households
Victim/survivor of domestic violence/SGBV
Unaccompanied single woman

Older persons at risk
Older person as caretaker for separated children
Older person with grandchildren
Unaccompanied older person

Persons with disabilities
Physical disability
Mental disability

Other
Single parent
Person requiring family reunion

Key actions:

- Jointly with the community, arrange systematic identification of individuals and/or groups with specific needs.
- Identify those who require immediate attention, such as for example unaccompanied and separated children, sick or malnourished, unaccompanied persons with severe disabilities etc., and those with needs who require medium term follow up.
- Register persons with specific needs so that the operation plans adequately for their protection and assistance.
- Ensure that persons with urgent medical needs and chronic conditions are referred to the health centres for immediate treatment.
- Provide a “fast-track” queuing system for registration and distribution purposes for persons with specific needs, in particular in regards to older persons or persons with disabilities.
- Establish up-to-date records and confidential individual files and a simple periodic reporting system, focusing on the needs identified and services provided as well as statistical data.
- Jointly with the community, and those affected, agree on a system to provide

basic services to groups with specific needs and monitor delivery of services and implementation of follow-up actions.

- Ensure that groups or individuals with specific needs are able to access distribution points and are not neglected in the delivery of goods: if necessary arrange for separate queuing systems or arrange for goods to be delivered to persons not able to attend distribution gatherings. Monitor the distribution of goods to groups or individuals with specific needs so that to ensure that they are not being discriminated or taken advantage of.
- Monitor the construction of shelter, water and sanitation facilities to ensure that they are adapted to individuals with specific needs.
- Provide transport for individuals with physical disabilities, frail older persons, women in late pregnancy or persons in severe psychological distress to access medical and other services as appropriate. Ensure that the person of concern is accompanied by a responsible attendant (usually a relative) and that a clear meeting point has been identified to prevent separation from family members.
- Avoid unnecessary repetition of basic interviewing, which might jeopardize the confidentiality as well as be traumatic for the person of concern, by ensuring that case records are being transferred if individuals with specific needs are being moved.
- Identify and strengthen local institutions which have facilities for care and treatment, such as clinics, schools, hospitals and recreational facilities.
- Undertake participatory assessment with groups or individuals with specific needs and ensure that they are able to attend meetings or conduct home visits to gather their views and incorporate them into operational planning.
- Provide incentive opportunities/training/employment/income-generating opportunities for those with specific needs or their families to facilitate support and longer term solutions.
- Assign tasks adapted to their disability and skills and personal situation.
- Undertake special measures to ensure that groups with specific needs are fully informed on protection and assistance measures and in particular distribution systems.
- Keep in mind that displaced persons most in need are often the least likely to come forward to make their needs known!

Women at risk

22. Different groups of women exposed to risk: Although not all women are at risk or exposed to protection problems, it is important to identify those women who are specifically at risk due to gender-related reasons. Protection problems include expulsion, refoulment and other security threats. Women may be survivors/victims of sexual and gender violence. Women torture survivors and those associated with fighting forces can also be at risk. Women could also experience different forms of exploitation like forced labour and face acute economic hardships or marginalization forcing them into engaging in risky behaviour, including survival sex. Groups or individual women could face discrimination and community hostility. Protection problems can become exacerbated based on family composition. Individual or groups of women at risk can be categorized either as single woman household, unaccompanied girls (please refer section 104 for unaccompanied and separated children), survivors of SGBV etc. Please refer to the chapter 18 on SGBV for planning and suggested actions in emergencies.

Key actions:

- Undertake focus group discussions with various groups of women to identify those single women who are at risk and require immediate responses and follow up with individual interviews to set up a case management system.
- Design and plan emergency responses that take into consideration the specific needs of those groups of women who are identified as "at risk", so as to ensure emergency assistance is provided and followed up with discussions for agreeing on other short term action plans.
- Combine a variety of methods like follow-up visits, observations and individual discussions to monitor the targeted assistance and support and check if the protection impacts are positive and as intended on the individual or group of women who require these targeted actions.
- Organize community meetings to ensure that established community structures are taking responsibility for providing community protection and support to individual and groups of women at risk.
- Identify and partner with women's groups and NGOs to support activities that undertake case work and draw up plans of action with individual women at risk.
- Ensure that women exposed to risk have opportunities to participate in any women's group activities that are organized for information sharing and raising awareness on entitlements etc.
- Undertake brief awareness raising workshops with local NGO partner staff members and community leaders so that the concept of individual and groups of women at risk are understood and response actions are supported.

Unaccompanied and separated children

UNHCR defines a separated child as a child, separated from both parents, or previous legal or customary primary care-giver, but not necessarily from other relatives. (it may therefore include children accompanied by other adult family members.)

An unaccompanied child is defined as a child, separated from both parents and other relatives and is not being cared for by an adult who, by law or custom, is responsible for doing so.

Orphans are defined as children, both of whose parents are known to be dead. In some countries, however, a child who has lost one parent is called an orphan.[1]

23. Children separated from their immediate next-of-kin during an emergency are often cared for by the displaced community, frequently within an extended family. It is only where children cannot be cared for by the community that special measures will be required for their care, but the situation of all unaccompanied and separated children should be monitored. Although the government of the country of asylum should take legal responsibility for these children, in practice if government resources are thinly stretched, UNHCR may have to take a more pro-active role.

24. The failure to protect family unity not only results in physical and emotional suffering, but subsequent efforts to reunite families are costly and difficult, and delays in family reunification will impede durable solutions. Continuity of existing care arrangements will help avoid further disruption and may facilitate reunion. Siblings should be kept together, as should unrelated children who have been living together and give each other emotional support.

[15] These defintions have been endorsed by the following agencies: International Committee of the Red Cross, the International Rescue Committee, Save the Children UK, UNHCR, UNICEF and World Vision International.

25. There is sometimes pressure to rescue children from dangerous situations but some child-only evacuations have caused years of separation and in some cases the breaks have been permanent. The physical dangers may be over estimated, while the children's psychological need to be with their parents may be under appreciated.

26. An assessment must be conducted to establish the extent of familiy separation and the situation of affected children. This should be carried out at the earliest possible stage of any emergency as part of a broader situation analysis in order to develop an appropriate response.[16]

27. Whenever possible, children should be placed with families and not be subject to institutional care. Ideally, they should be cared for by relatives or others from the same ethnic or cultural groups.[17] An unaccompanied child must be placed in a family where bonding can continue until the parent(s) or previous legal or customary primary care-giver is found. The child will then need time to re-establish a bond with his or her parent(s) or the previous legal or customary primary care-giver(s). A period of overlap with the two families may therefore be necessary, in order to permit the re-establishment of the relationship with the parents while avoiding an abrupt severance of the ties with the foster family. Where years have elapsed, the child's interests may be better served by remaining with the foster family. However, a formal individual Best Interests Determination is required to determine the best durable solution for the child (see below and UNHCR guidelines on Formal Determination of the Best Interest of the Child, 2006).

28. Criteria for foster family care should be worked out together with the community. Foster care arrangements should be formalized as quickly as possible by signed agreements, with an understanding that if the child's own family is traced, reunification is to go ahead.[18] The child should continue to have registration and ration documents separate from those of the foster family. Foster care arrangements should be monitored closely and regularly through outreach activities in the community and careful account should be taken of cultural attitudes towards fostering. Monitoring should also include the care arrangements of separated children, who are living with adult family members/relatives to ensure that children in foster care are not subject to exploitation, abuse, neglect or denial of other rights. While payment of individual foster families should be avoided, programmes should focus, in the context of wider community-based activities, on enhancing the ability of families to support the children in their care. Fostering of refugee children by families of the host country should be discouraged, as this puts these children at additional risk of abuse and exploitation and their situation is difficult to monitor.

Best Interest Determination

29. The use of Best Interests Determination (BID) is a means to ensure that specific protection and assistance is provided to children who are or may become deprived of the protection of their family. It is a necessary tool to ensure that all factors and rights under international law are taken into account when making a decision that has a fundamental impact on the child. The formal and documented proc-

[16] *Please see page 30-32, Tracing and Family Reunification in the Inter-Agency Guiding Prinicples on Unaccompanied and Separated children.*

[17] *Please see page 42-51, Care Arrangements in the Inter-Agency guiding Prinicples on Unaccompanied and Separate Children.*

[18] *While family reunification should be a priority, the decision to return a child to the country of origin for family reunification should be based on the best interest of the child. Family reunification should be balanced with, for example, the conditions in the country of origin, conditions in the country of asylum, the wishes of the parents and those of the child.*

ess enables UNHCR staff and partners to ensure that decisions are in line with the provisions and the spirit of the Convention on the Rights of the Child and other relevant international instruments and are set within a human rights framework. It ensures that such decisions take due account of the fundamental right to life, survival and development of the child to the maximum extent possible.

30. A determination of what is in the best interests of the child will have a fundamental and often long-term impact on the child. It requires a clear and comprehensive assessment of the child's background, particular specific needs and protection risks, while analysing this from an age, gender and diversity perspective, thus making it essential that suitably qualified personnel are involved in gathering information and determining the best interests of the child. A report and an assessment made by a specialist on protection, community services, or child welfare, to a multi-disciplinary panel capable of considering each child on a case-by-case basis, is the most appropriate mechanism for undertaking a BID.

Key actions:

- The description "unaccompanied children", or "separated children", should always be used in place of "orphans" in particular since the status of these children is rarely immediately clear in an emergency. Labelling children as orphans tends to encourage adoptions, (and in some cases, there may be enormous external pressure for orphanages and/or third country adoption) rather than focusing on family tracing, foster placements and increasing community support.
- Make a rapid assessment of the situation of unaccompanied and separated children, girls and boys, among the refugee population. Priority should be given to children under five years, child headed households and boys and girls at risk of (sexual) abuse, exploitation or military recruitment.
- Agree with the community on mechanisms to identify unaccompanied and separated children and who the children should be referred to for registration.
- Once identified, unaccompanied and separated children should be individually registered as soon as possible (see Annex 2 for the inter-agency registration form for unaccompanied and separated children).
- Ensure that unaccompanied and separated children are issued with separate registration documents and ration cards and that these documents (including a recent photograph), always travel with the child. These measures will avoid confusion if a fostering arrangement breaks down.
- As soon as unaccompanied and separated children are identified, start to trace their parents or families. Family tracing is not considered exhausted before a two year investigation has been completed. All claims for reunification must be verified, as mistakes and false claims sometimes occur.[19]
- Do not undertake evacuations which separate children from their parents or others recognized as primary caretakers (custody) unless essential to protect life and after careful determination that protection and assistance cannot be provided in place and that evacuation of the entire family is not feasible.
- If an evacuation is essential, the following safeguards should be observed:
  - Children should be accompanied by an adult relative, and if this is not possible, by a qualified caregiver known to the children, such as their teachers.

[19] *Please see page 47-39, Verification and Family Reunification in the Inter-Agency Guiding Principles on Unaccompanied and Separated Children.*

- The children's identities must be fully documented before departure. Whenever possible, documentation should travel with the children, and caregivers should be waiting at the destination. The evacuation must be co-ordinated with the designated lead agency.
- If the children are moved across an international border, written agreements with the government should be secured in advance in order to ensure family visits and reunions are possible.[20]

- Interim care must be provided to children who are unaccompanied or separated and where possible this should be in families within the child's own community, with close monitoring. The opinion of the child regarding the care arrangement should be taken into consideration.
- Where institutional care is necessary,[21] it should be small, decentralized within the community, and integrated into community activities.
- Unaccompanied and separated children should be integrated into the life, activities and services available to other children to ensure that they are not marginalized.
- Ensure continuity and stability in care (foster families and other) by employing refugee and national community services staff who are less likely to move on than international staff.
- Provide supervision, support and training to child care workers, including child interviewing techniques, child development, community mobilization and child trauma. Train refugees and aid workers to identify and register unaccompanied and separated children, girls and boys, from the outset of an emergency.
- Stigmatization needs to be avoided and the social integration of children orphaned by war, HIV/AIDS or other misfortune should be facilitated.
- Ensure that the BID is child-centered, gender sensitive and guarantees the child's participation.
- While conducting a BID take into account the views of the child and of persons close to the child and gather information on:
  - Key personal data of the child
  - History prior to separation
  - History of separation and flight itself
  - History after flight and current situation
  - The child's age and maturity
- Identify follow-up measures to address protection gaps as identified jointly with the child and person(s) close to the child and have a BID panel make a decision on the best interests of the child based on the report and assessment of a BID specialist.

Child headed households:

- Analyse the protection risks and assistance requirements of child-headed households with the affected persons and develop specific assistance packages accordingly.
- Pay particular attention to the shelter requirements of child-headed households and ensure that they are placed in locations where they will obtain the support and "monitoring" of responsible community members.
- Assistance to children who are heads of households should be integrated in any given community with overall as-

[20] *The InterAgency Guiding Principles on Unaccompanied and Separated Children (page 24-26) provides some useful guidance in addition to the points mentioned here, e.g. children should be given the opportunity to express their opinion, which should be taken into consideration; agencies or individuals should evacuate children only as part of a coordinated plan of action; informed consent of the parents.*

[21] *Institutionalization should be seen as a last resort even during emergencies.*

sistance to children in need of special protection.

- Monitor the delivery of all services to child-headed households and be aware of any potential for exploitation and abuse as this particular group is easily exposed to such protection risks.
- Provide child-headed households information on the services that are available to them and evaluate the delivery of assistance with them.

Family tracing and reunification

31. Tracing and reunion of separated family members is a priority action in emergencies and should be organized as quickly as possible, using all possible means in coordination with other agencies. Where possible, facilitate mailing services for refugees and IDPs to support tracing and reunification.

Key actions:

- Procedures for the reunion of refugee family members separated during flight or within the country of asylum should be agreed with the authorities and partners, in particular ICRC and implemented as soon as practicable.
- Tracing programmes should be set up and co-ordinated in the country of asylum, country of origin and regionally. At camp or local level, simple and effective tracing mechanisms include posting lists of names with photographs on the community notice boards in different locations, using the radio, or even making announcements by megaphone.
- The tracing arrangements must be widely promulgated; a central contact point in each site is likely to be needed. Tracing is a delicate task, and has to be organized by people who have the necessary experience and skills. A suitably experienced agency may be needed to implement these activities.
- Tracing requires the involvement of the refugees themselves, who will play a key role. The local population and authorities also play an important role.
- Confidentiality of information and protection of individuals is essential.
- Consider the causes of separation when establishing tracing systems. Separation may have been caused by large scale population movements but may also have been due to other factors such as children opting to leave their families, or placement of persons outside their family for survival purposes. Outsiders, often relief workers, may have removed a child from an apparently dangerous situation, without informing the family and without proper documentation.
- Combine a variety of systems: on the spot tracing, use of community mechanisms and formalized tracing at a regional level.
- Coordinate activities with agencies having expertise, e.g. the ICRC. Note that ICRC procedures, using the national Red Cross or Red Crescent societies, can be lengthy but may be the most appropriate for difficult cases.
- Ensure regional standardization of registration systems.
- Agree upon a communication network in the community, including a mailing system. A properly organized exchange of news (Red Cross messages) may considerably diminish the workload of a tracing service and accelerate the reunion of family members. Refugees have the right to send and receive mail.

Older persons

32. The UNHCR policy on older persons stresses the importance to see older refugees as active and contributing members in the community and emphasizes that older refugees have valuable resources and skills and can provide guidance and

advice in the actual displacement context as well as in the rebuilding of community structures.

Unaccompanied older persons

33. Unaccompanied older persons have particular challenges in emergency situations such as finding adequate accommodation. The standard issue of one tent per five persons may lead to them having to share with strangers, as well as being unable to protect their belongings while struggling to collect water, rations and fuel. Older persons risk being neglected in NFI distribution because they might not be able to attend the distribution or might need assistance in carrying the distributed items back to their shelter.

Grandparent headed households

34. In normal situations, older persons are often taken care of by their children. In emergency refugee situations family members might have become separated or have died, leaving older persons without their traditional family support mechanisms. In addition, in the absence of the parents, many older persons become the main care givers for their grandchildren. Without being able to fend for themselves, older persons risk becoming dependent on their grandchildren for the collection of fuel, water, food and economic activities.

Key actions:

- Undertake participatory assessment with older women and men to learn about their protection risks and concerns, as well as to seek their advice on solutions and traditional community practices for resolving problems.
- Design the emergency response taking into consideration the specific needs of older persons requiring additional support in areas such as:
- Shelter - ensure that the entrance to the shelter is high enough so that people do not have to bend to get in and out of the shelter.
- Food - consideration should be given to include undernourished older persons in the supplementary feeding programmes and the food basket should include items that older persons can consume/eat/chew easily. Arrange with WFP to provide grinding machines to ease access to ground soft cereal food.
- Water and fuel - limited mobility may preclude collection of water or fuel essential for food preparation and other basic needs.
- NFIs – ensure appropriate distribution, such as the number of blankets taking into account their age and health requirements.
- Set up a community-based distribution system involving neighbours and family members for provision of food, water, fuel and NFIs to older persons.
- Identify neighbours, relatives or others who can assist with food, water or fuel collection for grandparent headed household to allow children to be released from chores so that they can attend school.
- Find creative ways of including older persons in activities such as advisory groups on issues regarding the community, awareness raising groups for issues concerning adolescents and children and build on skills such as, for example, skills in traditional birth attendance.
- Regularly visit grandparent-headed households to monitor their welfare and provide support.

Persons with physical and mental disabilities

35. Initial care for women, men, girls and boys with disabilities should be through families and the community, whereas rehabilitation service such as wheel chair, crutches etc, should be introduced as soon as possible. The participation of persons with disabilities through participatory as-

sessments is essential because it will lead to better protection, as well as raising their self-esteem and help to reduce isolation. It is also important to note that persons with disabilities are at risk of sexual exploitation and violence and their protection situation should be regularly analysed with them through home visits and focus group discussions.

Key actions:

- Adapt the time and place for participatory assessments so that persons with disabilities are able to attend or visit them at home.
- Review how the community traditionally cares for persons with disabilities and ensure that these respect human rights standards.
- Adapt distribution systems so that persons with disabilities are able to access basic goods and work with the community leaders to arrange for "home delivery" of all items.
- In coordination with the community, appoint caregivers for persons with disabilities from among family and neighbours.
- Work with persons with physical and mental disabilities and their caregivers to ensure their specific needs are taken into account in sectors such as site planning, health, shelter construction, water, sanitation and education, as well as in defining nutritional needs, and food and NFI distribution.

  Coordinate with health institutions and organizations to include IDPs or refugees with disabilities into programmes of the host country.

Psychosocial needs

36. Most societies have some form of coping mechanisms for mental health conditions and an interpretation of what trauma is and ways of responding. In some societies healing is seen as a collective process promoted by the conduct of spiritual and religious practices. These beliefs shape people's behaviour and well-being and need to be taken into consideration[22] when building an appropriate response which supports communities to respond to psychosocial needs.

Key actions:

- Identify and analyse with the community, both women and men, the traditional forms of coping with trauma and who are the key actors in these processes.
- Explore whether the community based mechanisms respect human rights, particularly in relation to women and girls.
- Work with the main community actors to see how support can be provided to community-based mechanisms which respect human rights.
- Advocate for and integrate appropriate community-based psychosocial support in the emergency preparedness and contingency planning.
- Include and support traditional healers and/or religious leaders in psychosocial assistance programmes if appropriate.
- Provide appropriate psychological, social, economic, educational and medical support to survivors of rights violations and encourage active participation of the survivor in family and community activities.
- Encourage the re-establishment of normal cultural and religious events, as well as other activities, in order to support social networks.
- Promote the establishment of child-friendly spaces (which provide among others, recreational activities, psychosocial support, information on issues like hygiene, HIV/AIDS, and child rights, and access to trusted adults) and establish education systems as soon as possible even if in

[22] *Janaka Jayawickrama and Eileen Brady Trauma and Psychosocial Assessment in Western Darfur, Sudan, 2005.*

makeshift conditions. This will help in restoring some kind of normalcy and providing a daily routine and structure.

- Involve adults and adolescents in concrete, purposeful, common interest activities (e.g., constructing/organizing shelter, organizing family tracing, distribution of food, teaching children etc).

Establish an effective community services system for community-based activities

37. The purpose of adopting a community-based approach is to ensure that the emergency protection and assistance response is effective and to ensure sustainability of the programme through participation of the concerned community members from the initial stages. The participation of the host government, refugee/IDP communities and host population will create a sense of ownership of initiatives undertaken jointly and will help in handing over the responsibility of managing the programmes when the emergency phase is over.

38. The implementation of a community-based approach and ensuring adequate protection of groups with specific needs requires the establishment of an effectively trained and managed community services team. This team will comprise of both international and national staff, as well as support outreach workers from the host and displaced community. During the emergency phase, deployed community services staff will play a key role in setting up this system with national government partners, as well as national and international non-government partners. By the end of the initial emergency phase it is important that a Community Services Action Plan has been established to enable a smooth handover.

Key actions:

- Identify national government structures which can provide staff and support to the community services strategy and avoid setting up parallel structures where local and national facilities already exist.
- If possible, make an agreement with the national government structure to provide resources to support the implementation of community-based services.
- Identify all local and international non-government organizations with expertise in community-based services already working in the area and learn from their experiences.
- Together with these existing structures, assess community services staffing and resource needs, including the services of interpreters.
- Ensure the recruitment of local staff with knowledge of the culture and language of the community.
- Monitor the security of national staff to avoid harm while dealing with sensitive situations.
- Assess training needs of all staff and implement briefings on main issues until there is more time for more in-depth training. Prioritize training in:
  - CBA, including participatory assessment for the establishment of systems for identification;
  - registration and monitoring of those with specific needs;
  - prevention and response to SGBV;
  - Code of Conduct training; and
  - gender issues and people oriented planning.
- Ensure that all community services staff signs the Code of Conduct and the confidentiality agreement.
- Based on the findings of the initial participatory assessment, work with the team and community members to establish a Community Services Plan

of Action share it with all members of the multifunctional team.

- Work with local authorities on the recruitment of staff from the host community to reduce any potential for tension while taking into consideration local politics, security issues and other factors particular to the context.
- As much as possible, support local and national structures to include refugees and persons of concern as interpreters and outreach workers and in the provision of services. If interpreters are selected from the refugee or host population ensure balancing selection by age, gender and diversity and monitor them closely to ensure their security in sensitive situations.
- In all community services staffing structures ensure a gender balance is maintained and promote the same policy with all humanitarian workers, in particular UNHCR implementing partners.
- Build the capacity of the community by identifying training needs and by helping to organize practical and hands-on training in community work.
- Based on joint assessments with the refugee community, support the establishment of refugee or IDP community outreach teams, including persons from the host population, both men and women. Jointly with the community select community outreach workers based on their previous skills, including women and men and youth.
- Jointly with the community provide terms of reference for the community outreach team including tasks such as:
  - identifying resources, protection risks and needs;
  - collecting and disseminating information;
  - assisting in documentation and registration with a focus on groups with specific needs;
  - referring persons to units within UNHCR and/or its implementing or operational partners; and
  - establishment of community-based services and monitoring to support groups with specific needs.
- Train refugee community workers and draw on their own knowledge of their community, and make use of outside expertise (from within the host country if possible). Over time training should cover community outreach techniques, a community-based approach, gender awareness, children's rights, and include inputs from other disciplines such as public health, reproductive health, HIV and AIDS, nutrition, sanitation, protection, water and environment.
- Monitor the performance of the community outreach workers to ensure impartial assistance and confidentiality and evaluate their performance with the diverse groups among the community, as well as the work of the community services team as a whole.
- Coordinate with authorities of the host country for them to include refugees and IDPs in their programmes.
- As far as possible ensure continuity of staff in order to strengthen the relationship between UNHCR and the refugee/ IDP community.

Key references

- UNHCR Tool for Participatory Assessment in Operations
- "A community-Based approach to UNHCR operations" provisional release in 2007
- "Interagency guideline Mental Health and Psychosocial response in emergencies"(IASC)
- "Concept of Care" Trauma and psychosocial assessment in Western Darfur- Sudan 2005
- Interagency Guiding Principles on Unaccompanied and Separated Children
- UNHCR refugee Children Guidelines
- IOM/FOM/62/2006 - Sexual and Gender Based Violence SGBV
- Executive Committee of the High Commissioner's Programme Conclusion No. 105 (LVII), 2006, on Women and Girls at Risk
- INTERNAL DOCUMENT - UNHCR Guidelines on the Sharing of Information on Individual Cases - Confidentiality Guidelines
- UNHCR Policy on Harmful Traditional Practices Ref ADM 1.1, PRL 9.5,
  OPS 5.41 Dated 19 December 1997
- Information and Training Resources on Combatting Trafficking of Women and Girls for Sexual exploitation and Domestic Slavery. Compiled by UNHCR's Bureau for Europe, July 2004
- IASC GBV Guidelines
- List of resource materials for SGBV Training Of Trainers

11 A community-based approach and community services

12

Site selection, planning and shelter

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Situation

Suitable, well-selected sites and soundly planned refugee settlements with adequate shelter and integrated, appropriate infrastructure are essential from the early stages of a refugee emergency as they are life-saving and alleviate hardship. Accommodating refugees in emergencies may take the form of host families/communities, mass accommodation in existing shelters or organized camps. Initial decisions on the location of the camp should involve the host government as well as local authorities and communities. Likewise, layout should involve refugees. This approach is necessary to avoid long-term protection issues such as conflict with local communities and to ensure a safe environment for the refugees and the delivery of humanitarian assistance.

Objectives

To provide suitable sites and shelter, in order to accommodate refugees in emergencies.

Principles of response

- In addition to meeting the immediate needs, planning should take into consideration the long-term provision of services even if the situation is expected to be temporary.
- Decisions on site selection and camp planning are very difficult to reverse, therefore seek technical support.
- Avoid high population density congestion in settlements and in accommodation;
- Avoid very large settlements; refugee camps should normally be considered as the last option.
- Involve refugees in all phases of settlement layout and shelter design and construction.
- Use a bottom-up planning approach, beginning with the smallest social units, preserving traditional social arrangements and structures as far as possible.
- Develop a comprehensive master plan with a layout based on open community forms and community services, such as water points, latrines, showers, cloth washing facilities and garbage collection to promote ownership and maintenance of the services.

Action

- Identify the most suitable option or combination of options for accommodating the refugees.
- In the case of planned camps, assess the suitability of the refugee site and ensure that it meets the basic criteria.
- Provide suitable shelter.
- Simultaneously assess the most immediate needs for emergency shelter and provide the necessary materials that cannot be met from locally available resources.
- In the case of spontaneous settlement, identify the most urgently required measures to improve site planning and layout, and implement these as soon as possible.

Introduction

1. Aside from a life-saving measure, having a place to live is a basic human right and this should be upheld by providing shelter and a friendly environment. The layout, infrastructure and shelter of a camp will have a major influence on the safety and well-being of refugees. Therefore, other vital sectors such as water (good quality, quantity and ease of access), sanitation, administration and security, food distribution, health, education, community services, and income-generating activities should be taken into consideration during the humanitarian response.

2. Most refugee operations last much longer than initially anticipated, therefore, site selection, camp planning and provision of assistance should take this into consideration as well as bearing in mind the exit strategy from the start.

3. The role and responsibility of the local and national authorities in site selection is of fundamental importance. Equally, the refugees themselves must be involved as early as possible. Ideally, the needs and human rights of the refugees should determine the size and layout of the site. In practice, a compromise has to be made when considering all of the relevant elements.

4. good site selection, planning and shelter will:

i. uphold UNHCR's protection mandate;
ii. minimize the need for difficult, corrective measures later;
iii. make the provision of services easier and more cost-effective; and
iv. ensure most efficient use of land, resources and time.

5. Emergency refugee settlements generally fall into one of three categories:

i. dispersed settlement/host families;
ii. mass shelter; and
iii. camps: (a) spontaneous and (b) planned.

Dispersed settlement/host families

6. This type of arrangement is where the refugees find accommodation within the households of families who already live in the area of refuge. The refugees either share existing accommodation or set up temporary accommodation nearby and share water, sanitation, cooking and other services of the pre-existing households.

7. Accommodation is often found with extended family members or with people of the same ethnic background. This type of arrangement may occur in rural or urban settings. The advantages of this type of settlement are:

i. quick implementation;
ii. limited administrative support is needed;
iii. low cost;
iv. fosters self help and independence; and
v. it has less impact on the local environment than camps.

8. The disadvantages of this type of settlement are:

i. the host families and communities can become overburdened and impoverished;
ii. it can be difficult to distinguish the host population from the refugees and this may pose problems where population estimation and registration are required;
iii. protection, nutrition and health problems may not be as easy to detect as when the population is more concentrated; and
iv. shelter and other forms of assistance are likely to be needed by the host population as well as the refugees.

9. In order to alleviate some of these disadvantages the host communities can be supported through Quick Impact Projects (QIPs) where increasing needs of the community could be met through UNHCR assistance.

Mass shelter: public buildings and community facilities

10. This type of settlement is where refugees are accommodated in pre-existing facilities, for example, in schools, barracks, hotels, gymnasiums or warehouses. These are normally in urban areas and are often intended as temporary or transit accommodation. The advantages of this type of settlement are:

i. they are not continuously inhabited during normal use and refugees can be accommodated immediately without disrupting accommodation in the hosting area;
ii. services such as water and sanitation are immediately available, though these may be inadequate if the numbers are large; and
iii. the need to construct additional structures specifically for the refugees is avoided.

11. The disadvantages of this type of settlement are:

i. they can quickly become overcrowded;
ii. sanitation and other services can become overburdened;
iii. equipment and structure can be damaged;
iv. buildings are no longer available for their original purpose, thus disrupting public services to the hosting population (e.g. schools should be evacuated as early as possible); and
v. lack of privacy and increased protection risks.

Camps

Spontaneous camps

12. This type of camp is formed without adequate planning in order to meet immediate needs. Aside from creating a unfriendly environment, the provision of services may become cumbersome and costly.

Spontaneous camps should be avoided to the extent possible.

13. Generally, spontaneous camps have more disadvantages than advantages, for example:

i. re-designing the camp would be necessary (where resources are available); and
ii. re-location, as early as possible, to a well-identified site; especially if there is conflict with local community.

14. High density camps with very large populations are the worst possible option for refugee accommodation and an intolerable strain on local services. However, this may be the only option because of decisions by the host country or simply because of a lack of sufficient land.

Planned camps

15. This type of settlement is where refugees are accommodated in purpose-built sites where a full range of services, within possible means, are provided.

16. The advantages of this type of settlement are:

i. services can be provided to a large population in a centralized and efficient way;
ii. there may be economies of scale in the provision of some services compared with more dispersed settlements;
iii. the refugee population can be easy to identify and communicate with; and
iv. voluntary repatriation can be easier to organize.

17. The disadvantages of this type of settlement are:

i. high population seriously increases health risks;
ii. high risk of environmental damage in the immediate vicinity of the camp;
iii. high population concentrations and proximity to international borders

may expose the refugees to protection problems; and

iv. large camps may provide a hiding place and support base for persons other than refugees. It may be difficult to distinguish these people from the normal refugee population and thus they may continue to benefit from assistance.

Organization of response

- Site selection, planning and shelter have a major bearing on the provision of other assistance.
- This subject must therefore be considered as essential to the needs and resource assessment and response.
- Expertize and swift coordinated planning are necessary for a new site or the improvement of existing conditions.

Introduction

18. Site selection, planning and the provision of shelter have a direct bearing on the provision of other assistance. These will be important considerations in the overall needs assessment and planning of response. Decisions must be made using an integrated approach, incorporating both the advice of specialists and the views of the refugees.

Contingency planning

19. Ideally, sites should be selected and planned prior to the arrival of the refugees. However, an unoccupied, developed site may send the wrong signal and encourage people to cross the border.

20. Frequently, the scale, nature, timing or direction of movement of the refugee flow will mean that some or all aspects of a contingency plan may need to be modified in the face of changing or unforeseen events. However, the information previously gathered in the contingency planning process will usually be useful.

Information for site selection and planning

21. The contingency plan and information already available, combined with visual and technical evaluation, should assist in in the selection of the most suitable site. Information that is essential for site selection and planning will often be in the form of maps, reports, surveys and other data as reflected in the table in annex "Sites criteria".

It should be noted that each criteria should be reviewed and commented on in relation to the minimum standards (please see Key Indicators, Toolbox, Table 1) rather than using a grading system which would become misleading.

22. Sources of information for site selection and planning should include local authorities and communities, government offices, educational institutions and UN agencies. UNHCR Headquarters, through the focal point on Geographical Information Systems (GIS), can also support operations with maps, aerial photographs, satellite images and a special geographic database. Furthermore, the Technical Support Section (TSS) at Headquarters, upon request, could assist in the process of site selection and planning.

Expertize and personnel

23. Expertize may be required in the fields of hydrology, surveying, physical planning, engineering (e.g. water supply, environmental sanitation, road and bridge construction, building materials, etc.), public health, the environment and perhaps social anthropology. Familiarity with conditions in both the country of origin and of asylum is very important. Prior emergency experience and a flexible approach are particularly valuable.

24. Expertize and advice should be sought through UNHCR's Technical Support Section (TSS), who will advise on the fielding of a specialist to coordinate activities in this sector. Potential sources

of the necessary expertize are government line ministries, national and international NGOs, engineering faculties, local industry and professional organizations, as well as other UN organizations.

25. Site selection and settlement planning require broad consultations with all concerned in the planning, development and use of the site. When appropriate, multi-sector planning teams, work-groups or task-forces might be formed to better structure consultations and better solicit inputs. Consensus should be sought, though it is rare that the needs of all the parties will be fully satisfied.

Criteria for site selection

- Land may be scarce in the country of asylum and no site may be available that meets all of the desired criteria. If, however, the site does not meet the basic characteristics as mentioned in annex "Sites criteria" and is clearly unsuitable, every effort must be made to convince the host Government regarding another location. The problems associated with an unsuitable site would be enormous in terms of protection and financial implications, which would escalate over time.

Introduction

26. The social and cultural background of the refugees are important determinants in site selection, physical planning and shelter. In many circumstances, however, options will be limited and land that meets even minimum standards may be scarce. It is therefore wise to put on record the short-comings of the site and the rationale for its selection.

Water supply

27. A specialists' assessment of water availability should be a prerequisite in selecting a site.

The availability of an adequate amount of water on a year-round basis has proved in practice to be the single most important criterion, and commonly the most problematic.

A site should not be selected on the assumption that water can be found merely by drilling, digging, or trucking. Drilling may not be feasible or may not provide water in an adequate quantity and quality. No site should be selected where the trucking of water will be required over a long period.

Size of camp sites

28. While there are recommended minimum area requirements for refugee sites, these should be applied cautiously and with flexibility. They are a rule of thumb for an initial calculation rather than precise standards.

Ideally, the recommended minimum surface area is 45 m^2 per person when planning a refugee camp (including kitchen/vegetable gardening space). However, the actual surface area per person (excluding garden space) should not be less than 30 m^2 per person.

The bare minimum figure of 30 m^2 surface area per person includes the area necessary for roads, foot paths, educational facilities, sanitation, security, firebreaks, administration, water storage, distribution, markets, relief item storage and, of course, plots for shelter. The figure of 30 m^2 does not include, however, any land for significant agricultural activities or livestock. Although agricultural activities are not usually a priority during emergencies, small vegetable gardens (kitchen gardening) attached to the family plot should be included in the site plan from the outset. This requires a minimum increase of 15 m^2 per person, hence, a minimum of 45 m^2 overall land allocation per person would be needed.

29. Large camps of over 20,000 people should generally be avoided. The size of a site for 20,000 people should be calculated as follows, assuming space for vegetable gardens is included:

20,000 people x 45 m^2 = 900,000 m^2 = 90 hectares (for example, a site measuring 900 m x 1000 m).

30. If possible, there should be a substantial distance between each camp. The distance depends on a number of factors: access, proximity of the local population, water supplies, environmental considerations and land use and rights.

31. Refugee settlements should have potential for expansion to accommodate increase in the population due to natural increases or new arrivals. The excess of births over deaths means that the population could grow as fast as 3 to 4% per year.

Land use and land rights

32. In most countries land for the establishment of refugee camps is scarce. Often, sites are provided on public land by the government. Any use of private land must be based on formal legal arrangements through the Government and in accordance with the laws of the country.

Note that UNHCR neither purchases nor rents land for refugee settlements.

Headquarters should be consulted at once if there is a problem with land use and/or land rights.

33. Once a possible site has been identified, the process of site assessment for eventual selection should always include clarification of land-ownership and land rights. Almost invariably, land rights or ownership are known, even though these may not be well documented in public records, or may not be obvious. Nomadic use of range-land, for instance, requires huge areas and may not appear used.

34. The refugees should have the exclusive use of the site through agreement with national and local (including traditional) authorities. Traditional or customary land-use rights are very sensitive issues, and even if there may be an agreement with the national government to use a site, local groups may disagree with the site being used, even temporarily. Clarification of access rights and land-use restrictions are also necessary to define the rights of the refugees to:

i. collect fuel-wood, and timber for shelter construction as well as fodder for animals;
ii. graze their animals; and
iii. engage in agriculture or other subsistence activities.

Security and protection

35. In principle, the granting of asylum is not an unfriendly act by the host country towards the country of origin. However, to ensure the security and protection of the refugees, it is recommended that they be settled at a reasonable distance from international borders as well as other potentially sensitive areas such as military installations.

The Organization of African Unity Refugee Convention (OAU Convention) states: "For reasons of security, countries of asylum shall, as far as possible, settle refugees at a reasonable distance from the frontier of their country of origin".[1]

Exceptions should only be made to this rule where the interests of the refugees would be better served. For example, if there are good prospects for early voluntary repatriation and security and protection considerations are favourable.

[1] *Article II, paragraph 6 OAU Convention.*

Topography, drainage and soil conditions

36. Where water is readily available, drainage often becomes a key criterion. The whole site should be located above flood prone areas, preferably on gentle (2 to 4%) slopes. Sites on slopes steeper than 10% gradient are difficult to use and usually require complex and costly site preparations. Flat sites present serious problems for the drainage of waste and storm water. Avoid areas likely to become marshy or waterlogged during the rainy season.

37. Soils that allow swift surface water absorption are important for the construction and effectiveness of pit latrines. The subsoil should permit good infiltration (i.e. allowing water absorption by the soil, and the retention of solid waste in the latrine). It should be noted that very sandy soils which are good for infiltration are sometimes poor for the stability of the pit. Where drinking water supplies are drawn from ground water sources, special attention must be given to preventing contamination by pit latrines. The pit latrines must not reach into the ground water. The groundwater table should be a minimum of 3 m below the surface of the site.

38. Avoid excessively rocky or impermeable sites as they hamper both shelter and latrine construction. If possible, select a site where the land is suitable for at least vegetable gardens and/or small-scale agriculture.

Accessibility

39. The site must be accessible and close to sources of necessary supplies such as food, cooking fuel and shelter material. Proximity to national services is desirable, particularly health care services. Roads must be "all-weather" and provide year-round access. Short access roads to connect the main road with the site can be constructed as part of the camp development. There may be advantages in choosing a site near a town, subject to consideration of possible friction between local inhabitants and refugees.

Climatic conditions, local health and other risks

40. Settlement areas should be free of major environmental health hazards such as malaria, onchocerciasis (river blindness), schistosomiasis (bilharzia) or tsetse fly. A site may have unseen and/or irregular (but often locally known) risks such as flash flooding, or serious industrial pollution. For sites in dust-prone areas, regular dust clouds can foster respiratory diseases. Emergency and temporary shelter need protection from high winds. However, a daily breeze is an advantage. Climatic conditions should be suitable year-round and careful account should be taken of seasonal variations. For example, a suitable site in the dry season may be untenable in the rains. Likewise, mountainous areas may be suitable in summer, while in winter the temperatures may fall significantly below freezing. Seasonal variation can have a considerable impact on the type and cost of shelter, infrastructure, heating fuel and even diet. As far as possible, refugees should not be settled in an area where the climate differs greatly from that to which they are accustomed. For example, settling refugees from malaria-free high ground to a marshy area where the disease is endemic can be disastrous.

Vegetation

41. The site should have sufficient ground cover (grass, bushes, trees). Vegetation cover provides shade while reducing erosion and dust. During site preparation, care should be taken to do as little damage as possible to vegetation and topsoil. If heavy equipment is used, indiscriminate bulldozing or removal of topsoil has to be avoided at all costs. If wood must be used as domestic cooking fuel or for the construction of shelter, the refugees should be encouraged not to take their requirements from the immediate vicinity of the camp.

Rather, a more dispersed pattern of wood collection should be implemented in coordination with local forestry authorities (see section on site planning and management of natural resources below). A quick survey of available vegetation and biomass for these purposes should be performed. The site should not be located near areas which are ecologically or environmentally protected or fragile.

Site selection methodology

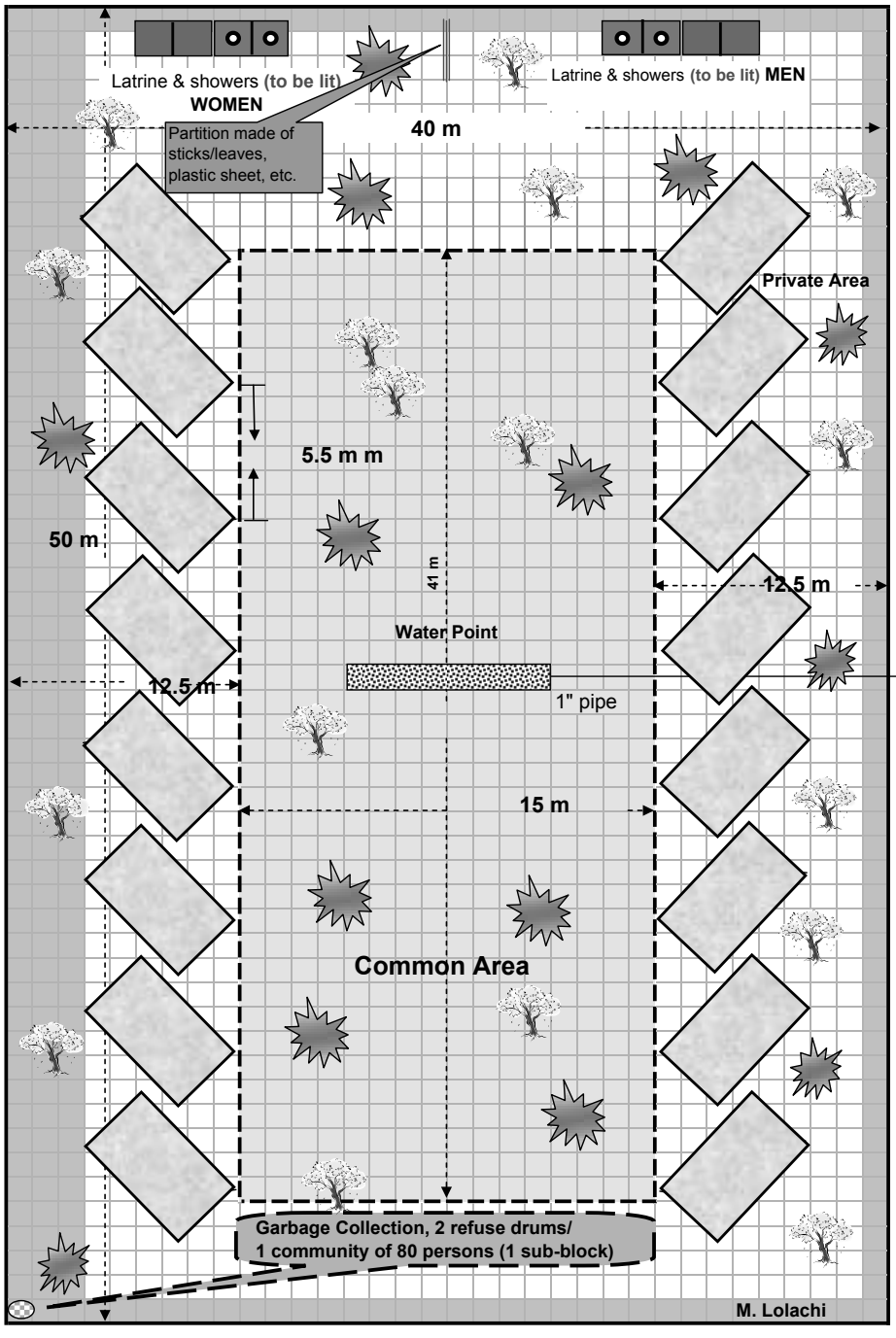
42. In order to have a concise review of a site, which has been pre-identified, the following general steps are recommended:

i. Have the recommended checklist (see annex "Sites criteria") at hand and share it with the team for their information and comments.
ii. Ensure the team includes local authorities and those who are knowledgeable of the site and its surroundings (including seasonal implications).
iii. Obtain suitable maps and other information showing topography, road networks, and water sources, as well as issues related to land use and land rights.
iv. Determine site characteristics through site visits while using the checklist to record your observations; highlight the pro's and con's of the site and its surrounding area.
v. Make simple estimates of the surface area of each potential site(s), through use of Global Positioning System (GPS); if unavailable, use vehicle trip-meter to estimate distances.
vi. Assess the implications of characteristics that have been recorded in coordination with team members while avoiding weighted average methods that could become misleading.
vii. Final decisions should be made on implications for each criterion as recorded by the team and in consultation with UNHCR offices.

Site planning: general considerations / recommendations

- The overall physical layout of a site should reflect a decentralized community-based approach, focusing on family, community or other social groups.
- Site planning should use the "bottom-up" approach starting from the characteristics and needs of the individual families, and reflect the wishes of the community as much as possible through participatory assessment.
- Each community should be planned to include its own immediate services, such as latrines, showers, waterpoints, garbage collection and cloth washing facilities. This is to promote ownership, which will lead to better maintenance of facilities by the community.
- Ensure communities are not a closed form, e.g. square-shaped, but resembling more of a H-shape, where both sides are open for better interaction with other communities.

Self-contained Community



Sub-Block - Modular Design Concept, NTS

Technical Support Section, TSS

: Shelters, 16/sub-block, 1 shelter/family,
16x 5 = 80 refugees/sub-block, each shelter area=3x6=18 m2
Gabled (truss) frame/ ridged roof strucutre and/or tent

Introduction

43. The physical organization of the settlement will markedly affect the protection, health and well-being of a community. Good site planning will also facilitate an equitable and efficient delivery of goods and services.

It is imperative that all of the related standards are taken into consideration during the physical organization of the camp.

Master plan

44. A "master plan" or overall site plan should show the overall configuration of the site, its surroundings and characteristics, and its proximity to natural and existing features including settlements. The plan should take into account the social organization of the refugees and principles of module planning, and should cover the following physical features.

45. Natural and existing features:

i. contours (e.g. lines joining points of identical elevation are called contour lines);
ii. rivers, forests, hills, flood plains, and swamps;
iii. rocky patches and sandy soils;
iv. existing buildings, roads and bridges; and
v. farm land, electrical power grids and water pipelines.

46. Planned features:

i. shelter areas and potential expansion areas;
ii. roads and footpaths;
iii. drainage system and terracing;
iv. environmental sanitation plan;
v. water distribution plan;
vi. utilities, camp lighting, etc.;
vii. administration areas;
viii. educational and health facilities;
ix. warehousing facilities;
x. distribution centres;
xi. feeding centres;
xii. community centre;
xiii. playground/sports centre;
xiv. area for religious activities;
xv. markets and recreation areas;
xvi. fire prevention breaks; and
xvii. agricultural plots.

47. A topographical and planimetric survey is crucial as the basis for site planning. The plan or map should have a metric scale between 1:1,000 and 1:5,000, and in case of large camps a scale of at least 1:10,000. A topographical survey describes the physical features of a landscape (rivers, valleys, mountains). A planimetric survey describes locations within an area (e.g. the camp site).

Services and infrastructure

48. The following are standards for services and infrastructure and should be referred to when preparing the master plan:

1 water tap	per	1 community (80 – 100 persons)
1 latrine	per	1 family (6 – 10 persons)
1 health centre	per	1 site (20,000 persons)
1 referral hospital	per	10 sites (200,000 persons)
1 school block	per	1 sector (5,000 persons)
4 distribution points	per	1 site (20,000 persons)
1 market	per	1 site (20,000 persons)
1 feeding centre	per	1 site (20,000 persons)
2 refuse drums	per	1 community (80 – 100 persons)

49. There are two situations for which site planning is required:

i. reorganizing existing, spontaneously-developed sites; and
ii. new sites.

The design standards to be applied should be the same in each case, although methods, approach and timing may differ substantially.

50. Where refugees have spontaneously settled, they may be understandably reluctant to relocate. In such cases, involvement of refugee representatives and refugees themselves through par-

ticipatory assessment and age and gender mainstreaming in planning will facilitate a better understanding and acceptance by the refugees. An early and clear demarcation of plots, including areas reserved for services, is advisable.

Comprehensive but swift planning is essential for a new site.

Modular planning

51. Planning should start from the perspective of the individual refugee household. Begin by considering the needs of the individual family, such as distance to water and latrines; the relationship to other members of the community (other relatives, clan, or ethnic groups); traditional housing and living arrangements. Developing the community layout (U-shaped rather than square-shaped), and then considering the larger issues of overall site layout, is likely to yield markedly better results than beginning with a preconception of the complete site layout and breaking it down into smaller entities.

52. Thus, planning and physical organization of the site should start from the smallest module, the family, and then building up larger units as follows:

Module	Consisting of	Aprox. No. of persons
Family	1 family	4 - 6 persons
1 community	16 families	80 persons
1 block	16 communities	1,250 persons
1 sector	4 blocks	5,000 persons
1 camp module	4 sectors	20,000 persons

These figures are indicative and should be adjusted according to actual conditions.

53. Modular planning does not necessarily mean using a grid layout for the site. The linear, or grid layout, with square or rectangular areas separated by parallel streets, has often been used for its simplicity of design and speed of implementation. However, every effort should be made to avoid a rigid grid design which does not account for community layout and interaction and presents difficulties in identifying proper community-based locations for services such as latrines, water points, showers etc. Grid design does not promote ownership of services, which is crucial for proper usage, cleaning and maintenance. Furthermore, it undermines the protection concerns such as the long distances that refugees have to walk for services and susceptibility to violations. Whatever design is used should take into account the natural features of the site and the identity of the refugee community.

54. The social organization, cultural background and family structure are some of the main factors that influence the physical layout of a site and should be part of the initial needs and resource assessment. This information should be gathered through review of existing documents, observations and discussions with the refugees, and others knowledgeable about this society. A full socio-economic survey of the refugee population should be conducted when/if resources allow, and will be important in subsequent planning, particularly for self-reliance and durable solutions.

Environmental considerations

55. Environmental considerations should be integrated into physical planning and shelter from the very start of an emergency. Location and layout of refugee camps, provisions made for emergency shelter, and the use of local resources for construction and fuel can have a major negative environmental impact. It is in the earlier stages of an emergency where the greatest environmental damage can occur and habits are formed. Environmental damage has health, social and economic consequences for the refugees and local population, and can have political repercussions.

Rehabilitation effectively starts in the emergency phase, and the costs of environmental damage can be substantially reduced by implementing environmental protocol early in an emergency.

56. In order to safeguard the welfare of refugees and local population by protecting their environment, the following steps can be taken:

i. Site selection: avoid sites close to environmentally protected areas. A site should be located at least a day's walk from protected areas or reserves.

ii. Site preparation: discriminately preserve existing vegetation and top-soil.

iii. Camp size and density: generally, the smaller the settlements the better; allocate 30-45m^2 of area per person.

iv. Camp layout: the layout (particularly roads) should follow contour lines. This will reduce erosion, preserve topsoil, and avoid the creation of dangerous gullies. A site layout that encourages community living arrangements (which can also promote security) safeguards the environment within that community.

v. Shelter design (energy-saving through insulation): in cold climates, with extended winter seasons where continuous heating is needed, passive energy saving measures, e.g. sufficient insulation of roof, walls, and floors can save significant fuel and prove cost-effective over time.

vi. Shelter and fuel: materials for these often come from the immediate surroundings of the camp. It is crucial at the outset to initiate a system to manage and control the use of local natural resources including wood for construction and fuel. Meeting the initial need for shelter materials from the local resources can be particularly destructive, so collection of such materials should be carefully managed, and/or provided from an alternate source.

57. A simple natural resources management plan should be drawn up as soon as possible. A key feature of a basic plan will be controlled harvesting and collection of fuel-wood and timber. This should be discussed with government bodies, such as forestry departments. Controlled fuel-wood and timber harvesting in the vicinity of the camp can include: defining certain areas and trees (by marking) which should not be harvested, allowing only dead wood to be collected; establishing an environmental awareness programme to define clear rules from the outset regarding harvesting wood and to encourage respect for the local resources; assigning responsibility for managing and harvesting certain areas to certain groups.

58. The decision on supplying fuel-wood from outside the vicinity of the camp (e.g. trucking in wood), how to supply it and the quantity which is necessary must be made according to the specifics of the situation. The organized supply of fuel-wood or other fuel, such as kerosene, can have complex repercussions and should be instituted with care. Organized supply of free fuel on a regular basis is only appropriate in certain circumstances, e.g. where there are severe restrictions on fuel from other sources. Where fuel-wood is also readily available locally, its distribution free of charge from outside the vicinity may actually lead to increased consumption. In addition, refugees rely on local natural resources for income, therefore if free fuel-wood is provided for cooking purposes, collection of wood will continue for income generating purposes (e.g. the sale of fuel-wood or timber, charcoal making, etc.). Therefore, to retain its value fuel-wood should generally be supplied in return for work.

59. The source and impact of wood supplied to the refugees also needs to be considered:

i. Is it being harvested sustainably?
ii. Are the environmental problems merely being moved elsewhere?

Care should be taken to prevent the emergence of local monopolistic suppliers. Finally, it should be remembered that, if it is necessary to introduce free fuel supply in the initial stages of an emergency, it will be difficult to later modify such arrangements.

60. A more comprehensive natural resource management plan for the site and its immediate surroundings should be drawn up as soon as possible (with specialist advice if necessary). Such a plan should be based on a baseline environmental survey.

A comprehensive natural resource management plan would cover (in addition to controlled harvesting of timber for construction and fuel-wood, as mentioned earlier): promotion of fuel-saving stoves and fuel efficient cooking techniques and supply of key energy saving devices (e.g. lids with cooking pots, provision of mills or milled grain). In addition to awareness raising programmes, identify the scope for better use of existing natural resources (e.g. using waste water, common areas, and areas around shelters), kitchen gardens, tree planting, and reforestation where necessary.

Gender considerations

61. In emergencies, there may be a loss of normal community structure and the changes in demographic proportions may have altered refugees' daily routines. This could also have a negative effect on traditional mechanisms for the protection and assistance of persons with specific needs. As a result of a conflict, the change of social composition in refugee communities may also include:

i. increased numbers of female-headed households;
ii. large numbers of unaccompanied children;
iii. reduced number of able-bodied men; and
iv. disruption of the extended family, with its role as social caretaker.

All the above requires our attention when planning to accommodate such refugees.

62. It is important that the specific needs of persons are taken into account in site planning. It may be difficult to reach these people if they do not traditionally form part of the leadership structure of the community. In such cases, the needs and resource assessment should obtain views of all concerned through age, gender and diversity mainstreaming.

63. Specific actions should be taken to ensure that refugee communities are organized to assist groups with specific needs with their shelter construction. Specific attention should be given to refugees unable to complete their own shelter construction.

Site planning: specific infrastructure

- Underestimation of surface area required for social infrastructure and communal services, including a playground for children, is an issue which will adversely affect the creation of a humane environment for refugees, and should be avoided.

64. At the start of an emergency, it may be difficult to construct all the administrative and communal services anticipated. Free areas should therefore be allocated for inclusion or future expansion of these services.

Sanitation

65. While water requirement is a major factor in site selection, sanitation requirements dictate site layout. High population density coupled with poor sanitation is a severe threat to the health and safety of refugees. This is often the case in spontaneous camps. Some organization of basic sanitation should be planned before reorganizing the site or transferring the refu-

gees (and thus, the problem) to a new site. This should include prohibiting uncontrolled defecation and the establishment of public latrines. Sufficient space must be left for alternate latrines. If communal latrines are unavoidable, there should be a plan for their maintenance and they should be accessible by road for facilitation.

66. For all sites, new or reorganized, the goal should be one latrine per family. Only if the latrine remains under the control and maintenance of a family group is safety and hygiene assured in the long run. The ideal location of the family latrine is on the family plot, as far as possible from the shelter. If this is not possible, the next best option would be latrines for identified groups of families, not exceeding twenty persons per latrine facility.

67. A system of cleaning and maintaining latrines by the community should be discussed prior to construction.

Water supply

68. Where possible, the maximum distance between any shelter and a water distribution point should be not more than 100m, no more than a few minutes walk. The layout of the site should contain the water distribution grid as an integral part of the service plan and the pipes should be underground. Water pipes should be kept at a depth that traffic or other surface activities do not cause damage (40 to 60 cm). In countries with very low temperatures, the pipes must be positioned at frost free depth (60 to 90 cm). Experience shows that water distribution to small, socially cohesive groups of 80 to 100 persons considerably reduces water wastage and destruction of taps, standposts and concrete aprons.

69. To aid hygiene, effluent and used water from water supply points should be well-drained and eventually absorbed in soakage pits or used to irrigate gardens.

Roads

70. A site should have access and internal roads and pathways connecting the various areas and facilities. Access roads should be all-weather roads above flood levels and have adequate drainage. If there has to be a significant amount of vehicle traffic on the site, it should be separated from pedestrian traffic. All structures, including family plot fences, should be set back approximately 5 - 7 m from roads to provide adequate visibility for pedestrians and vehicles.

Fire prevention

71. In general, a firebreak (area with no buildings) 30 m wide is recommended for approximately every 300 m of built-up area. In modular camps, firebreaks should be situated between blocks. This area would be an ideal for growing vegetables or recreation. If space allows, the distance between individual buildings should be adequate to prevent collapsing, burning buildings from touching adjacent buildings. The distance between structures should therefore be a minimum of twice the overall height of any structure. If building materials are highly inflammable (straw, thatch, etc.) the distance should be increased to 3 to 4 times the overall height. The direction of any prevailing wind will also be an important consideration.

Administrative and communal services

72. Buildings for administrative and communal services should be traditional structures, and if possible, of a multi-purpose design to facilitate alternative uses. For example, buildings for initial emergency services could later be used as schools or other community facilities. The list below includes administrative and communal services most often needed. The division is indicative only – the importance of maximum decentralization has already been stressed. Whether centralized or decentralized, administrative and other fa-

cilities should be located and designed so that they are accessible to all.

73. Services and facilities likely to be centralized (depending on the size of the camp) are:

i. site administrative office;
ii. services coordination offices for health care, feeding programmes, water supply, education, etc.;
iii. warehousing and storage;
iv. initial registration/health screening area;
v. tracing service;
vi. therapeutic feeding centre (if required);
vii. marketplace; and
viii. community centre.

74. Services and facilities likely to be decentralized:

i. water points;
ii. latrines;
iii. bathing and washing areas;
iv. garbage collection;
v. supplementary feeding centres (if required);
vi. education facilities;
vii. in areas; and
viii. commodity distribution centres.

75. The location of the centralized services will depend on the specific situation and, in particular, on the space available. With sufficient space, there may be clear advantages in having the centralized services in the centre of the camp. Where space is scarce, it may be better to have the centralized services located near the entrance of the camp. In particular, this will avoid supply trucks having to drive through a densely populated site, with the attendant problems of dust, noise and danger to pedestrians. If some form of closed camp is unavoidable, at least the centralized administrative services will probably have to be located near the entrance. The warehouses should always be near the administrative office for security reasons.

Shelter

- Refugee shelter must provide protection from the elements, space to live and store belongings, privacy and emotional security.
- Blankets, mats, and tarpaulin must be provided.
- Refugee shelter should be culturally and socially appropriate and familiar. Suitable local materials are best, if available.
- Shelter must be suitable for variance in the seasons.
- Except for tents in certain circumstances, prefabricated or special emergency shelter has not proved to be a practical option on either cost or cultural grounds.
- Wherever possible, refugees should build their own shelter, with the necessary organizational and material support.

Introduction

76. Shelter is likely to be one of the most important determinants of general living conditions and is often one of the significant items of non-recurring expenditure. While the basic need for shelter is similar in most emergencies, such considerations as the kind of housing needed, what materials and design to be used, who constructs the housing and how long it must last will differ significantly in each situation.

77. Particularly in cold climates or where there are daily extremes of temperature, lack of adequate shelter and clothing can have a major adverse effect on protection and well-being of refugees, including health and nutritional status.

In addition to shelter, provision of sufficient blankets, mattresses, additional plastic sheeting and provision of heaters will be a high priority.

78. Fire prevention measures should be established when providing heaters and it is thus necessary to deal with the procurement, storage, and/or distribution of fuel.

79. Adequacy of emergency shelter is encouraged to be assessed at any time, including arrangements already made by refugees.

The key to an adequate shelter is the provision of roofing material in line with climatic conditions and living habits of the refugees.

If materials for a complete shelter cannot be located, provision of adequate roofing material will be the priority, as walls can usually be made of earth or other materials found on site or available locally.

80. Wherever possible, refugees should build or assist in building their own shelter, with the necessary technical, organizational and material support. This will help to ensure that the shelter will meet their particular needs, promote a sense of ownership and self-reliance, and reduces costs and construction time considerably.

Type of shelter

81. Individual family shelter should always be preferred to communal accommodation as it provides the necessary privacy, psychological comfort, and emotional safety. It also provides safety and security for people and possessions and helps to preserve or rebuild family unity.

82. Emergency shelter needs are best met by using the same materials or shelter as would be normally used by the refugees or the local population. Only if adequate quantities cannot be quickly obtained locally should emergency shelter material be brought into the country. The simplest structures, and labour-intensive building methods, are preferable. Materials should be environmentally friendly and obtained in a sustainable manner.

Standards

83. At the beginning of an emergency, the aim should be to provide sufficient material to the refugees to allow them to construct their own shelter while meeting at least the minimum standards for floor space as follows:

i. minimum of 3.5 m^2 per person in tropical, warm climates, excluding cooking facilities or kitchen (it is assumed that cooking will take place outside); and
ii. 4.5 m^2 to 5.5 m^2 per person in cold climates or urban situations, including the kitchen and bathing facilities.

84. The design of shelter should, if possible, provide for modification by its occupants to suit their individual needs. In cold climates, for example, it is very likely that persons with specific needs will remain inside their shelter throughout the day, thus more space will be required.

Plastic sheeting

85. Plastic sheeting has become the most important shelter component in many relief operations. In urban areas, roofs can be repaired with UV-resistant heavy duty plastic sheeting.

86. Collecting wood for shelters' support frames or stick skeletons can considerably harm the environment if collected from surrounding forests. It is therefore important to always supply frame material which is sufficient to support plastic. The frame material should come from sustainable, renewable supply sources. Bamboo is ideal, if available. Standard specifications for plastic sheeting can be found in Annex 1 to chapter 21 on supplies and transport.

Tents: light weight emergency tents (LWET)

87. Family tents may be useful and appropriate, for example, when local materials are either not available at all or are only seasonally available or for refugees of nomadic background. The life-span of an erected canvas tent depends on the manufacturing, length of storage before deployment, as well as the climate and the care given by its occupants. Where tents

are used for long durations, provisions for repair materials should be considered. Larger or communal tents may serve as transit accommodation while more appropriate shelter is constructed.

88. UNHCR has developed a lightweight emergency tent with a long shelf life which will save on transportation costs due to its light weight. Standard specifications for tents can be found in Annex 1 to chapter 21 on supplies and transport.

89. In general, tents are difficult to heat as walls and roof do not provide sufficient insulation. Therefore, tents are not suitable as cold climate shelters, but if there is no choice, they can save lives and bridge the time until more suitable shelters are established.

90. If required, additional blankets and plastic sheeting can be provided to increase heat retention. It is also possible to heat some tents if enough heat is produced in a tent stove. This stove needs fuel (e.g. wood or kerosene) around the clock to maintain a comfortable temperature. While using wood, environmental aspects should be considered. Whereas in use of kerosene procurement, storage and distribution could pose difficult challenges for the operation.

Prefabricated shelters

91. Neither pre-fabricated building systems nor specially developed emergency shelter units, even winterized shelter units, have proved effective in accommodating refugees. Main reasons include:

i. high unit cost;
ii. long shipping time;
iii. long production time;
iv. transport problems, including cost;
v. assembling the shelter unit;
vi. does not allow for cultural and social norms; and
vii. cooling problems in hot climates.

Typically, emergency shelter provision should have been made before these systems are used.

Shelter for cold conditions

92. Climates where cold weather with rain and snow prevails over extended periods (3 to 5 months), demand that people live primarily inside a house. In particular, persons with specific needs will require heated, enclosed spaces.

93. Shelters which are sufficient to withstand cold conditions have to be of a high standard and are complex and expensive to build. The following should be considered:

i. structural stability (to withstand snow- and wind-loads);
ii. wind protection of walls, roofs, doors and windows;
iii. protected and heated kitchens and sanitary facilities; and
iv. provision for heating and chimneys.

94. To help people survive the impact of cold weather in an emergency, a strategy should focus on the following:

i. **Individual survival**. It is extremely important to protect the human body from heat loss. Particularly during sleep, it is important to be able to keep warm by retaining body heat with blankets, sleeping bags, clothing and shoes. Heat can be generated by providing food with high calorific value;

ii. **Living space**. It is very important to concentrate on a limited living space and to ensure that cold air can be kept out of this space. This can be done by sealing the room with plastic sheeting and sealing tapes. Windows and doors should be covered with translucent plastic sheeting and stapled on window and door frames. Walls, ceilings and floors of the living space should be designed to insulate from cold air and to retain warm air as efficiently as possible;

iii. **Heating**. Keeping the inside of a shelter at a comfortable temperature (15 to 19° C) depends to a large extent on the outside temperature, the type of construction, the quality of the insulation, the orientation of the building, and on the type and capacity of the stove. Depending on conditions, a stove with 5 to 7 kW performance should have the capacity to heat a space with a floor area of 40 to 70 m^2 in most cold areas. When the stove for heating is used for cooking as well, particular attention should be given to its stability.

Reception and transit camps

95. Reception and transit camps are used when it is necessary to provide temporary accommodation for refugees. These camps might be necessary at the beginning of a refugee emergency as a temporary accommodation pending transfer to a suitable, safe, longer term camp, or at the end of an operation, prior to repatriation, as a staging point for return.

96. Whether the transit camp is used in an emergency or as part of a repatriation operation, the camp should be designed for short stays of 2 to 5 days in addition to a high turnover rate in a communal setting.

97. The required capacity of a transit camp will depend primarily on how many people will be channeled through the camp and their expected duration. This will depend on the absorption or reintegration capacity at the receiving end as well as the total time foreseen to carry through the operation.

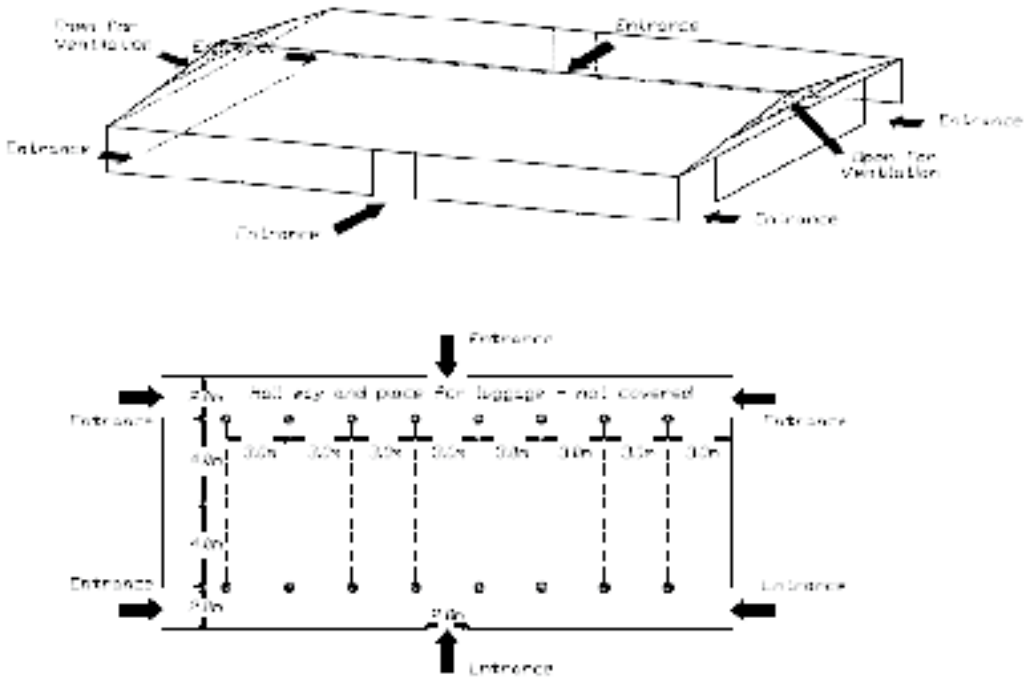
98. The primary criteria for site selection for a transit camp are:

i. good access (road, port, airport);
ii. the availability of water;
iii. good drainage (minimum 2% slope);
iv. adequate conditions for sanitation; and
v. strategically located to serve the purpose of the operation.

99. The transit camp must be strictly functional and equipped with considerably higher construction standards than regular refugee camps. Operational maintenance must be fully supplied through the camp management. In particular, cleaning and disinfection of accommodation and sanitation areas need to be carried out on a regular and ongoing basis. Prepared food should be provided and individual food preparation should be avoided. The transit camp will therefore need kitchen facilities, wet food distribution and a dinning space, if possible. In view of the expected short-term stay, a minimum of 3.0 m^2 per person is needed.

100. Standards for the construction of transit facilities are:

i. accommodation: in barracks, communal tents (subdivided for families of 5 persons for privacy reasons) should be heated in cold climates; for example, a tent of 85 m^2 can accommodate approximately 14 to 25 persons;
ii. sanitation: 20 persons per latrine, 50 persons per shower, plus regular and intensive maintenance is required;
iii. water supply: absolute minimum provision of 7 litres/person/day plus water required for kitchens, cleaning and sanitation;
iv. food preparation: approximately 100 m^2 per 500 persons;
v. storage: 150 to 200 m^3 per 1,000 persons;
vi. a public address system;
vii. lighting;
viii. arrival and departure zones which are separated from accommodation zones;
ix. arrival zones should include registration and medical clearance facilities;
x. administrative offices and staff accommodation;
xi. one health post and separate accommodation for quarantine;
xii. security fencing (depending on circumstances);
xiii. the design of the transit centre should include a concept of visibility and ease of movement.



Notes

--The proposed size is 27m x 12m sufficient for 90 persons.

--Length can be altered at 3.0 metre increments to suit need and situation.

--Width can be reduced by only 1.0 metre to bring total width of the hallway to 1.5 metres in place of 2.0 metres.

--The better quality plastic sheeting or plastic roll should be used. It should be noted that usage of the green plastic rolls should be limited to enclosed spaces.

--Drawings not to scale; intended only for general use.

Public buildings and communal facilities

- Public buildings should be used only as short-term accommodation to gain time to provide more suitable shelter.
- From the outset, intensive maintenance of infrastructure and utilities should be provided.
- The UNHCR shelter standards should be applied.

101. Public buildings such as schools are sometimes used initially as shelter. This is particularly the case in cold conditions which demand very rapid shelter response.

102. Where possible, such accommodation in public buildings should be a temporary solution. The supporting infrastructure of the building (water, electricity, sanitation) will deteriorate quickly from concentrated use, to the extent that living conditions can become dangerously unhealthy. The buildings decay rapidly primarily because they are unsuited to such large numbers and lack the necessary infrastructure and utilities. In addition, the very low sense of responsibility by its inhabitants contributes to the deterioration.

103. Furthermore, since the normal use of the building has to be suspended with various social and economic consequences, both local and national governments are reluctant to transform public buildings into humanitarian shelter. If such use is permitted, the need for quick evacuation

of the building should be borne in mind as this may be requested by the government.

104. In order to ensure a healthy environment, it is particularly important to ensure regular operational and preventive maintenance in public buildings. Neglecting to maintain a building from the outset can have serious health consequences for the refugees and economic consequences for the host government.

Annex Sites Criteria

Sites Criteria		Site # (name):
1. Potential Beneficiaries		
a	Numbers	
b	Type or categories	
2. Location		
a	Distance from major towns	
b	Distance from the border	
c	Security and protection	
d	Local health and other risks	
e	Distance From the protected areas	
3. Basic Characteristics of the Site		
a	Area, expansion possibility	
b	Land use and land rights	
c	Topography	
d	Elevation	
e	Soil condition	
f	Water availability	
g	Drainage	
h	Sanitation possibilities	
i	Climatic condition	
j	Vegetation/ other environmental condition	
4. Complementary/Supportive Points		
a	Nearby villages/communities	
b	Accessibility	
c	Proximity to National services	
	- Health	
	- Education	
d	Electricity & distance to Ovehead High Voltage source	
e	e. Proximity to economical centres	
f	f. Proximity the IG/Agriculture	
g	g. Harvesting of the wood for construction	
h	h. Collection of fuel firewood for fuel	
5. Observation / Recommendation		

13

Commodity distribution

CONTENTS **Paragraph** **Page**

Situation

In emergency situations of population displacement there is always loss of personal property. Very often refugees flee with little more than the clothes they are wearing. In addition to food support people affected by crisis, therefore, need certain non-food items for their survival. These emergency situations are characterized by an urgent need to distribute life sustaining commodities other than food, such as, shelter materials including tents, plastic sheeting, blankets and sleeping mats, cooking utensils and water jerry cans, personal hygiene items such as buckets, soap, sanitary cloth and sometimes washing powder. The fair and organized distribution of emergency relief items is often problematic and groups and individuals from among the refugees may use the confusion of the emergency to gain unfair control over the relief items that are being distributed.

Objectives

To provide life-sustaining commodities to the refugee community in a fair and organized system, according to specific needs, population culture and within the environmental and geographic context.

Principles of response

- The design of the distribution system should be based on a thorough understanding of the social structure of the refugees.
- The target of the commodity distribution should be towards the family or household unit, however, assumptions should not be made about family size or structure.
- The refugees, especially including women, should be consulted and participate in the design of the distribution system. No one group should have a monopoly role over others.
- The refugee population should be kept well informed on the timing of distributions as well as the content and quantity of commodities to be distributed.
- Ensure that the population benefits equally and fairly from the commodity distribution and groups with specific needs are especially targeted and monitored and that distribution systems have 50% women in the management and monitoring.
- The commodity distribution cycle should be regular and predictable. Irregularities in the distribution cycle can increase tensions and can lead to riots.

Action

- Assess accurately and as early as possible the displaced population's demographics, cultural and traditional/social structures. Roles and responsibilities within the refugee groups are to be taken into consideration.
- Assess cultural and traditional commodities prior to the emergency and take these into consideration during the planning stage of the distribution system during the emergency.
- Use appropriate community structures (or set up new structures if necessary by gender e.g. to include women) to consult the refugees on the design and operation of the commodity distribution system.
- Set up an information system by which the operation of the commodity distribution system can be regularly conveyed to the refugees (and others of concern).
- Have in place an effective refugee participatory monitoring system for a fair and organized distribution system.

1. The principles in the chapter apply to the distribution of both food and non-food items.
2. The handbook "Commodity Distribution: A Practical Guide for Field Staff" (UNHCR, 1997) is essential reading for those who plan to set up and run a commodity distribution system (see key references at the end of the chapter).

Introduction

- Commodity distribution must be according to specific emergency needs of the targeted displaced population.
- Commodities must be distributed fairly and in an organized manner. Family/household size, age and gender makeup of the population, culture and social structure should be taken into account in the distribution ration.
- Distribution must be monitored to ensure emergency needs are met, with equal access to all refugees especially groups with specific needs.
- However ingenious the distribution system may be, it is unlikely to work fairly without the acceptance and support of the refugees themselves.
- UNHCR's distribution systems should provide for urgent and fair material assistance to and in conjunction with the affected population families.

When to start distribution

1. There is usually a degree of uncertainty when planning distributions. Ideally, distribution of commodities should start only after full needs and participatory assessment with refugee women, girls, boys and men has taken place and when the size and demographics of the beneficiary population is approximately known (*an accurate figure can only be known after registration*). However, the reality of almost all emergency programmes is that distributions normally start prior to these ideal conditions being reached. Try not to start distribution until there is at least a minimum framework and infrastructure in place and plan as quickly as possible as to how subsequent distributions will be improved.

Choosing a commodity distribution system

2. Two basic issues are:

i. how much responsibility should be given to the refugees themselves; and
ii. what resources are available to set up and run the system (including time, space, experienced staff as well as financial and material resources (see Table 1).

3. There are three broad categories of distribution system (see Table 1).

Note: Families affected by crisis are often quite varied with households headed by a single parent, a grandparent or child-headed households. Families are often extended to include the elderly, cousins and other members who may not be have lived together previously. Families may also split up to gain access to extra rations or commodities.

Distribution systems can be classified according to who receives the commodities.

Table 1 – Commodity distribution systems

Through group leadership	Through groups of heads of family	Through individual heads of family
System Description		
Commodities are given in bulk to a representative of a large group of beneficiaries who further divides it among the group.	All of the commodities for the group of families are handed over to a representative of the group. The group usually consists of about 20 heads of family. The commodities are then immediately redistributed to the individual family heads by the representatives.	Commodities are handed over directly to each family head.
Types of situation in which these systems have been used:		
Early days of an emergency. • Mass influx of refugees. • No formal registration. • Large populations.	When the population is comparatively stable, and/or have ration cards. • Where the beneficiaries are living in camps. • Where the population is comparatively homogeneous.	When the population is comparatively stable, and/or have ration cards. • Where the beneficiaries are living in camps, settlements or integrated within the local population.
➤ ➤ ➤ ➤ ➤ Amount of resources needed increases ➤ ➤ ➤ ➤ ➤		
➤ ➤ ➤ ➤ ➤ Degree of self regulation by refugees increases ➤ ➤ ➤ ➤ ➤		

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- Where the beneficiaries are living in camps.
- Where the population is comparatively homogeneous.
- When the population is comparatively stable, and/or have ration cards.
- Where the beneficiaries are living in camps, settlements or integrated within the local population.

As the amount of resources needed increases the degree of self regulation by refugees increases.

4. There will probably be a period in the early stages of an emergency when it will not be possible to register or issue ration cards. However, effective distribution of commodities is possible without ration cards.

Components of distribution systems

General considerations

5. The ideal distribution system should be safe and easily accessible to the intended beneficiaries.

- Safe: Distribution should be organized in such a way that the system is safe for all who use it. Particular attention should be given to persons with specific needs and vulnerable groups.

- Accessible: Distribution points should be close to where people live and located so that access for groups with specific needs is not restricted.
- Design of distribution centre: Physical structure, proximity to road access and warehouse/s, location for security reasons (not remote or in a crowded location).
- Equal: Who receives the commodities or when the commodities are distributed are important issues to consider when ensuring that the population benefits equally; distribution should preferably be made to women (see Annex).

6. The refugees themselves (be careful not to give refugee "leaders" too much say or control) can provide the most effective monitoring and control of the distribution system. In order to do this they must be informed and involved from the start, as to the type and quantity of commodities to be distributed and method and timing to be used.

An information system (including the use of notice boards) needs to be put in place whereby the refugees can be continuously informed of changes in the quantity, type or method of distributions.

7. In the early stages of a new operation, particularly in large emergencies, effective control over distribution may not be possible (however sophisticated the system is, top priority should be given to effective control – otherwise the refugees and humanitarian workers safety is put at risk). However, from the start, each action taken should contribute to a process whereby control by UNHCR is progressively established and emergency needs are met. For example the provision of plastic sheeting, tents and other shelter material is very important because it reduces the mobility of the population. Once shelter is issued, the population can settle and commodity distribution and other services will be easier to organize. Where has this ever been practiced? Either you set up tents beforehand and refugees are given "addresses" as in project profile or the distribution system is set up to distribute plastic sheeting.

Refugee involvement

8. Ensure the refugees are well informed (both women and men). They must know what they should receive, how much, when and how. This information should come to them directly rather than through their leadership.

The refugees should be able to see the distribution process for themselves as they are the best monitors and controllers of the process.

Ensure that the refugees participate at all levels of the distribution process. The indicator checklist for non-food items (Annex 1) should be used to assist in equal and appropriate distribution of commodities through the involvement of refugees and awareness of specific needs. Be aware, however, of the dangers of non-representational leadership (see chapter 7 on coordination and site level organization).

9. Irregularities in the distribution cycle undermine the confidence of the beneficiaries and increase their need to circumvent the system.

Logistical considerations

10. In camps, the distribution system should allow beneficiaries to collect rations close to where they live (not more than 5 km away) and at regular monthly intervals. For dispersed populations refugees should not have to travel more than 5 km to distribution sites.

11. In the case of food distribution, it is usually preferable to distribute dry uncooked rations in bulk. Avoid mass cooked food distribution for the general ration (see chapter 16 on food and nutrition).

Managerial considerations

12. Distributing relief commodities involves several organizations and many individuals, for example, the government, WFP and NGOs. Coordination structures must be put in place, including regular meetings of all interested parties. The frequency of these meetings will depend on the situation. At the start of an emergency daily meetings will probably be needed. As the situation normalizes the frequency of meetings can be reduced to one per month.

13. It is important to understand the roles and responsibilities of the main actors involved at various stages of commodity distribution. In the case of food distribution the modalities of distribution as well as the reporting requirements are set out in a tripartite agreement between UNHCR, WFP and the implementing partner. The respective roles of UNHCR and WFP in relation to food aid are set out in their Memorandum of Understanding (Appendix 3). See Chapter 15 on food and nutrition for more information on food distribution and on of the role of WFP.

14. The family/household, as a basic social unit, is the target of distribution. This applies to food and non-food items. Providing assistance to and through households is effective as the basis for the distribution system and also supports the family unit. However this does not mean that the ration has to be handed to each family directly. In some situations distribution can be more effective through groups of families or other community structures.

15. Avoid payment in kind to distribution workers. It makes monitoring difficult and, in times of shortages people may be deprived of commodities in order to pay staff.

16. Ensure regular UNHCR monitoring and spot checks of all commodity distribution to ensure effective delivery and no abuse of power by those in control, including sexual favors and exploitation.

17. In camps, aim to have at least 1 distribution site per 20,000 refugees.

18. Plan to have a minimum of 2 distribution staff per 1,000 beneficiaries.

Ensure age, gender and diversity mainstreaming

- **Involve refugee women and acknowledge their role in commodity distribution by ensuring they participate meaningfully in management structures.**
- **Ensure equal and representative participation of all beneficaries.**
- **Find out about cultural and economic differences and social structures within the population.**
- **Identify groups with specific needs and discuss with them the system.**
- **Use participatory assessment to set up systems and assess their effectiveness.**

The role of refugee women

UNHCR policy

19. UNHCR's policy is to ensure the maximum possible appropriate involvement of refugee women in all aspects of distribution. Determining the nature of this involvement requires consultation with refugee women and men and a careful evaluation of the totality of the needs and responsibilities of refugee women and their families. Failure to take these considerations into proper account can have negative implications that go well beyond the distribution system itself.

20. In the great majority of refugee communities, the objective of fair distribution will be best served by having an appropriate balance of men and women. However, it is normally women, and in particular single female heads of household, who are either under-represented or excluded.

Areas of women's involvement

21. There are three areas where refugee women should be involved:

- in the decision-making processes and monitoring;
- in the distribution itself (women supervise and/or hand out the commodities); and
- in collecting the commodities (where they are distributed to women not men).

22. Women must be directly involved in decision-making and monitoring, including being involved in planning the system and determining their own participation in its implementation. Women should comprise 50% of the commodity distribution or food committees.

23. Women should choose representatives who will be involved in the distribution itself. The extent and nature of this participation will depend on factors specific to that situation.

24. If women themselves feel that the most effective way to ensure that they receive their fair share and retain control of its use thereafter is by actually collecting, or at least being present at the distribution of food and non-food items for their household (whether or not they are its head), this should be ensured.

Equal and representative participation of all persons of concern

25. To address the issues of equal participation and effective commodity distribution, the following actions are recommended in situations that concern UNHCR:

- Ensure that men and women are involved in the planning and implementation of distribution – meet with them separately - to ensure that power dynamics are not silencing women or older persons.
- Make sure that both men and women know the quantity and variety of items they should receive.
- Ensure that the design of the distribution system is based on a thorough understanding of the social structure of the displaced (through group leadership [male and female leaders], through groups of heads of family, or through individual heads of family) including child-headed and grandparent-headed households and that the displaced are kept continuously informed on the design.
- Make sure that distribution times and sites are easily accessible and safe to men, women, children, older persons, sick, and disabled.
- Make sure crowd controllers monitor queues, and provide a separate queue for persons with specific needs (such as those not able to stand in line for some time due to age ill health or pregnancy).
- Ensure a mechanism for displaced men and women to file complaints or indicate unmet commodity needs directly to UNHCR.

Meeting gender roles and cultural differences

26. Non-food items vary according to culture and context and should suit the needs of the population and the climate. In addition, the roles and responsibilities of the population vary according to cultural and social context. The following questions and points should be taken into consideration when planning and implementing gender commodity distribution:

- Who is responsible for carrying of and different usage of water?
- Who does household chores, cooking, caring for children?
- Who collects firewood or fuel used to cook and heat home? Ensure that women are consulted about the location and means of collecting fuel

for cooking and heating in order to address issues of personal safety.

- Ensure that men and women are consulted as to what commodities are culturally appropriate and familiar.
- Distribute appropriate sanitary supplies for women and girls, based on their preferences.
- Ensure that clothing is appropriate to climatic conditions and cultural practices, separately suitable for men, women, girls and boys, and sized according to age.
- Make sure that bedding materials reflect cultural practices and are sufficient in quantity to enable separate sleeping arrangements as required amongst the members of individual households, in particular to cover the needs of older persons, adolescents and child-headed households.
- Ensure that cooking items provided are culturally appropriate and enable safe practices.
- Ensure that existing local practices and environmental issues are taken into account in the specification of stove and fuel solutions.

27. Groups with specific needs

- Ensure that there is no discrimination or restricted access to non-food items (NFIs) based on sex, age or abilities.
- Ensure that distribution sites are in a secure area that is accessible to men, women, unaccompanied children, elderly, sick and disabled persons.
- Conduct regular consultations with women, girls, boys and men and groups with specific needs such as older persons, unaccompanied and separated children; child-headed households and disabled persons on commodity issues to ensure any protection concerns are highlighted and resolved.
- Ensure that the demands of collecting fuel on particularly vulnerable groups, such as female-headed households and households caring for people living with HIV/AIDS (PLWH/A), are addressed and that special provisions (such as the choice of less labour-intensive fuels, the use of fuel-efficient stoves and accessible fuel sources) are made available.

Monitoring

Be aware of the potential for abuse and sexual exploitation and train all staff and refugees on their roles and responsibilities and complaints mechanisms.

28. Monitoring the distribution system is an important management responsibility of UNHCR. General principles of monitoring are described in chapter 8 on implementing arrangements. Monitoring distribution includes monitoring the actual distribution of the commodity and spot checks in the camps on distribution days. See chapter 16 on food and nutrition, and "Commodity Distribution: A Practical Guide For Field Staff", for more details about monitoring distribution systems.

Key references

Commodity Distribution: A Practical Guide For Field Staff, UNHCR, Geneva, 1997.

Memorandum of Understanding on the Joint Working Arrangements for Refugee, Returnee and Displaced Persons Feeding Operations, UNHCR, Geneva, 1997.

Model Tripartite Agreement: UNHCR, WFP and the Implementing Partner, WFP/UNHCR, March 1998.

UNHCR Training Videos: Under Watchful Eyes, UNHCR, 1995 – Sorting it Out, UNHCR, 1993.

Code of Conduct

SG's Bulletin

Annex 1: What do we need to know in order to plan and implement age and gender sensitive distribution of NFIs?

Ask/find out	Information to look for
What are the population demographics?	• Number of households. • Number of women, men, girls and boys. • Number of female, male, grandparent and child headed households. • Number of persons by age and sex with specific needs (unaccompanied and separated children, disabled, sick, elderly). ☐ Number of pregnant and nursing women.
What are the cultural and social roles and responsibilities?	☐ Responsibilities for carrying of and different usage of water. ☐ Who does household chores, cooking, caring for children. ☐ Who collects firewood or fuel used to cook and heat home. ☐ Who undertakes agricultural activities and looks after animals.
What did people have before the crisis?	☐ What did the population use before the displacement, e.g. cooking practices – what fuel source was used? ☐ What type of clothes did people wear, e.g. scarves for women? ☐ What hygiene products (including sanitary materials) do they need? Are most appropriate? ☐ Who/how are decisions made about reproductive health? What NFI could be necessary?

Annex 2: Indicator checklist for non-food items

	Indicator Checklist for NFIs	Status
1.	Men and women are involved in planning and implementation of NFIs selection and distribution.	
2.	Information is gathered on family structures and a distribution system is set up accordingly.	
3.	Information is gathered on special NFI needs based on age and sex.	
4.	Displaced persons have knowledge of quantity and variety of items they should receive.	
5.	Men and women benefit equally if there is payment for NFI distribution (gender balance in employment).	
6.	Women, girls, men and boys have at least one full set of clothing in the correct size, appropriate to the culture season and climate.	
7.	People have access to a combination of blankets, bedding or sleeping mats to provide thermal comfort and to enable separate sleeping arrangements as required.	
8.	Women and girls have sanitary materials for menstruation.	
9.	Training or guidance in the use of NFIs is provided where necessary (e.g. men to learn how to cook, women to build shelters).	

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Water

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Situation

Water is essential to life, health and dignity and is therefore a basic human right. In emergencies, it is often not easily accessible in adequate quantity and quality, thus creating a major health hazard. Hence, water is among the primary criteria in the selection of a site for a refugee camp.

Objective

To provide a sufficient amount of clean drinking water for the persons of concern and to meet their household and other communal needs in such a way that facilitates easy and safe access and is reliable, efficient, cost-effective and environmentally benign.

Principles of response

- Give priority to quantity while respecting quality
- Refugee women, girls, boys and men should be directly involved in the development and operation of the water supply.
- Ensure consideration of water supply at the site selection and planning stages and coordinate response closely with physical planning, public health and environmental sanitation measures.
- If at all possible, avoid the need to treat water – it is better to use a source that does not need treatment. If large numbers of refugees are concentrated in camps, disinfection of drinking water is absolutely necessary. Other types of treatment should be considered according to the characteristics of the raw water.
- Provide a reserve supply and spare capacity to meet temporary difficulties and the needs of new arrivals.
- Water is a precious natural resource; over exploitation will affect refugees, the host community and all other flora and fauna in the vicinity. Monitoring is essential to avoid any such over exploitation.

Take account of seasonal variations in water quantity and quality.

- Seek expert advice and coordinate closely with the appropriate national services.

Action

- Calculate the water requirement and organize an immediate assessment of water supply possibilities; this calculation should be based on a figure of 20 litres per person per day (excluding leakage) and must also include the communal building needs.
- Make an inventory of water sources and assess all sources in terms of their water quality and yield.
- Protect existing water sources from pollution and provide good quantities of water of a reasonable quality.
- Improve access to supplies by developing sources and a storage and distribution system to deliver a sufficient amount of clean water, including a reserve supply. There must also be enough distribution points located in secure locations and provision of appropriate and adequate storage capacity at household level.
- Ensure regular testing of water quality.
- Set up a support system for operation and maintenance as well as carrying out adequate surveillance.
- Maintain and update information on water resources obtained during needs assessment, planning, construction, operation and maintenance.
- Monitor access to water by the different members of the population, particularly older persons, those with disabilities and child-headed households.

- Ensure that those who collect water are not exposed to violence, including sexual and gender-based violence (SGBV), on the way to and from water collection points.
- Consider who collects water and how this impacts on their other daily activities when designing accessibility. Bear in mind that, as it is usually women and children, water collection can keep children from attending school and can be time consuming for women who already have a very full day.

Introduction

1. People can survive longer without food than without water.

The provision of water demands immediate attention from the start of a refugee emergency. The aim is to assure availability of enough water to allow its effective distribution in the required quantities, and to ensure that it is safe to drink and is easily accessible.

Adequate storage capacity and back-up systems for all components of a water system must be assured; interruptions in the supply may be disastrous.

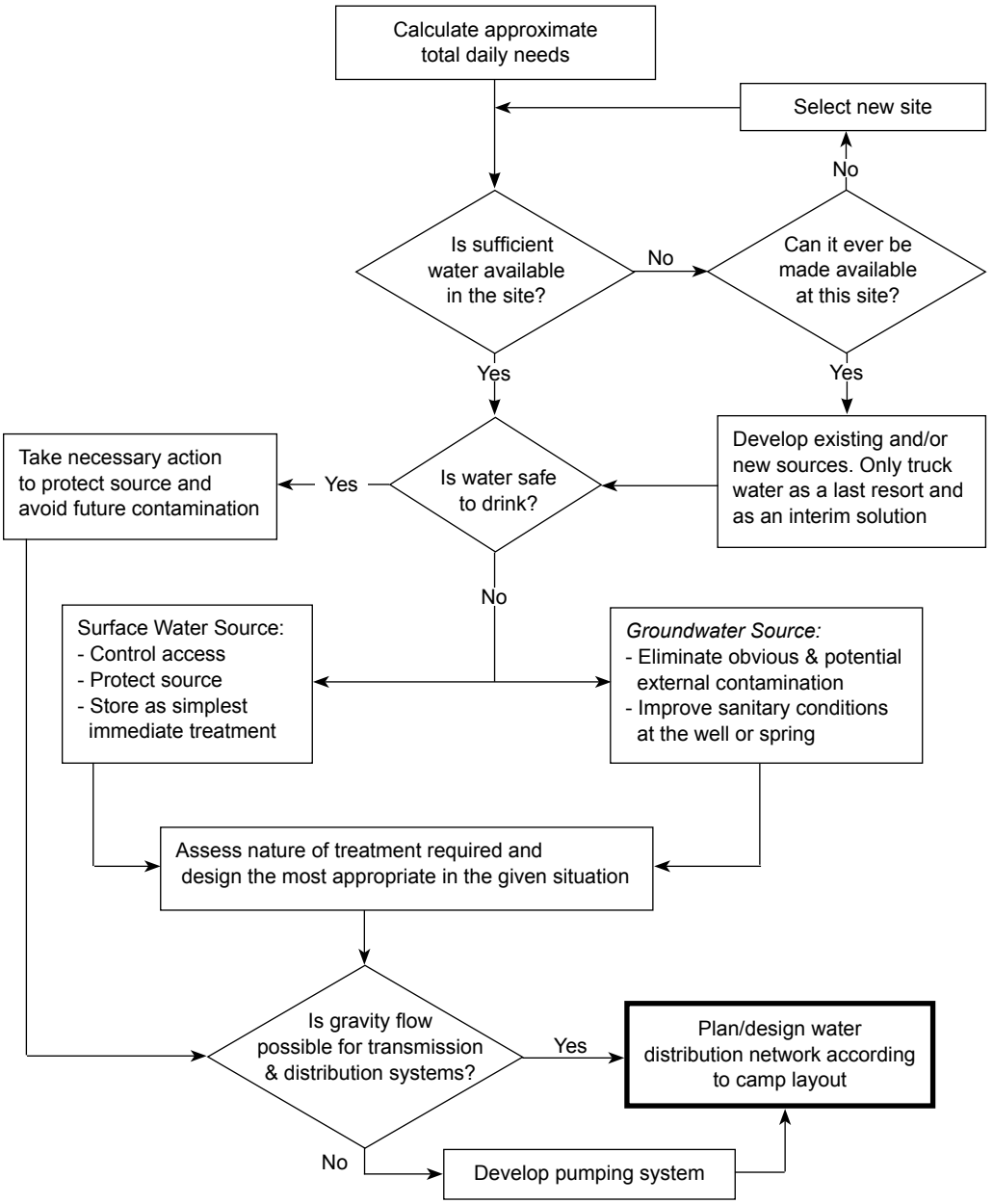
2. If it is evident that available sources are inadequate (in terms of yield or water quality), arrangements must be made to find alternative sources. If necessary, water may have to be imported to the site (by truck, barge, pipelines, etc.). Where even the most basic needs for water cannot be safely met by existing resources, or when time is needed for further exploration and development of new sources, refugees should be moved to a more suitable location.

3. Water quality is difficult to assess. Always assume that all water available during emergencies is contaminated, especially if it is taken from surface water bodies (lakes, ponds, rivers, etc.). All sources of water used by refugees must be separated from sanitation facilities and other sources of contamination. In many circumstances, treatment will be needed to make the water safe to drink. Safety of the water must be assured right through to its consumption in the household. Hence, poor storage practices at household level must be tackled by hygiene promotion and provision of appropriate means for storage.

4. As it is difficult to predict the life-span of a refugee camp, it is best to plan on a cost-effective, long-term basis.

5. Figure 1 shows some of the considerations for planning an emergency water supply system.

Figure 1 – Considerations in Emergency Water Supply



6. The sectors of water, sanitation and site planning are highly interdependent. This chapter should be read in conjunction with the chapters on these topics.

7. In a refugee camp, access to clean water is not just ”what” but also ”how” we provide this life sustaining resource. A water supply system in a camp situation should therefore consider the following:

- *Adequacy and equity of water distributed*: Sufficient supply for basic needs for each and every person throughout the camp, including in school and health units.
- *Acceptability and safety of water supplied*: Potable and palatable in terms of appearance, taste and odour. Water quality is monitored regularly for faecal contamination and water safety plans are in place.
- *Social costs (burden) on the users*: Facilities located centrally and not too far from the dwellings, with minimum waiting time, and safe and user-friendly designs.
- *Physical safety of the users*: Facilities located in a secure physical environment; water distribution time and duration planned according to users convenience and cultural habits, and limited to day-light hours.
- *Reliability of supply*: There needs to be continuous maintenance of the water supply system as well as adequate water storage at the family and community level in case of interruptions.
- *Environmental concerns/hazards*: Sustainable exploitation of water sources, waste water management, improved drainage for storm water to avoid water-induced hazards etc.
- *Efficiency of supply*: Avoiding water wastage during fetching from tap stands and other system losses.
- *Participation of stakeholders*: Refugees and other sectors (health, physical planner, sanitation) involved in water system development and operation as well as maintaining a good rapport with the host community.

Assessment and organization

- An immediate, on the spot, assessment of local water resources in relation to needs is essential.
- Technical expertise is required and local knowledge is most important. Outside expertise should be brought in only when clearly necessary. The government’s central and local authorities should be involved as much as possible in this assessment. Knowledge of the local terrain and conditions is indispensable.
- Work with refugees, use their skills and train them to operate and maintain the system.
- Involve refugees, particularly women and children in determining distribution points.
- Technology and equipment should be simple, reliable, appropriate and familiar to the country.
- Refugees may compete with the local population for water resources. This may cause problems between the two groups and lead to violence, including SGBV.
- Available sources must be protected from pollution at once.
- The water supply system must be supported by appropriate public health measures and hygiene promotion activities.

Assessment

8. The objective of an assessment of water resources for human consumption is to ascertain the availability of water (its quantity and quality) and the associated technical parameters related to distribution in relation to the demand.

9. The assessment of supply possibilities requires special expertise and involves identifying possible sources and assessing the potential for development and exploitation. A typical checklist of issues to be considered when carrying out initial assessments would include:

- Procurement and studying of local maps, aerial photos, satellite imagery etc. to determine topography and water sources.
- Consolidation of regional details on land use (urban, industrial, agricultural, protected areas), climate, security, access roads, etc.
- Details of main actors and agencies working in the area and local government structures and policy.
- Current typical water consumption and sanitation practices in the area.
- Logistics and supply possibilities in the area.
- Yield estimations (volumes, flow, seasonal variation, recharge etc.).
- Current water quality and potential pollution risks.
- Legal issues in the area as well as ownership rights etc.
- Costs and operations and maintenance requirements and opportunities in the area, availability of skilled personnel.

Further information on preparedness measures in different setting can be found in Emergency Water Sources (WEDC, 1997).

10. Sources of water can be identified by: the local population, the refugees themselves, the lie of the land (groundwater is often near the surface in the vicinity of rivers and in other low places; its presence at shallow depths is usually indicated by some types of vegetation), maps (topographical, geological), remote sensing imagery (satellite images, aerial photography), previous surveys of water resources, national or external experts (hydrologists, hydrogeologists).

11. Assessing the water resources requires expertise in, for example, water engineering, sanitation and in some cases logistics as it involves identifying various options for supply system development on the basis of local physical features, topography and overall environment of the camp site. Further surveys will be necessary to cover relevant information on the refugees, other beneficiaries, and the socio-economic characteristics of the host community. The results of such assessments and surveys should be systematically filed to ensure that such data will be available for future reference.

12. If it becomes clear that locally available expertise including that from partner agencies will not suffice, assistance from the Technical Support Section (TSS) at Headquarters should be requested without delay until a long-term solution can be secured.

13. Seasonal factors must always be carefully considered.

Supplies that are adequate in the rainy season may dry up at other times.

Local knowledge, historical and hydrological information and statistical interpretation should all be taken into account to determine the seasonal patterns.

Organization

14. Bear in mind that the economic and social bases of refugee groupings differ from those of the host communities. In addition, an influx of refugees may overstrain water resources used by the local population and lead to tension between the two groups. Special arrangements should be made with local authorities and other implementing partners for adequate operation and maintenance arrangements. The technology used in the water supply

systems should be carefully evaluated to ensure it is appropriate and that long term operational needs (fuel, spare parts, management, etc.) will be within reach of the refugees and camp managers.

15. The provision of safe water could become impossible without the beneficiaries' understanding and cooperation. As far as possible the system should be developed in collaboration with the refugees who should be involved in its operation and maintenance from the start.

Even the best system needs continuing maintenance, otherwise it will soon loose efficiency or break down completely.

Refugees without prior experience should be trained.

16. In order to be effective, water quality control and treatment have to be combined with adequate sanitation provision, improved personal hygiene and environmental health practices. Basic public health education stressing the importance of avoiding pollution of the water by excreta and of the use of enough clean containers in the household, will be essential.

17. The water supply system design and construction must be closely coordinated with site planning and layout and must be supported by health, education and environmental measures, in particular sanitation. It is only through close collaboration between these sectors that the public health and environmental protection impacts be maximized.

As a general rule, technology should be appropriate to the country and should draw on local experience.

Where pumps and other mechanical equipment are necessary, supplies should be standardized as far as possible across UNHCR and partner operations.

Locally available material and equipment should be used as much as possible.

Local familiarity, availability of spare parts, fuel and ease of maintenance are priority considerations.

18. Both organizational and technical aspects of the complete water supply system need to be carefully monitored. The use of the system must be controlled and water wastage or contamination prevented. Maintenance must be assured, and technical breakdowns quickly repaired.

The need

- **Demand:** For domestic needs and personal hygiene, calculate on at least 20 litres per person per day, after leakage. Absolute minimum survival allocation is 7 litres per day. Communal building needs will require extra water.
- **Quality:** To preserve public health and personal hygiene, a large amount of reasonably safe water is preferable to a smaller amount of very pure water.
- **Monitoring:** The water must be safe, test the physical, chemical and bacteriological quality of new sources before use and regularly thereafter, and immediately following an outbreak of a disease which might be caused by unsafe water. Groundwater levels of well should be checked regularly to verify the sustainable use of this resource.

Quantity

19. Minimum water needs vary: it increases with air temperature and physical exercise. As a general indication, the following amounts of water are desirable:

Minimum daily requirements:

Minimum survival allocation: 7 litres per person per day. This should be increased to 20 litres per person as soon as possible.

Communal needs and a spare capacity for possible new arrivals should be added.

Health centres: 40-60 litres per patient per day.

Feeding centres: 20-30 litres per patient per day.

Schools: 3 litres/pupil/day.

Mosque: 2 to 5 litres/person/day.

Hand washing at communal latrines and Offices: 1 to 2 litres/user/day for hand washing, and 2 to 8 litres/cubicle/day for cleaning.

20. Further needs may include: livestock, sanitation facilities, other community services, irrigation and construction of camp infrastructure (e.g. roads or concrete structures). Annex B of UNHCR's Water Manual provides additional indicative figures on water requirements including livestock and agricultural crop needs. The more convenient the supply, the higher will be the consumption.

A larger quantity of reasonably safe water is preferable to a smaller amount of very pure water.

21. A reduction in the quantity of water available to individuals will directly affect the overall health status of the refugee population. As supplies are reduced, personal and domestic hygiene suffers, and the reduction is reflected in increased incidence of parasitic, fungal and other skin diseases, and diarrhoeal diseases.

Even those individuals who may have traditionally lived on less than the normally recommended amount of water will require more water when living in a refugee camp, because of crowding and environmental factors.

22. The availability of water will be a factor in deciding on a sanitation system. Pit latrine systems do not need water to function; but showers, washing, laundry or pour-flush toilet facilities all require water.

23. Water will probably be of little use in controlling major fires on refugee sites owing to a lack of sufficient quantity and pressure.

If more refugees are expected to arrive, plans must allow for a substantial spare capacity over the initially assessed needs.

Quality

24. The water must be both acceptable to the refugees and safe to drink. Water that tastes and looks acceptable will be drunk by refugees who may unknowingly expose themselves to the dangers from microbiological organisms or harmful chemicals.

25. The most serious threat to the safety of a water supply system is contamination by faeces; once the water has been contaminated it is difficult to purify it quickly under emergency conditions.

26. Take great care to avoid pollution by livestock. Separation of human water supply points from those used by animals is a must. As a rule of thumb, cattle need about 30 litres of water daily. Water will also be needed, after the emergency phase, to irrigate food (vegetable gardens, crops) cultivated by refugees.

27. Water may contain pathogens, particularly certain viruses, bacteria, protozoan cysts and worm eggs which are transmitted from faeces to mouth directly in the water or via hands, flies or food. Water contamination by human faeces is the major concern, although animal faeces in water may also cause disease transmission. Water contamination by urine is a significant threat only in areas where urinary

schistosomiasis (*Schistosoma haematobium*) is endemic but should be avoided as best practice.

By far the greatest risk associated with polluted drinking water is the spread of watery or bloody diarrhoea and infectious hepatitis (Hepatitis A).

28. Acute watery and bloody diarrhoea are caused by a variety of viruses, bacteria and protozoa. The numbers of viruses and protozoa in water will decrease with time and more rapidly at warm temperatures. Bacteria behave similarly, but in exceptional circumstances may multiply in polluted water. The infectious dose of the viruses and protozoa is typically very low (<10), whereas the dose of bacteria needed to establish an infection in the intestine may be larger (~10^4).

Monitoring

29. New water supplies should be tested for bacteriological quality before use and existing ones checked regularly and tested again immediately following any outbreak of disease which might be caused by unsafe water.

30. Potability analysis involves studying the chemical, physical and bacteriological characteristics of the water. Although it is possible to examine water for a specific pathogenic organism, a much more sensitive test for routine analysis uses an indicator organism, called faecal coliforms, the majority of which are *Escherichia coli* (or *E. coli*), which is a normal inhabitant of the intestine of warm-blooded animals and is excreted in large numbers. If these bacteria are found in water, faecal pollution is indicated and the sample is therefore potentially dangerous. Concentrations of faecal coliforms are usually expressed per 100 ml of water.

31. A typical rule of thumb for the number of samples to undertake is 1 sample per 5000 beneficiaries per month. Water quality testing kits are available that use aseptic techniques to take samples, process them and incubate them at 44°C for faecal coliforms.

32. Every time a water quality sample is taken from the house, tap, supply system or source, a sanitary survey form (comprising of 8 to 12 questions usually) must also be completed. This is a systematic assessment of visible risks to water quality at that point. Such forms can help understand the reasons for water quality problems and deterioration in quality over time. They are also useful for identifying remediation interventions. Further details are given on the TSS Toolkit available on the UNHCR Intranet or on CD-Rom, upon request at Headquarters.

33. The results from the sanitary survey and the water quality analysis can be used as a guide to the level of risk the people drinking are exposed to when using a particular water source. The following table outlines typical levels of water quality and corresponding risk levels.

Table 1: Water quality, risk and priority levels

Faecal coliform level	No. of risks identified by sanitary survey	Risk level	Priority of intervention
0	0	Extremely low	None
1 to 10	1 to 3	Some pollution: low risk	Low
11-100	4 to 6	Polluted: intermediate to high risk	High
101- 1000 and above	> 7	Very polluted: very high risk	Urgent

34. In cases where the water is disinfected by chlorination, it is easier and more appropriate to test for the presence of free available chlorine at household level than for bacteria. The presence of a water turbidity of <5 NTU and a free chlorine in the range between 0.2 mg/l and 0.5 mg/l at the distribution point indicates an adequate quality water.

35. The water must, of course, be safe at the time of consumption or use in the household, not just at the distribution point. Domestic hygiene and environmental health measures to protect the water between collection and use are important. The water in storage tanks and any tanker trucks should also be tested regularly.

36. Where drinking water is scarce, use non-potable, brackish or salty water for washing.

Immediate response

- If even the minimum amount of water cannot be made available in time from local sources, the refugees should be moved to more suitable site or water trucking should be organized until longer term supply evaluations can be finalized.
- Whatever the water source, take immediate action to prevent pollution by excreta. (See chapter 17 on sanitation and hygiene for further details).
- Organize a distribution system that prevents pollution of the source and ensures equity if there is insufficient water.
- Ensure that refugee families have adequate means to fetch and store water.
- If in doubt on water quality, chlorinate the supply, or in emergency epidemic outbreaks, distribute chlorine tablets (or compatible other commercially available products) for use at the household level, if boiling of water is not feasible.

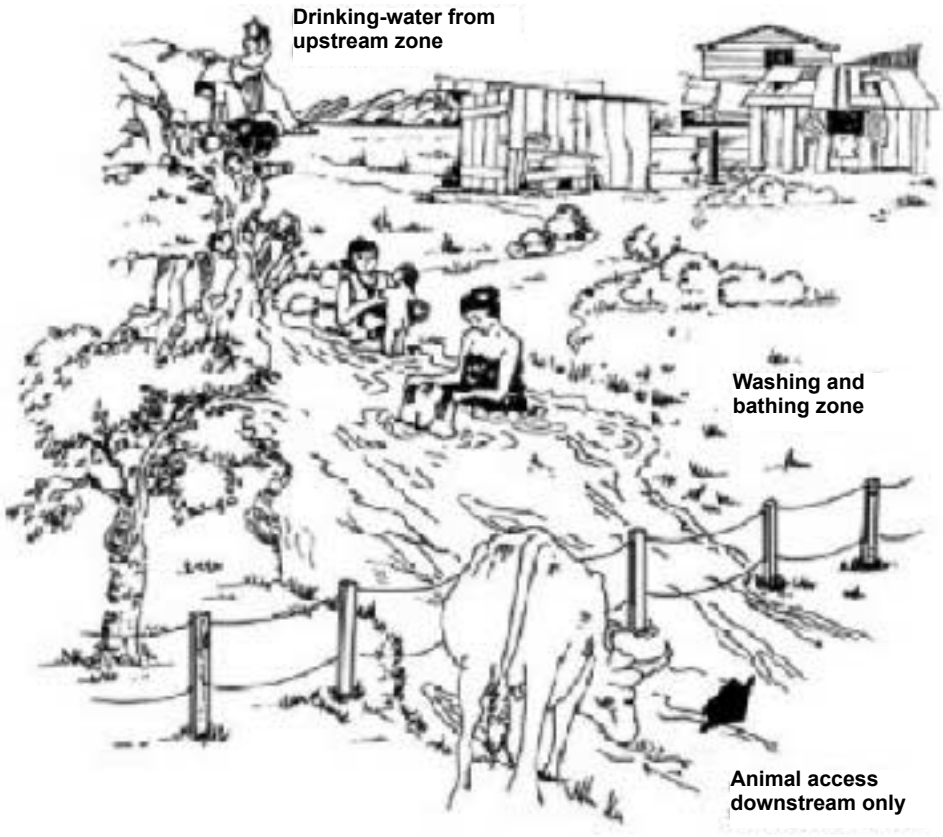
37. Work with community leaders to organize the refugee community and make the community aware of the possibilities and dangers of existing water sources and convey the idea of trying to prevent pollution of these sources by excreta. If the source is flowing, supplies must be drawn off upstream and a special area set aside for this. Then allocate an area for washing, and finally downstream of the settlement, allow any livestock to drink (see Figure 2). Fence off parts of the river banks as necessary, and beware of any dangers in the water, such as reptiles.

38. Where the source is an open spring, fence off, cover and control the source and if the source is a well prevent refugees from drawing water with individual containers that may contaminate the source by providing a windlass or hand pump.

39. If possible, arrange to store water and to distribute it at collection points away from the source. Not only does this help avoid direct contamination but storage can make water safer.

40. From the start, families will need to be able to carry and store water at the household level. They must be able to transport at least 50 litres (from water distribution points to the household) and store at least 20 litres per household (1 household = 5 persons). Suitable containers (10-20 litres) are essential. Collapsible jerrycans are recommended, especially when their transportation to the site may involve airlifts. Jerrycans must have narrow inlets to prevent contaminating objects and children's hands from getting in. For this reason, buckets and other wide necked containers are not recommended. Sometimes empty cooking oil containers are available which may be appropriate. As jerrycans are subject to much wear and tear, bi-annual redistribution of jerry cans should be undertaken in camps.

Figure 2 – Use of fences to demarcate human and animal watering places; From Environmental Health in Emergency and disasters, WHO (2002)



If the immediately available supplies of water are insufficient, action to ration supplies and to ensure equitable distribution will be a priority.

41. Rationing is difficult to organize. The first step is to control access to the sources, using full-time guards if necessary; uncontrolled distributions are open to abuse. Distribution at fixed times during daylight hours for different sections of the site should be organized. Vulnerable groups may need special arrangements. Every effort must be made to increase the quantity of water available so that strict rationing is unnecessary.

42. In parallel to these steps, action must be taken to improve and consolidate the water supply system as a whole keeping in mind the long-term plans. The following sections outline the main considerations.

Water supply systems

(See chapter 12 of UNHCR's Water Manual)

- A water supply system is a combination of structures with the following purposes:
  - extraction from the source, and its protection;
  - purification/treatment of the water;
  - transmission to the refugee camp or settlement;
  - storage – collection, treatment, balancing supply, service, household;
  - distribution network/reticulation (including tap stands); and
  - waste-water disposal.

- It is vital to ensure the system components are compatible with each other and appropriate in view of the supply and demand, and can be maintained from locally available resources and at the lowest possible overall (capital, operation and maintenance) costs.
- The system will have to be planned, designed, constructed and put into operation in a short period of time (involving the refugee population as much as possible). The complexity of the task requires professional expertise which should be sought at the beginning of the project. Pay attention to long-term operation and maintenance requirements from the start such as diesel, chlorine, new taps and maintenance personnel.

43. As soon as possible, make an overall plan for the longer-term water supply system. At least some elements of the plan will be problematic – there is often a lack of basic data or difficulty in obtaining the planning or design tools (cartography, hydrological data, etc.). The following steps should be taken:

i. Search for potential sources within a reasonable distance from the proposed camp site.
ii. Carry out preliminary surveys to assess water quantity and quality (see above). In addition, collect relevant information on the beneficiaries using participatory assessment on the socio-economic characteristics of the host community and on the physical environment of the refugee sites.
iii. Outline implementation arrangements for construction and operation.
iv. Produce a preliminary design concept (see chapter 12, paragraph 2, of UNHCR's Water Manual) with alternative plans to take into account implementation time, technology considerations and cost-effectiveness.
v. Commission detailed surveys to refine all aspects and details of the adopted design.
vi. Produce final designs and estimates.
vii. Organize refugees involvement on the project.
viii. Implement the project, including technical supervision, maintenance, monitoring and reporting.
ix. Organize operation and maintenance, including the establishment of a committee in which refugees and relevant assistance sectors are represented (health, sanitation, community services).

44. See UNHCR's Water Manual for additional information and details on these issues (chapter 6, paragraphs 1, 36; chapter 11, paragraphs 2, 3, 11; chapter 12, paragraphs 5, 12-8, 16).

45. An ill-conceived or badly managed water supply system will soon create problems. The long-term needs of the refugees should be considered while searching for solutions to the emergency needs. All efforts to avoid long-term problems will prove, with time, very valuable.

46. All information gathered during the assessment and planning as well as design data, including sketches and maps locating pipeline and water supply facilities should be properly documented for future reference. This basic data collected and maintained during the emergency phase, is often subsequently lost or misplaced, and is essential for operation and maintenance of the system and for its upgrading, and for monitoring the level of services to see if the basic minimum standards are met.

Water sources

(See UNHCR Water Manual, chapter 6)

- Rain water, groundwater from springs and wells or water from municipal and private systems are usually of better quality than surface water from sources such as rivers, lakes or dams and should be used if available.
- Surface water should be considered to be contaminated and must be treated prior to use.
- Physical protection of the source from pollution will be essential.
- New or repaired sources and equipment should be disinfected before use.
- Develop a data bank of water sources.

Introduction

47. There are three main natural types of fresh water: surface water (streams, rivers, lakes), groundwater (underground or emerging as springs) and rain water.

48. Considerations in choosing between alternative sources of water in an emergency include:

i. speed with which the source can be made operational;
ii. volume of supply;
iii. reliability of supply (taking into account seasonal variations and, if necessary, logistics);
iv. water quality, risk of contamination and ease of treatment if necessary;
v. rights and welfare of local population;
vi. simplicity of technology and ease of maintenance; and
vii. relative cost comparison considering capital outlay and operation and maintenance expenditure.

49. Take careful account of systems and methods already in use locally. Adoption of well-proven and familiar techniques, combined with action to improve protection against pollution is often a sound solution.

50. Besides organizational measures to protect the water supply, some form of treatment may be necessary. However, if possible use sources that do not require treatment. The treatment of unsafe water, particularly in remote areas, can be difficult and requires trained supervision to be reliable.

51. Gather as much technical information as possible on the different water sources to allow a simple cost-benefit analysis of alternative solutions. The decision on which sources to develop and the technological approaches to be used should take into account the need to develop systems to efficiently cover both immediate and longer-term needs.

Surface water

52. Water from streams, rivers, ponds, lakes, dams and reservoirs is rarely potable. Its direct use is likely to require treatment measures (at least sedimentation and disinfection) that may be complicated to plan and implement during most refugee emergencies.

Rainwater

53. Reasonably pure rain water can be collected from the roofs if these are clean and suitable. This method can only be the major source of water in areas with adequate and reliable year-round rainfall; it requires suitable shelter and individual household storage facilities. It is, therefore, not a suitable solution in most refugee emergencies.

54. Rain water may be a useful supplement to general needs, for example through special collection for community services such as health and feeding centres. Rain water may be a useful source of safe water for individual use at a time when other water is plentiful but unsafe.

Groundwater

55. Groundwater is contained in aquifers. Aquifers are rocks or groups of rocks (ranging from sediments to porous and fractures rocks) capable of transmitting, storing and yielding water.

56. The use of groundwater during refugee emergencies would almost always be the preferred solution: if available, groundwater usually provides the most cost-effective alternative to obtain quickly the necessary quantity and the best quality. However, the decision to use it for long-term needs should be made after a detailed assessment of the aquifer and all factors relating to the recharge, transmission and release of water and on the availability of relevant expertise and equipment.

Springs are the ideal source of groundwater and should be protected against pollution at the source.

57. Water from a spring is usually pure at the source and can be piped to storage and distribution points. It should be taken off from above the refugee camp site if possible. Care should be taken to check the true source of spring water, as some apparent springs may really be surface water which has seeped or flowed into the ground a short distance away. The yield of water from a spring may vary widely with the seasons. It will be at its minimum at the end of the dry season and early in the rainy season. Seek local advice.

58. The intake or collection chamber can be by a simple structure built of bricks, masonry or concrete, from which the water flows directly through a pipe to a tank or collection point. Care must also be taken to prevent contamination above the take off points (see TSS toolkit).

59. Groundwater can be raised by infiltration galleries, tube wells, dug wells or boreholes. (Infiltration galleries extract groundwater horizontally, for example through tunnels and/or ditches). The choice of method will depend on the depth of the water table, yield, soil conditions and availability of expertise and equipment.

60. Without good groundwater resource surveys, preliminary test drilling, or clear local evidence from nearby existing wells, there is no assurance that new wells or boreholes will yield the necessary amount of water of the right quality. They can also be expensive.

A hydrogeological survey must be undertaken before starting any extensive drilling programme.

61. Any new well or borehole must first be developed to full and sustainable yield by an initial period of pumping (usually up to 48 hours). This allows the safe yield to be calculated and pumps out finer soil particles, allowing water to pass more easily into the well. Yields can be raised by increasing the size of the well below the water table, for example in the case of a shallow well, by an infiltration gallery across the line of groundwater flow. If wells are sited too close together, yields will be reduced.

62. Wells, boreholes, infiltration galleries and pumps should be disinfected immediately after construction, repair or installation, as they may have been polluted during the work – two or three buckets of a 2.5% chlorine solution in water would be a suitable disinfectant which would then be cleaned from the well by removing 3 to 5 well volumes. They should be located where surface water and, in particular, any seasonal rain or flood water, will drain away from the well head. They should be above and at least 30 metres away from any sanitation facilities and their discharge. Special techniques are used in the design and construction of these facilities to avoid the pollution of their water.

Sea water

63. Sea water can be used for almost everything but drinking, thus reducing fresh

water requirements. In locations where no adequate sources of fresh water exist but where sea water is near, desalinization is one possible but costly option. Neither of the two basic methods – distillation using the sun's heat nor the use of modern desalinization plants – is likely to meet immediate fresh water requirements in a major refugee emergency, and is therefore strongly discouraged. If no fresh water sources are available at a given site, relocation of the refugees must be considered as a matter of urgency.

Municipal and private systems

64. Existing municipal and private water supply systems in the vicinity of the refugees, for example those belonging to industrial or agricultural establishments, may be able to meet part or all of the need during the emergency phase and should be used where possible before taking unnecessary measures to develop other sources. A substantial increase in the yield and quality of such systems may be possible.

Pumping equipment

(See UNHCR Water Manual, chapter 7)

- Pumps will generally be needed in refugee emergencies. Seek expert local advice on what is suitable, and remember that operators, fuel and spare parts will be needed.
- As much as possible, use gravity rather than pumps for water distribution and treatment systems.
- Emergency water supply solutions involving pumps should be designed to ensure long-term and effective operation: avoid ad-hoc solutions.

65. Once an adequate source of water has been established, arrangements are needed to store and distribute the water to meet minimum needs.

The distribution system should use gravity whenever possible: gravity fed systems are much less costly and easier to maintain than pumping systems.

66. In areas subject to seasonal flooding, or where the level of a river source varies markedly, great care must be taken in placing any pumps, distribution, storage and treatment systems. It may even be necessary to mount a pump on a raft.

67. Water can be raised in two basic ways: by hand, using some kind of water container or bucket, or by using pumps (which may be driven by hand or engine). A captive rope and bucket (i.e. a windlass) carries a lower pollution risk. In this system, only the single rope and bucket that is fixed to the well is used to draw water – refugees fill their own containers from this captive bucket. The system is more reliable and much cheaper than a pump.

Where it can meet the demand, a hand operated system is to be preferred. Not more than 200 people should depend on a well with one rope and bucket.

68. The main uses of pumping equipment in refugee water supply systems are:

i. pumping water from wells or boreholes;
ii. pumping water from surface water intakes; and
iii. pumping water into storage reservoirs.

69. Additionally there may be a need to use pumping equipment for other purposes, for example, feeding water treatment plants, boosting the flow through long pipelines, feeding water tankers.

70. All pumps have moving parts and require regular maintenance. Professional advice should be sought on the selection and placing of pumps. Local familiarity, fuel supplies, spares, ease of maintenance and, above all, reliability, will be the major considerations in pump selection. Hand-pumps may be appropriate because they reduce dependence on outside supply of spare parts and fuel. However, in a refugee emergency, the sudden and large concentration of people requires maximum output of available water. Motorized

pumps have a far greater output and may, therefore, be indispensable.

71. In some circumstances, pumps powered by solar panels may be suitable. Such pumps have relatively high capital costs but are usually reliable and involve no direct running costs, just maintenance costs. The pumps naturally work best in direct sunlight but will still work with light cloud cover. A solar pump might be a solution when the output of a hand pump would be insufficient but large mechanized pumps are not necessary.

72. The minimum daily period during which a pump should be idle is that required to allow the level of water in the source to recover to its old level. Pumps should not be operated for more than ~14 hours a day and preferably not be run at night. Always have a pump on standby in a major supply system to cover repairs and maintenance.

Treatment

(See Water Manual, chapter 8)

- The most serious threat to safety of a water supply is contamination by faeces.
- Only treat water to the extent necessary. Disinfection of drinking water is required if large numbers of refugees are concentrated in camps.
- All water treatment methods require some expertise, regular attention and maintenance.
- In refugee emergencies, the priority is to improve the physical and the bacteriological characteristics of drinking water. Only under very special circumstances would the improvement of chemical quality be considered.
- Cloudy or turbid water should be clarified before disinfection because chlorinating cloudy or turbid water is ineffective.
- Water purification at household level using chlorine tablets or sachets or boiling are not generally appropriate for large-scale water treatment but may be useful in epidemic outbreaks.

Introduction

73. The potability of any source has to be assessed before a decision to use it for human water supply is taken.

74. The importance of trying to find a source that does not require treatment is obvious.

If treatment is necessary it should be the minimum required to ensure acceptably safe water, using appropriate technology and a reliable operational and maintenance system.

75. Correct plant operation and maintenance must be assured. Besides disinfection, other types of treatment should be considered in accordance with the characteristics of the raw water.

76. Determining how to treat water on a large scale is best done by experts. However, simple and practical measures can be taken before such help is available. All methods require regular attention and maintenance.

77. Besides physical measures to protect water at its source and initial disinfection of water sources (usually by chlorine), there are four basic methods of treatment: storage, filtration, chemical disinfection and boiling. These can be used singly or in combination.

Storage and sedimentation

78. Storage is the simplest method of improving water quality. It causes some pathogens to die off and any heavy matter in suspension to settle ("sedimentation").

Leaving water undisturbed in containers, tanks or reservoirs improves its quality.

79. Storage of untreated surface water for 12 to 24 hours will already cause

considerable improvement in its quality; the longer the period of storage and the higher the temperature, the greater the improvement. Be aware, however, that in refugee emergencies, it is very seldom that the amount of water available would be enough to allow the water intended for drinking purposes to be stored for more than a few hours before it is distributed to users. Where sedimentation tanks are used, their capacity alone should equal one day's consumption, thus allowing sedimentation to take place overnight.

80. Longer storage time can help control schistosomiasis (bilharzia), as the parasites die if they do not reach the fresh water snail within 24 hours of excretion by an infected person, or if they do not reach a human or animal host within 48 hours of leaving infected snails. Thus two day's storage would provide an effective barrier to transmission of the disease, provided snails or people do not enter the tank.

81. Sedimentation clarifies cloudy water which can be greatly speeded up by the addition of aluminium sulphate (Alum). A two-tank system is often used, the first tank being a settling tank with the second storing the clarified water. If additional treatment (e.g. chemical disinfection) is required, it can be done in the second tank, and a third one used for storage if necessary.

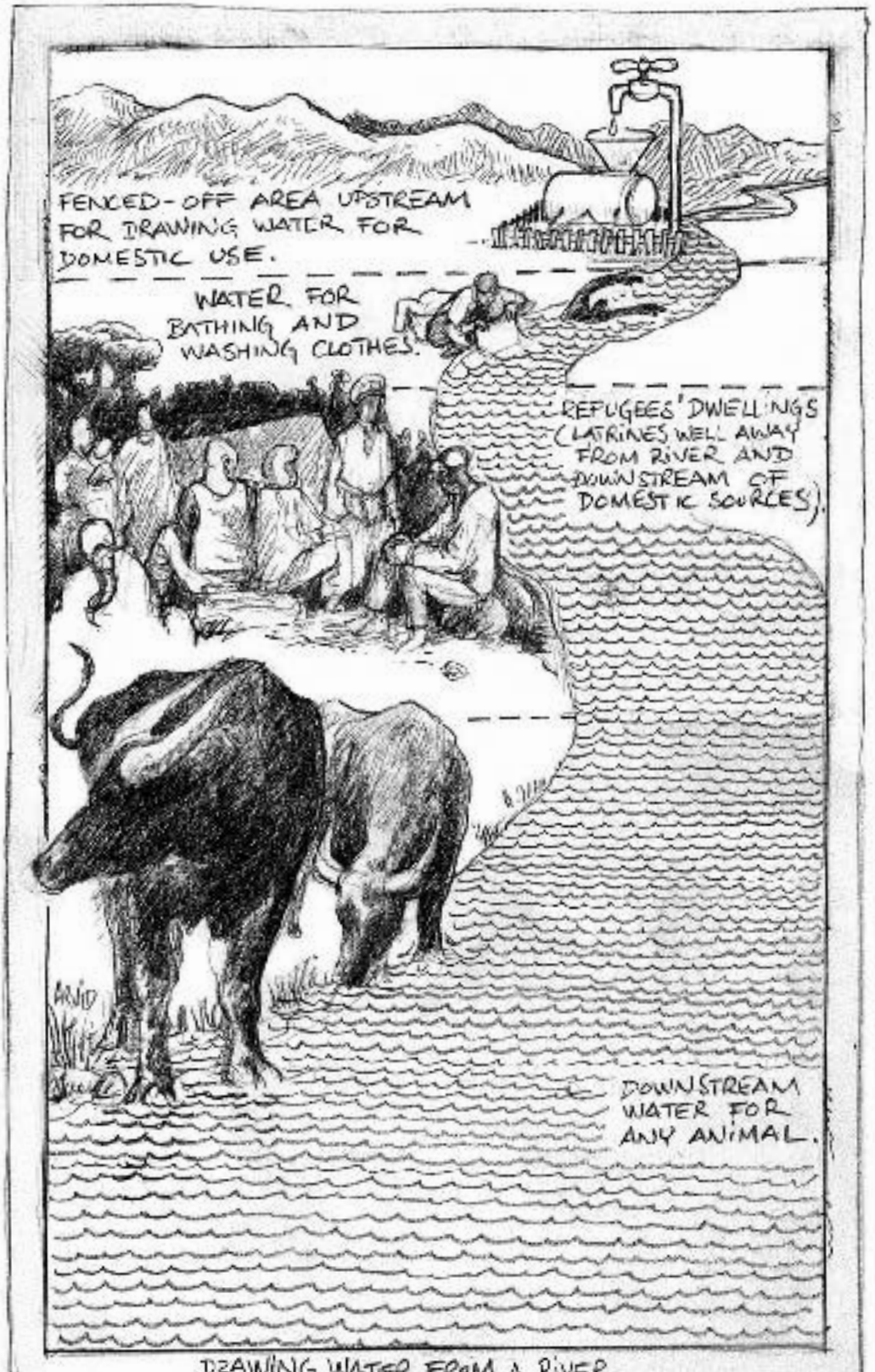
82. Great care should be taken to prevent pollution of stored water. Storage tanks must always be covered: the dangers of contamination of open tanks more than offset the advantages of direct sunlight. The storage area should be fenced off, and if necessary guarded, to prevent children playing or swimming in the water.

Filtration

83. Sand filtration can be an effective method of water treatment. A proper slow sand filter works in two ways. Passage of the water through the sand physically filters out solids, and, more importantly, a thin and very active layer of algae, plankton, bacteria and other forms of life develops on the surface of the sand bed. This is called the "schmutzdecke", where microorganisms break down organic matter.

84. The rate of filtration depends on the surface area, depth and type of sand through which water is passed, and the depth of water above the level of the sand surface. The usual size range of the sand is 0.3 - 1 mm. Provided the rate of filtration is slow enough, the quality of the treated water is very good.

85. Many types of sand filters are described in the available technical guides (see key references). A packed drum filter can be improvised if drums and sand are available and this may be a good way of providing limited quantities of safer water quickly, for example for a health centre. The water passes down through sand on a 5 cm layer of gravel and is drawn off at a rate that should not exceed 60 litres per hour for a 200 litre drum. If a tap is used, unfiltered water equal to the amount drawn off is simply added to the top. Other types of sand filters include slow sand filters, horizontal sand filters and river bed filters or infiltration galleries (suitable only where the bed is permeable). These can be used to treat larger amounts of water but are likely to be more difficult to set up quickly and effectively. For a river source a possible intermediate measure is to dig a well close to the bank. The water recovered will be river water but will have been filtered through the bed and bank.



DRAWING WATER FROM A RIVER

Chemical disinfection

86. Disinfection of water on a large scale is a rule in all refugee emergencies. Purification of wells, sand filters, pumps and piped water systems will be required initially. Iodine or various forms of chlorine can be used for disinfection and purification. Chlorine is more widely used, cheaper and often more readily available. The most generally suitable form of chlorine for refugee emergencies is calcium hypochlorite powder. Slow-releasing chlorine, High Test Hypochlorite (HTH), tablets for wells are another option. Expert advice is essential for large-scale chlorination. As with all other water treatment methods, disinfection requires regular attention; it will be of little value if it is not fully reliable. Whilst clear water usually only requires chlorination, turbid water usually requires sedimentation and/or filtration before the chemical disinfection. Chlorination should therefore take place after any sedimentation or filtration process has been undertaken. It requires at least thirty minutes to act.

87. Care must be taken to ensure strict control of any chemical disinfection process and particularly to test the water for chemical residual levels after each disinfection and before distribution. After chlorination, and once chlorine has reacted, (about 30 minutes after dosage) there should be 0.5 mg/l (0.5 parts per million) of free available chlorine left in solution, in other words, still available to kill bacteria. The amount of chlorine required to achieve this is usually a broad indication of the level of pollution. If the amount of free available chlorine is significantly higher than 0.7 parts per million, people may not be prepared to drink the water; over-chlorinated water tastes unpleasant and will have the reverse of the desired effect if people therefore prefer untreated water.

88. A pocket size chloroscope (chlorine comparator kit, preferably of the DPD1 type) tests for residual chlorine levels. This test is simple and all treatment plant attendants should be trained to use it to frequently check the water quality. In view of the fact that water may be kept in storage, after chlorination, for some time before distribution, and bearing in mind that residual chlorine levels tend to drop with time, it is important to ensure any water leaving the plant should have, at least, a residual chlorine content of 0.5 mg/l (or parts per million) of free available chlorine to be regarded as safe.

89. When chlorination equipment is not working, the water should not normally be distributed. Therefore to ensure a continuous water supply, back-up chlorination equipment should be available in any water treatment plant.

90. Chlorine and iodine water purification tablets are also available, but are rarely suitable for water treatment for large populations. They may be used in health or supplementary feeding centres.

Boiling

91. Boiling is the surest method of water sterilization. At low altitudes, water that is simply brought to a rolling boil can be assumed to be free of pathogenic bacteria. Boiling should, however, be continued for one minute for every 1,000 metres of altitude above sea level, as the boiling temperature reduces with altitude. Domestic fuel supplies may limit the feasibility of this option as boiling requires about 1 kg of wood per litre of water, although environmentally friendly stoves can reduce this amount of wood. However, if the refugees have traditionally boiled their water and can continue to do so, this should be encouraged and, at least initially, might make the need for other types of treatment less urgent.

Storage

- All refugee sites must be provided as soon as possible with adequate water storage facilities, in the distribution system as well as at household level;
- Water storage may be the only means of ensuring a constant availability of water to cover the needs of a camp population;
- In general, use local technology for the design and construction of storage tanks or reservoirs. However, using prefabricated tanks may sometimes be the only way to provide water quickly enough in emergencies. Whereas large ferro-cement tanks (45 to 90 m^3) (see TSS toolkit for details) are a good solution to use in long-term operations while prefabricated tanks are used in the initial emergency phase;
- Ensure that the size, location and overall design of storage tanks are compatible with all other system components and design characteristics.

92. In nearly all systems, it will be necessary to store water in covered tanks between the sources and distribution points. As well as providing an essential reserve both during the emergency and for long-term use, storage will facilitate monitoring, collecting, treating and distributing safe water.

All refugee sites and families must be provided with facilities as soon as possible to store an adequate reserve of water.

93. The size of the reserve to be used will depend on the number of people and on the nature of the water supply system.

Water can be stored in various locations:

i. at the water collection point in tanks;
ii. in central storage tanks (before or after treatment) to balance supply with demand and to allow for gravity-fed distribution;
iii. at distribution points in tanks, including public stand-pipes or other service points at health centres, camp administration facilities, staff houses, etc.; and
iv. at the refugee household level in small containers. These containers should not be the same as the ones used to collect and transport water from distribution points.

94. Whatever the type of storage needed, adequate enclosure should be provided to prevent any contamination from humans, animals, dust or any other source. A tight cover and dark storage also prevent algal growth and breeding of mosquito larvae.

95. In areas with pronounced dry and rainy seasons, the construction of a pond reservoir to collect water may be an option (depending on the local topography), despite the dangers of pollution and of mosquito breeding. Catchment tanks for the collection of surface water can also be considered. Pits are dug in the ground to catch and hold the water which runs off hard ground during heavy storms. They need a special lining to hold the water and should be covered if possible.

96. Tanks above ground may be needed where the water table is very high and contamination cannot otherwise be avoided. Many types of simple and portable storage tanks are available, and some can be supplied with a complete distribution system. Headquarters' advice should be sought if local resources cannot meet this need.

Distribution

(See UNHCR Water Manual, chapter 10)

- An appropriate water distribution system should ensure an even coverage of water needs among camp beneficiaries.
- Keep the distribution system simple.

- Under normal circumstances, water distribution in refugee camps should be carried out through public distribution stand-pipes located centrally with safe access.
- Every measure should be taken to minimize wastage and leakage of water in the distribution system as well as at the stand-pipes.
- Refugees must have easy but controlled access to water.

Ideally, no dwelling should be further than 200 metres or a few minutes' walk from distribution points.

97. Experience has shown that where people have to fetch water from considerable distances, they tend either not to fetch enough to limit water-washed diseases or to collect water from closer but contaminated sources. Water distribution will be an important consideration in the layout of the site to avoid potential sexual and gender-based violence (SGBV) and mitigate against other social burdens as often it is women and children who have the task of water collection. The areas round the distribution points should be paved with stones or gravel, or protected by boards, with a run off structure to allow proper drainage.

98. Water can be distributed to individual users in many ways, depending on local conditions. Uncontrolled access by individual consumers to primary water sources should be avoided.

A distribution system should have a sufficient number of outlets to ensure that people do not need to wait for long periods to have access.

99. Service and administrative buildings should be provided with private connections.

Equity in the distribution of scarce water is an extremely important consideration.

100. While persons with special needs (the sick, wounded, most severely malnourished, children, pregnant and lactating women and the disabled) should have adequate and assured allocations, scarce water must be evenly shared among the rest of the population. Refugees should be encouraged to assume responsibility for equitable distribution. Arrangements should be carefully monitored to detect and prevent abuses. In some situations, water meters have proved a cheap and effective way of identifying excessive use and reducing wastage/leakage.

101. Standpipes with push taps are recommended to be used as outlets where possible. Multiple tap standpipes are normally constructed, each installation having usually between 2 and 6 individual taps. Taps are very vulnerable and spares must be available. Where water supplies are limited and the site is crowded, valve distribution points which can be chained shut may be the only effective solution.

There should be at least one tap per 80-100 refugees and no more than 200 refugees per hand pump or per well with one rope and bucket.

102. The larger the number of people using a single source or outlet of water, the greater the risk of pollution and damage. Whatever the final distribution system, this must be carefully controlled and supervised – guards are often needed.

103. The design, construction, operation and maintenance of the water supply system should be carried out bearing in mind the need to minimize water wastage (from taps, pipes etc.) This is particularly important in systems based on low yield water sources or on those requiring treatment or pumping.

104. The community itself will also generate a certain amount of waste water. This must not be allowed to become a danger to public health, and it may instead be usefully recycled, for example to water livestock, irrigate vegetable gardens, clean pour-flush latrines or else be diposed of via a soakaway.

Potential environmental impacts:

105. The following provides a generic list of potential environmental impacts associated with water and related activities in a camp situation:

- Depletion of the source as a result of unsustainable extraction or collection of water.
- Contamination of the local water (surface and sub-surface) regime due to improper disposal of waste water and human-waste, faulty design and operation/maintenance of the piped water network, excessive extraction of groundwater (salt water intrusion in case of coastal zones and other harmful constituents in the local geological formation) and other related activities in the camp.
- Impacts to local environment due to construction and operation of water supply system (physical structures and chemicals if used), intensity and magnitude of which would largely depend on the nature and size of the project and the sensitivity of the local ecosystem.
- Impact on social environment caused by potential conflicts with the host communities when sharing the same water sources.
- Camps and settlements may be subject to flooding if wrongly located (e.g. in river beds, in wadis, low-lying flood-plains).
- Inappropriate drainage, soil and water conservation measures as well as poor water management in irrigation systems may lead to erosion, floods, groundwater contamination and soil salinization.
- Camps or settlements close to open streams or over unconfined aquifers may cause downstream contamination.

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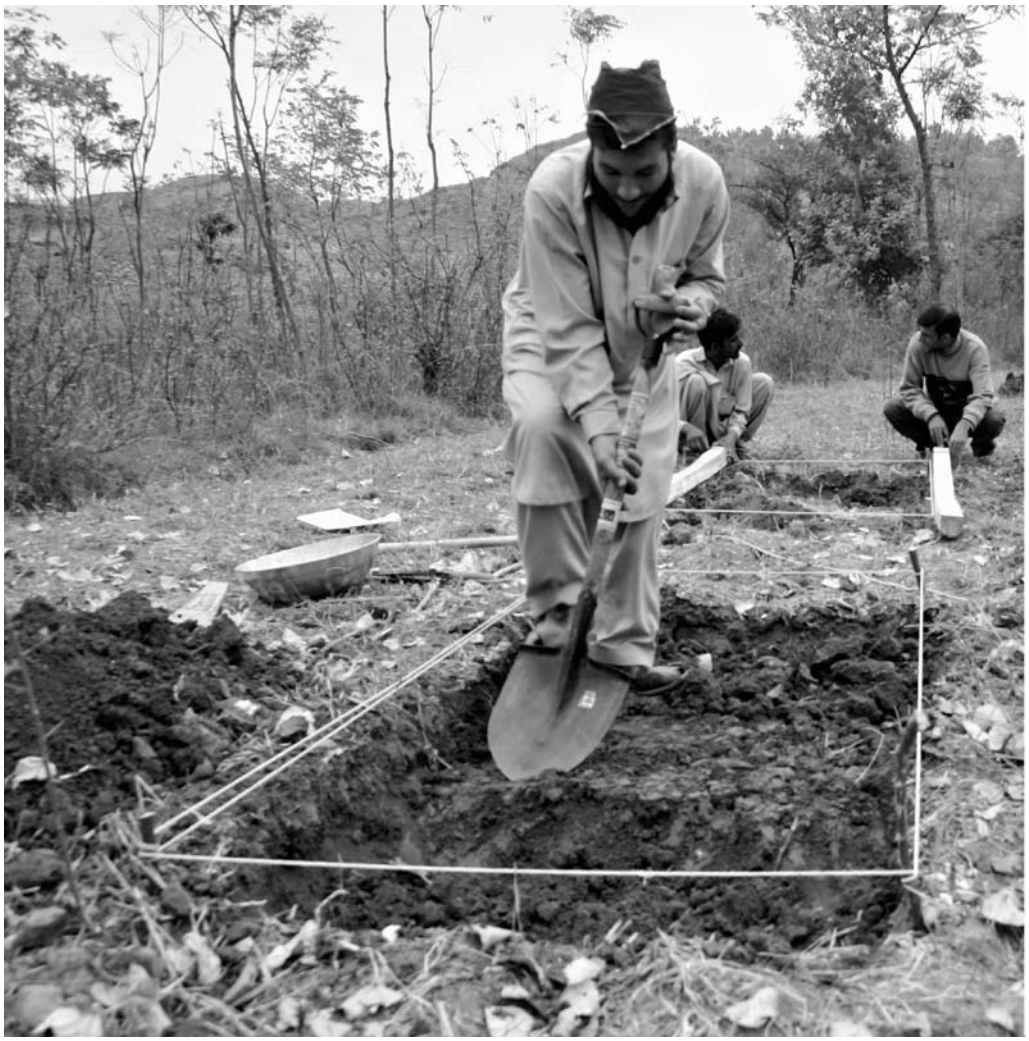
15

Sanitation and hygiene



CONTENTS

Situation

Overcrowding, a lack of access to basic services, a harsh environment and disruption of normal sanitation habits can threaten the lives and well-being of the refugees in emergencies. Proper sanitation is a key aspect of the hygiene cycle involving water and health and is fundamental to a multi-sectoral approach in emergency response.

Objective

To prevent the spread of disease, and to promote a safe hygienic living environment for the refugees.

Principles of response

- Programmes must be developed in cooperation with the refugees and, as far as possible, run by them with gender-balanced approaches. The measures taken must be culturally acceptable to the refugees.
- Swift provision of a basic system for human waste disposal is better than delayed provision of improved systems.
- Take full account of sanitation needs in site selection and layout.
- Make full use of locally available human, material and technological resources. This includes using both skilled and unskilled refugee labour, using public health or sanitary engineering expertise available in the national institutions, and relying on the traditional practices of the refugees and the local people.
- The materials and technology chosen should be as simple as possible.
- The sanitation programme must include provisions for continuous maintenance of the sanitation facilities and services. Allied to this are on-going hygiene promotion activities.
- The best guarantee that latrines will be used and kept clean is to allocate them on an individual or family basis. Refuse disposal should be arranged on a community basis.
- Wherever possible, restrict the use of chemicals (for the control of rats, flies and other pests particularly) to specific places and for a limited period of time. Environmental measures should be favoured instead.

Action

- Localize defecation and prevent contamination of the water supply sources.
- Collect baseline data on the site and draw a sketch of the area to locate potential zones for sanitary facilities.
- Develop appropriate systems for disposal of excreta, garbage, and waste water. Control vectors of public health importance such as mosquitoes, flies, fleas, lice, bugs, rodents and other vermin.
- Plan the amount of facilities and services to be provided. Optimum standards are: for excreta disposal - one latrine per family; for refuse - one bin of 100 litre capacity for 10 families or

  50 persons; for solid waste management - one landfill of about 60 m^3 (50 m^2 by 1.2 m deep) for 500 people (WEDC, 2002); one sanitarian for every 5,000 persons, and one sanitation assistant for every 500 persons.
- Establish sanitation teams for the construction and maintenance of infrastructure;
- Set up services for vector control and burial of the dead.
- Establish a monitoring and reporting system for all environmental health services in coordination with the general health surveillance system.
- Include sanitation and hygiene promotion as an integral part of health education.

Introduction

1. Sanitation includes: safeguarding water quality; proper disposal of human excreta, waste water, garbage and dead bodies; insect and rodent control; safe food-handling practices; and effective site drainage. Such measures are essential, along with good personal, household and community hygiene practices, to achieving improvements in public and environmental health. All these activities, and the provision of health care, are very much inter-related and should be considered together. In particular, this chapter should be read in conjunction with the chapters on water, health and site planning.

2. Disruption and the crowding of people together who are accustomed to living in different and less crowded conditions, makes adequate sanitation of critical importance. Basic services are often lacking. In these conditions, indiscriminate disposal of human and other waste poses a serious threat to health and so cultural practice under normal conditions may need to change.

3. Due to unfavourable environmental factors or socio-cultural habits, the implementation of sanitation programmes in refugee camps can be difficult. Additional constraints include:

i. inappropriate sites that are easily flooded, barren and/or inaccessible;
ii. lack of space;
iii. limited availability of local materials due to either natural factors or considerations related to environmental protection;
iv. limited time for the community to get organized if only in a rudimentary way; and
v. lack of qualified personnel.

4. Sanitation measures integrated with effective hygiene promotion work by and with the refugees are important. Monitoring will be essential, the effectiveness of the services will depend to a significant degree on regular and thorough maintenance and inspection.

Basic principles and standards

- Take full account of sanitation needs in site selection and layout.
- Analyse sanitation and hygiene issues as part of the initial needs and resources assessment.
- Seek professional advice from those with local knowledge.
- Consult and involve the refugees in the design and location of sanitary facilities, and particularly their maintenance.
- Integrate hygiene promotion activities into the community health programme and pay special attention to sanitation matters at schools for refugee children.

5. As stressed in the chapter on site planning, sanitation will be a very important consideration in site layout, and the organization and operation of the sanitation services must be integrated with other community services.

6. Developing adequate sanitation in a refugee emergency is difficult; but correcting mistakes is even more difficult. Expert advice should be sought from a public health engineer who is familiar with the habits of the refugees and nationals of the country of asylum, and if possible has experience of refugee emergencies. Assistance should first be sought locally from sources such as government departments, the UN system, NGOs, universities, consultants or contractors. If these cannot meet the need, Headquarters' assistance should be requested.

7. Good sanitation depends to a great extent on the attitudes of the community and the people who run the system. The systems and services developed should be able to operate effectively with a minimum of outside involvement. Refugees themselves must be trained to run the sanitation and hygiene promotion programmes.

8. The public health education programme must place proper emphasis on the importance of sound sanitation practices. The link between excreta contamination and disease must be clearly understood by all.

Whatever the success of the sanitation system with adults, children will present both a special opportunity and a special challenge.

Children are both the main sufferers from excreta-related diseases and also the main excreters of many of the pathogens that cause diarrhoea (it is important to remember that children's faeces have higher concentrations of pathogens than adults). Teaching sanitation measures and sound hygiene practice in schools is therefore essential.

9. Measures to contain human excreta and to dispose of refuse should be taken immediately.

Table 1: – Number and types of sanitary facilities required

	FIRST OPTION	SECOND OPTION	THIRD OPTION
EXCRETA DISPOSAL	1 latrine / family (or 1 latrine / two families)	1 cubicle / 20 persons	1 cubicle / 100 persons or defecation field
	STORAGE	**TRANSPORT**	**FINAL DISPOSAL**
REFUSE/GARBAGE	1 bin, 100 litres /10 families or 50 persons	1 wheelbarrow /500 persons and 1 tipper /5,000 persons	1 landfill (50m^2 and 1.2 m deep) / 500 persons **and** 1 incinerator and 1 deep pit for each clinic

Since it is almost impossible to estimate how long refugees will stay in a given site, more long-term facilities should also be established simultaneously. For example, once a defecation field has been established, latrine construction should begin at once. The greater the time lag between those two actions, the more difficult to shift people from their previous habit (defecation in the open) to subsequent building and use of latrines. Even in hot, dry climates, human excreta disposed of on the ground can favour the transmission of diseases.

10. Communal facilities, especially latrines are difficult to maintain and keep clean. However, refuse management (especially transportation and final disposal) is better organized on a communal basis. Sufficient bathing cubicles (separate for male and female) should be allowed for when communal facilities are required. Domestic waste water drainage requires a combination of both individual and communal systems. Drains collecting waste water from each household have to be connected to main ones which will channel those waters away from the living quarters.

11. General norms and standards related to specific activities (excreta disposal, solid waste, vector control, etc.) should be seen as indicative only and be adapted in each case to the prevailing social, cultural and physical conditions. Table 1 above gives standards which can help to work out a preliminary quantitative estimate of the most urgent needs.

12. Surveys of the status of sanitation programmes should be carried out regularly and corrective action taken (see Annex 1, Sanitation Survey Form).

Human resources and organization

- Appoint a focal point.
- One sanitarian for every 5,000 persons and one sanitation assistant per 500 persons should be recruited from among the refugees or from other sources.
- Community participation is the key to successful sanitation projects.

13. A focal point for sanitation must be appointed at the very start of the emergency, and responsibilities of various partners clearly defined. There are not many agencies specializing in sanitation.

14. The first step in appointing the focal point is to investigate the availability of local expertise (a civil engineer specialized in sanitary engineering as an ideal example). Recourse to outside assistance has to be contemplated if local expertise is not available.

15. At camp level, sanitation teams or brigades, provided with basic hand-tools, should be set up to carry out urgent tasks (digging trenches or pits for excreta and waste disposal). A hygiene promotion programme should be launched simultaneously. Each team should be headed by staff that have good knowledge of sanitation (including medical and engineering aspects).

One sanitarian for every 5,000 persons and one sanitation assistant per 500 persons should be recruited.

16. It is always more efficient to have only one agency responsible for both sensitizing people to sanitation and supervising related activities. Education on sanitation should focus on the "how and why" of hygienic containment of human excreta, and simple methods for waste disposal and hygiene at a household level (water storage in the home, habitat and personal hygiene, etc.). Women, teachers, leaders, and school children should be actively involved in such a programme.

17. Community participation is a key to the success of sanitation projects. Hygiene education is a prerequisite to that participation. It should nevertheless be recognized that it takes time to convince both the community and individuals about benefits they can expect from a sanitary environment. Concrete examples such as pilot latrines near clinics, market or other places are therefore very important to support environmental health programmes.

18. Refugees should be provided with tools and basic materials (and incentives in some cases) to encourage them to contribute to the improvement of their own living conditions. They should be gradually integrated into the sanitation teams, the ultimate goal being that the refugees themselves should do most of the maintenance tasks.

19. Annex 2, Resource Inventory Form, gives a checklist of the human and material resources needed for sanitation and hygiene promotion work.

Human excreta disposal

- Take immediate action to localize excreta disposal and prevent contamination of the water supply.
- Carefully consider cultural and physical factors and ensure that appropriate anal cleaning materials and hand-washing facilities are available.
- Communal trench latrines may be needed initially, but in most circumstances pit latrines are much better.
- Ensure that latrines are located in secure areas so that they can be used at night and are safe for women and children.

- Facilities should be designed in such a way that they can be used by all people including children, the elderly, pregnant women and people with disability or illness.

Introduction

20. The priority is to create an efficient barrier against faecal contamination. This can be assured through a careful planning of camp layout and the provision of a sufficient number of sanitary facilities, ensuring that these facilities are properly used and kept clean, and do not become the source of problems such as bad smells and flies, and do not collapse when it rains.

The most common cause of breakdown is inadequate maintenance, even for properly designed and installed systems.

21. The best guarantee of proper maintenance is the individual family allocation of latrines. Breakdown of latrines will lead to contamination of the environment and a high risk of infection and disease. There must be regular inspection and maintenance.

Even when in working order, latrines will not be used unless they are clean. Latrines must be cleaned daily.

22. Individual families will be responsible for their own units, but where communal latrines are unavoidable, special arrangements to keep them clean will be essential. Particular attention must be given to the maintenance and cleanliness of the latrines serving community facilities such as health centres. Refugee workers with proper supervision will be required. It may be necessary to pay or otherwise compensate those who are responsible for keeping communal latrines clean and operational.

23. Disinfectants prevent the biological degradation of excreta. However the regular addition of soil or ashes, if available, to trench or pit latrines may help control insect breeding and reduce odours.

Disinfectants should not be poured into the pits or tanks of latrines.

24. Two main factors will affect the choice of an excreta disposal system: the traditional sanitation practices of the refugees and the physical characteristics of the area, including the geology, the availability of water, rainfall and drainage. Failure to take proper account of these can easily result in the system itself rapidly becoming a health hazard.

25. The essential starting point is to find out the traditional sanitation practices of the refugees and how these can be modified to reduce health risks in a refugee emergency. The following information will be required:

- previous sanitation system and practices;
- method of anal cleaning;
- preferred position (sitting or squatting);
- need for privacy;
- segregation of sexes and other groups or individuals with whom it is culturally unacceptable to share a latrine;
- cultural practices of children;
- cultural taboos (for example, against contact with anything that may have touched excreta of others);
- social factors, including likelihood of community action to ensure proper use of proposed system;
- need for special orientation (direction) of latrines in some cultures; and
- systems used locally in neighbourhood of site.

26. Arrangements must be made to assure the availability of appropriate anal cleaning materials at or near all latrines. This is essential for hygiene.

The latrines must be safe for children, and must be able to be used at night.

Pay attention to security for women: for communal units some form of lighting should be provided and it may be necessary to provide guards.

Immediate action

27. Initially the refugees are likely to defecate indiscriminately, contaminating their environment and often the water supply. In consultation with the community leaders, the best first step is to demarcate defecation fields to localize and contain excreta.

28. Designate an area or areas (about 50 m x 50 m each) away from the dwellings and down wind, but sufficiently close to be used. Separate areas for men and women are usually desirable. Within the defecation field, strips of land – roughly 1.5 m wide, 20 m long, on each side of a central access path – will be used, one after the other, beginning with strips farthest from the entrance.

29. Based on a recommended surface area of 0.25 m^2 per person per day, exclusive of access paths, defecation fields of the size above would be sufficient for about 250 people during a month, or 500 people during two weeks. Operating defecation fields beyond one month is not advisable.

30. Fence the area(s) and provide privacy by means of partitions and shallow trenches (in the strips) and spades, if possible. Covering excreta with ash, lime or just soil lessens health risks. Locate such areas where the surface water run-off will not cause contamination. Protect the area with cut-off ditches.

31. A publicity campaign will be required to encourage refugees to use these areas and not defecate indiscriminately near dwellings or the water supply. At least one attendant should be assigned to each defecation field. A hand-washing facility should always be installed nearby.

Selection of a system: basic considerations

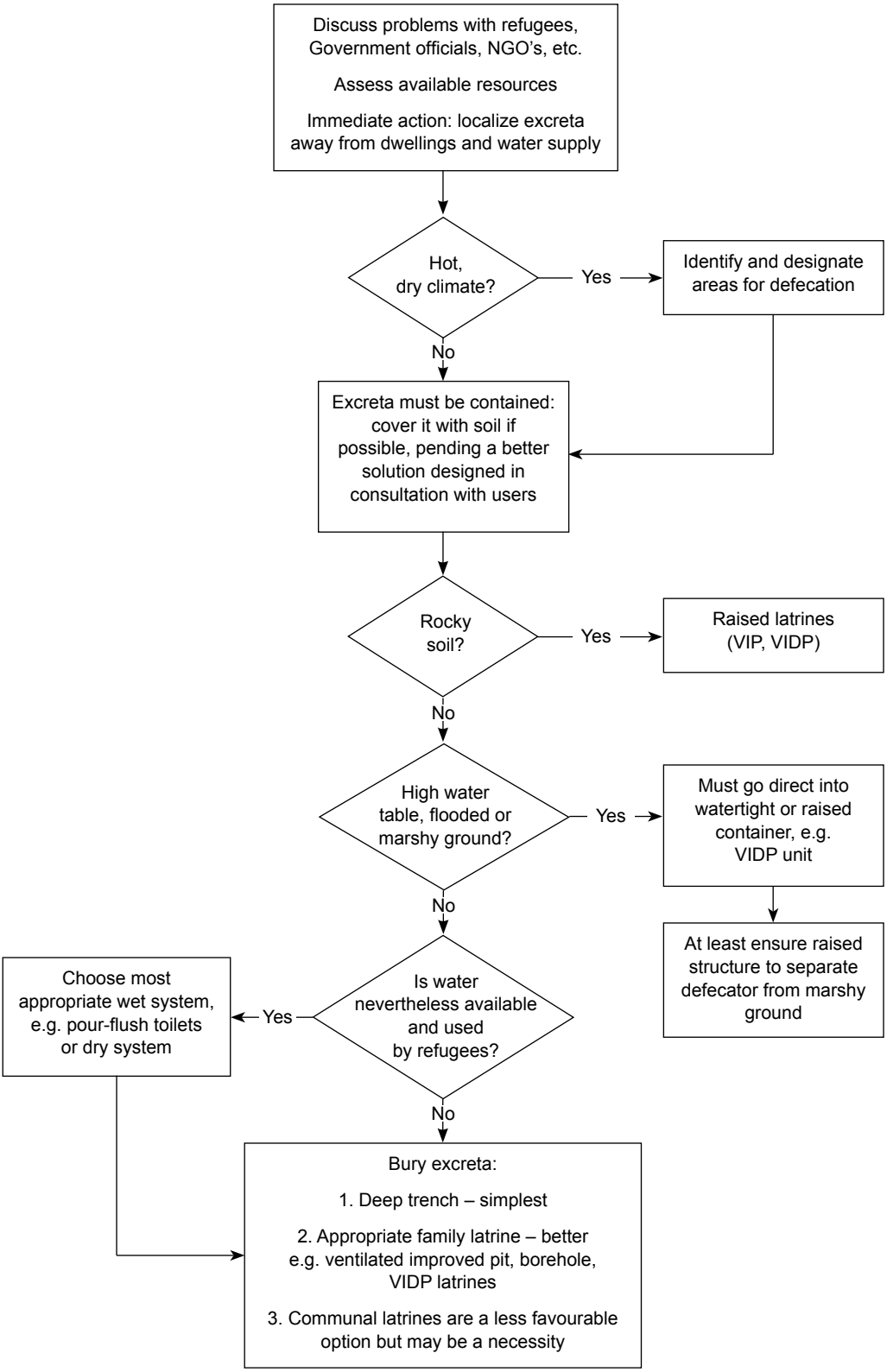
32. The selection of an excreta disposal system suitable for a particular situation requires consideration of a number of factors. In an emergency, however, time is the critical factor. Pollution of the environment by excreta, with all its attendant risks, cannot be stopped without immediate sanitation measures. Thus the range of choice is always much more limited at the very outset of an emergency.

33. Temporary systems, to meet the most immediate needs, will have to be improved or replaced by others as soon as possible, in order to maintain adequate sanitation standards.

In emergency sanitation, act first and improve later.

34. Figure 1 illustrates some considerations to be taken into account in excreta disposal.

Figure 1 – Considerations in excreta disposal



35. The design of sanitary facilities should be governed by cultural factors (discussed above) and by the following considerations:

i. **Flies and smells.** These can be reduced by: installing vent pipes topped with anti-corrosive screens, covering faeces regularly with ash, treating latrines with biological larvicides to control fly larvae, using fly traps, etc.

ii. **Flooded pits or collapsed walls.** These can be avoided by ensuring proper construction including having a raised superstructure, well-built base and mound, pit lining, and good drainage. Sometimes these steps are not taken because of, for instance, financial considerations. However, a large number of latrines built quickly and cheaply will not necessarily solve environmental health problems.

iii. **Life-span.** To dig a pit for excreta is not a very exciting exercise. Normally, the pit should be designed to last two to three years (the capacity of a dry pit should be at least 0.07 cubic metres per person per year). If its dimensions have not been properly calculated, people will have to dig a new pit a short time later. Community members would understandably be reluctant to do this and the site would become covered with pits, some containing un-stabilized faecal matter hazardous to human health. In addition, shortage of space limits the number of latrines which can be built.

iv. **Cleanliness and privacy.** Communal installations are rarely kept clean and become unusable within a very short period of time and encourage transmission of diseases. Therefore family latrines should be preferred whenever possible. Sanitary facilities should preserve users' privacy. Cubicles should be partitioned off within each block. At a family and individual level, socio-cultural considerations often make it compulsory to build separated units for men and women. Disregard for these simple criteria might result in misuse and abandonment of facilities.

v. **Location.** No contamination by excreta of water resources should occur. Latrines should be at least 30 m from any groundwater source and the bottom of any latrine at least 1.5 m above the water table. Latrines must be close enough to users' shelters to encourage their use (not more than 50 m). They must be far enough from shelters and other buildings to prevent potential smells and pests from bothering or harming the population (at least 6 m from shelters if possible).

36. There are a number of latrine options: once cultural and physical factors have been taken into account, the key factors to consider are low cost, simplicity of construction and ease of maintenance.

Trench latrines

37. Trenches can be used for a few months. If necessary, and where space is available, this solution can continue for longer periods, with new trenches being dug as old ones fill up.

Trench latrines should be dug 1.8 to 2.5 m deep and 75-90 cm wide. Recommended length per 100 persons is 3.5 m.

38. A platform and structure will be needed, providing a seat or squatting hole as appropriate, with lid. When the trench is filled to within 30 cm of the top, it must be covered with soil and compacted. Trench sides must be shored up if there is a danger of collapse.

Pit latrines

39. The pit latrine is the most common excreta disposal system used around the world (see Figure 2a). It has major advantages over a trench latrine. It consists of four basic components: a pit, a base, a squatting slab (or plate) and a superstructure.

40. If used by only one or two (a maximum) families these latrines are usually well maintained. Pit latrines can also be used in clusters as communal facilities.

41. Pit latrines are most suitable in conditions of low to medium population density – up to about 300 persons/hectare – but have been used satisfactorily in areas with twice this density. Space is needed not only for the construction of one pit latrine per family, but also for new pits when the old ones are full. This is an important consideration when pit latrines are used as communal facilities.

42. When the pits are three-quarters full, they must be filled with soil and the superstructure and squatting plate moved to a new pit. Applying layers of ashes as the pit fills will speed up the decomposition of excreta and in time the site can be used again.

43. The pit should be about one metre across and over two metres deep. The rim of the pit should be raised about 15 cm off the ground and ditches should be dug around the base to divert surface run off. The pit wall should always be reinforced for one metre below ground level to prevent collapse.

44. The basic variety has both odour and insect problems, which can be considerably reduced by making the simple improvements in another version of pit latrine, commonly know as the ventilated improved pit (VIP) latrine (see Figure 2b), and also by adding soil and ashes in the pit and using lids.

Where pit latrines are used, the ventilated improved version should be built whenever possible.

45. In a VIP latrine the vent pipe should be at least 15 cm in diameter, about 2.5 m high, painted black and placed on the sunny side of the latrine for maximum odour and insect control. Blackening the external surface of the vent pipe only marginally increases the venting velocity, but this factor may be of greater importance under "no wind" conditions. The vent pipe must be fitted with an insect proof gauze screen

Figure 2a

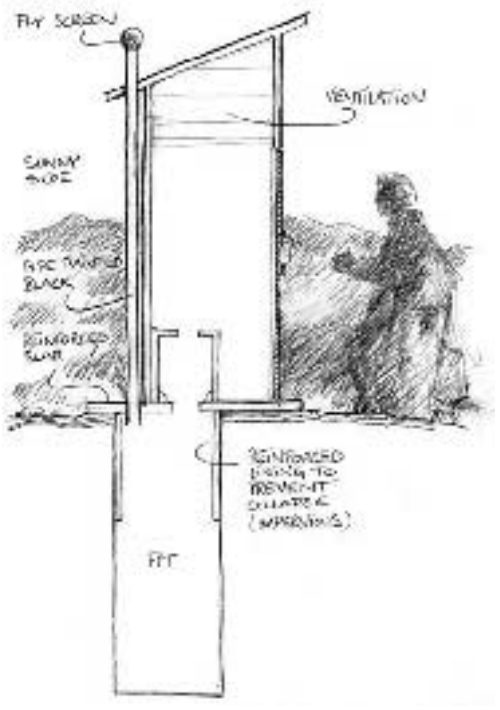
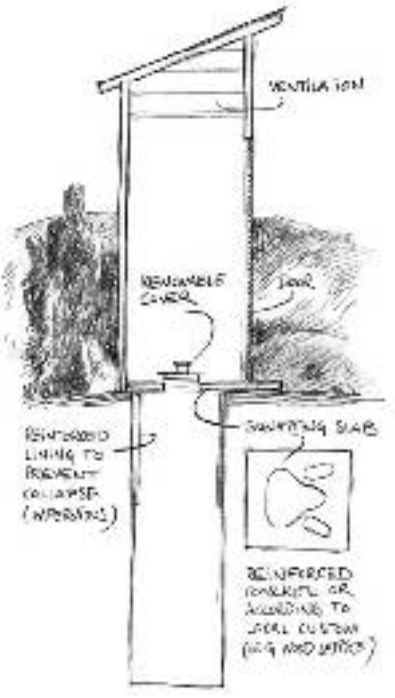


Figure 2b



(so it works as a fly trap). The hole should not be covered by a lid as this impedes the air flow.

Borehole latrines

46. Borehole latrines (Figure 3) are dug with a hand auger or mechanical drill and require a smaller slab than a pit. The borehole is 35-45 cm in diameter and any depth up to 7 metres. The advantage of the borehole latrine is that it can be constructed quickly as a family unit if augers are available. The disadvantages are that the side walls are liable to fouling and fly breeding, they are smellier than vented systems and the risk of ground water contamination is greater because of the depth.

Ventilated improved double pit (VIDP) latrine

47. Raised (or built-up) pits can be used where it is not possible to dig deep pits because the water table is high or excavation is difficult (for example in rocky ground).

48. The VIDP latrine (Figure 4) (also called alternating twin pit ventilated latrine) has two shallow pits, both of which are ventilated by separate vent pipes capped with fly screens. It is a good option in crowded areas which may become even more crowded, as it preserves the space needed for replacement latrines.

49. Two pits give more flexibility. A pit fills up in two to three years, and it should then stand for at least one year. This gives enough time for the night soil to dry out and decompose, so that it can be removed more easily and not pose a health hazard. While the full pit is decomposing, the other pit is used. The two pits must not be used at the same time.

Pour-flush (PF) latrine

50. Pour-flush latrines (Figure 5) are simple in design but need permeable soil for their soak-away. A water seal is made by a U-pipe filled with water below the squatting pan or seat. It is flushed by pouring ~1-3 litres of water into a pit or

Figure 3

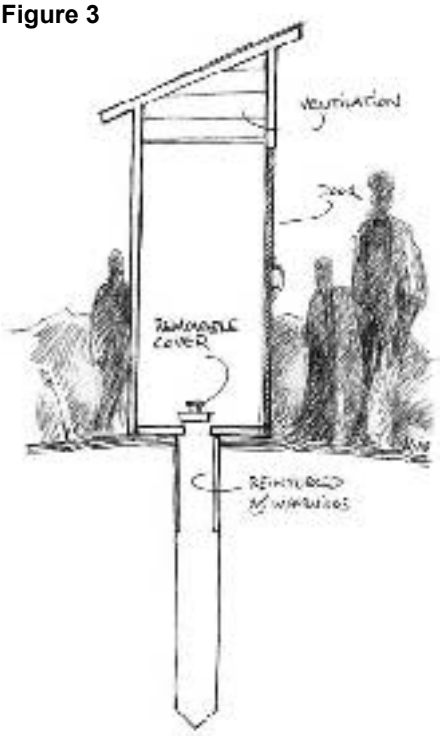
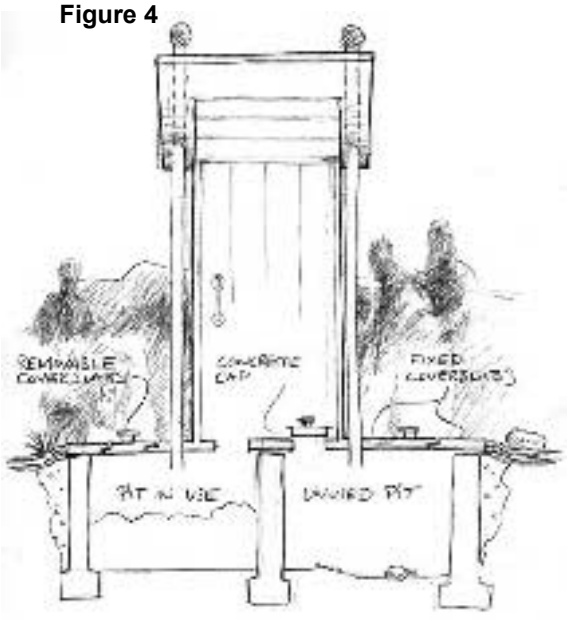
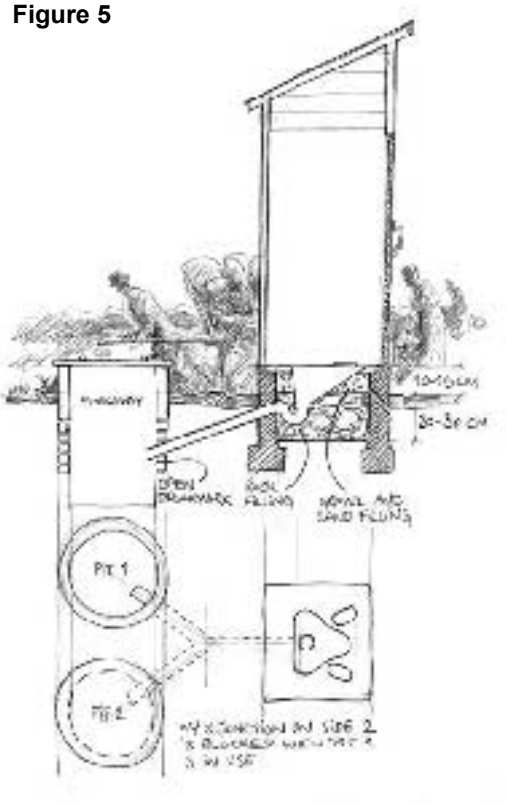


Figure 4



soak-away. This system is suitable where water is used for anal cleaning and where refugees are used to flushing. It is not suitable where paper, stones, corncobs or other solid materials are used for anal cleaning. Pour-flush latrines will be used properly only if water is readily available. A large container with a 3 litre dipper should be made available close by the latrines.

Figure 5



Stabilization ponds

51. Where liquid effluent has to be disposed of in impermeable soil, stabilization (oxidation) ponds are a simple and cheap solution, particularly in hot climates. Various systems are described in the technical references (see references and the TSS technical resources toolkit). If ponds are used they must be securely fenced off.

Solid wastes

- Improper garbage disposal increases the risk of insect and rodent-borne diseases, and an effective system must be established for the storage, collection and disposal of garbage.
- Garbage disposal areas must be designated and access to them restricted.
- Large amounts of dust and/or smoke can damage health. Preventing destruction of vegetation is the best preventative measure against dust.

General considerations

52. The quantity of garbage generated by refugees is often not considered substantial and it therefore tends to be neglected. However, the daily amount of garbage as well as its weight can be significant, in market places in particular.

Uncontrolled accumulation of garbage is unhealthy, and promotes an increase in rodent and insect borne disease.

At the beginning of an emergency hygiene and waste disposal is usually poor, so vermin and other pests including rodents proliferate very rapidly.

53. Food is occasionally distributed to refugees in metal cans. How those are disposed of should be given particular consideration not only for aesthetic reasons but also because of health hazards (injuries to children, potential breeding sites for mosquitoes, etc.). In addition, this kind of garbage is not biodegradable.

54. Medical waste (used syringes and needles, contaminated bandages, laboratory specimens, etc.) generated by health centres, are a hazard. Access to medical sanitary services should be well controlled, and the waste should be treated separately, without delay (see below).

The safe disposal of all medical waste requires particular attention.

Garbage management

55. There should be routines for the storage, collection and disposal of garbage – this will be particularly important in high-density sites.

Storage: metal drums can be used as refuse bins at individual dwelling level. A 200 litre drum cut in half is often used. Bins should have lids if possible and drainage holes in the bottom. A ratio of one container (100 l capacity) per 10 families has proved to be effective. The containers should be placed throughout the site in such a manner so that no dwelling is more than about 15 metres away from one. Using concrete structures as refuse bins is neither economical nor practical: they are difficult to empty properly so rodents are encouraged and garbage is dispersed around the area.

56. Collection and transportation: garbage should be collected from the containers regularly, daily if possible. Camps near a city could benefit from existing refuse-dump services. Using tractors with trailers is expensive and should be considered as a last option and only for large and densely populated camps. Wheelbarrows and/or carts (hand or animal carried) are usually more appropriate.

57. Disposal and treatment:

i. Sanitary land-filling (also known as controlled tipping) remains the most advisable method. Areas designated for burying garbage should be well away from dwellings, and fenced off.
ii. Incineration is justified on a small scale and usually only for medical waste. After each incineration, cover the waste with a layer of soil.
iii. Composting is an attractive option but requires technical knowledge, which may not be available. In addition, garbage must be sorted to produce good compost.

Dust and smoke

58. Large amounts of dust and smoke carried in the air can be harmful to human health by irritating eyes, the respiratory system and skin, and by contaminating food. The best preventive measure for dust is to stop the destruction of vegetation around the site. Dust can also be controlled by spraying roads with water, especially around health facilities and feeding centres, and limiting or even banning traffic. Smoke can be controlled by four categories of interventions that vary in cost and effectiveness (WHO, 2004):

i. behavioural modifications to reduce exposure (e.g. encouraging mothers to keep their young babies away from the fire);
ii. household changes to improve ventilation (e.g. increasing the number of window openings, providing gaps between the roof and walls, or moving the stove out of the living area);
iii. improvements to cooking stoves (e.g. ventilation by flues, hoods or chimneys, or increases in combustion efficiency - nearly all pollutants damaging to health are products of incomplete combustion); and
iv. interventions to enable people to use higher-quality, lower-emission liquid or gaseous fuels (e.g. petroleum-based kerosene and liquid petroleum gas, or biomass-based alcohol and bio-gas).

Waste water

- Waste water must be controlled as soon as possible and drainage provided. Any potential contamination of the local environment by waste water must be prevented.

General considerations

59. This aspect of sanitation should always be considered from the beginning. Drainage prevents water from stagnating around water distribution points, and drains the rainfall as well as domestic waste water originating from various

sources (toilets, showers, kitchens, etc.). Other measures to help control vectors include eliminating ponds.

60. Drainage can very quickly become a problem and corrective measures are difficult once shelters and other infrastructure have been built. For example, people often wash next to water sources, causing problems which could be avoided if special separate washing areas are constructed with duckboards or stones and proper drainage.

61. Some families manage to channel waste water away from their homes and use it to irrigate vegetable gardens. Although this should be encouraged it should not disrupt the main drainage system.

62. Good drainage should be a priority at the following locations:

i. water points (standpipes, taps, handpumps);
ii. sanitary facilities such as showers, toilets and washing areas: waste water from these places should either be used to irrigate vegetable gardens and fruit trees or drained into absorption trenches or soak-away pits;
iii. shelters: household members usually manage to protect their shelters from runoff waters by means of perimeter drains; it is nevertheless important to ensure that such water is collected and disposed of through main drains; and
iv. markets and slaughter areas where water will be used to clean slaughter slabs.

Treatment

63. In some circumstances waste water should be treated, for example waste from sewers collecting effluent from pour-flush toilets. Some treatment package units are available on the market; but these are usually expensive, complex, and difficult to operate and maintain.

64. However, there is a broad range of waste water treatment technology. Sanitary engineering professionals should be consulted to select the most appropriate technology.

Pest and vector control

- Insects and rodents carry and spread diseases and can spoil food supplies.
- Physical screens are the best immediate measures.
- Preventive action to eliminate or limit breeding areas and conditions favourable to the vectors is the best long-term solution.
- Specialist supervision of all chemical measures and local knowledge of resistance is necessary.
- Avoid chemical control where possible.

General considerations

65. The environment in a refugee emergency is typically favourable to the proliferation of disease-carrying insects and rodents ("vectors"), which can also destroy or spoil large quantities of food.

66. Flies tend to breed in areas where food or human excreta are present; mosquitoes where there is stagnant water; and rats where there is food, garbage and cover. As a result of overcrowding and inadequate personal hygiene, lice, fleas, mites, ticks and other arthropods may also cause health problems. Table 2 gives an indication of common vectors and related diseases.

67. Reducing the numbers of flies, mosquitoes and rodents quickly in an emergency is difficult and physical screens may be the best immediate measure. Over the longer term, the most effective method of controlling insects and rodents is preventive: to improve personal hygiene, sanitation, drainage, garbage disposal and food storage and handling practices and thus make the environment less favourable for

the vectors. Examples of practical measures are the removal of stagnant waste water, regular garbage collection, controlled disposal of excreta and the provision of soap and sufficient water for washing. The recommended monthly supply of soap is 250 g per person per month. The programme should provide for regular inspection and be integrated with other public health measures.

68. The problems should be discussed with the refugees and education given on the significance of vector control. Where solutions unfamiliar to the refugees are employed, these must be carefully explained.

69. Whatever the nature of nuisances and pests, one should avoid having systematic recourse to chemical control by means of pesticides (insecticide, rodenticide, molluscicide, etc.). Such products are costly and toxic to both human beings and the environment. There is a risk of poisoning during transport, storage, handling and, of course, spraying the chemicals. Also, pests can develop resistance to the chemicals.

Physical control

70. Measures described in this chapter to deal with excreta and waste disposal will also help control pests (flies and rodents particularly).

71. The elimination of stagnant water and other breeding and resting sites for mosquitoes through drainage is important and the drainage network must be maintained.

Chemical control

72. Obtaining precise information on chemicals which are used or authorized to be used in the country (i.e. registered list of pesticides if any) should be the first priority.

Insecticide spraying carried out on a routine basis must be avoided, and in any event should be consistent with the rules and procedures in force in the host country.

73. Advice from specialists, particularly medical entomologists, should be sought to minimize the risks and to maximize the impact on target-species. Outdoor spraying must be carried out in enough time before the rains so as to be effective.

74. Staff assigned to such tasks must be trained on technical aspects, informed about health hazards linked with handling and spraying of pesticides, and protected by means of adequate clothing (mask, boots, gloves, etc.).

75. The use of rodenticides should always be adopted in agreement with medical staff. Rats are favoured carriers of vectors (such as fleas) of bubonic plague and murine typhus. When these diseases may be present it is more important to take measures directly against the vectors themselves – i.e. the fleas, rather than the rats – because destroying the rats will simply cause the fleas to leave the dead bodies of the rats and become more of a threat to people.

Table 2 – Vectors which may pose significant health risks

VECTOR	RISKS
Flies	Eye infections (particularly among infants and children), diarrhoeal diseases
Mosquitoes	Malaria, filariasis, dengue, yellow fever, encephalitis
Mites	Scabies, scrub typhus
Lice	Epidemic typhus, relapsing fever
Fleas	Plague (from infected rats), endemic typhus
Ticks	Relapsing fever, spotted fever
Rats	Rat bite fever, leptospirosis, salmonellosis, Lassa fever

76. The body louse is the only proven vector of louse-borne epidemic typhus and relapsing fever. If there is a serious increase in body louse infestation, quick action is required by properly trained personnel. This generally involves dusting individuals' inner clothing and bedding with an insecticide or the use of clothing fumigants. There is widespread resistance in lice to some insecticides and expert local advice must be sought.

General hygiene

- Sanitary engineering must be complemented with sufficient hygiene promotion work with adequate community participation.

77. Habitat hygiene, food hygiene and personal hygiene, while being integral parts of sanitation, are also related to wider health education and community issues and so it is worth constantly repeating that the most effective manner to sustain effective sanitation activities is to complement them with visible and concrete participatory hygiene promotion activities on the ground.

78. Gender-balanced community participation in sanitation activities is a key to successful implementation, however, to make participation work in practice, the community members must have the necessary resources – human, institutional and material – to enable them to take on their responsibilities.

79. Activities to improve living conditions should take place at all levels – site, community, family and individual – and not be restricted to just one level. Elementary rules of hygiene should be observed by everyone.

80. There are three essential steps to improve living conditions:

- Avoid overcrowding and overpopulation, which increase transmission (through direct or indirect contact) of diseases brought about by vectors such as fleas and lice.
- Reduce faecal/oral transmission risks by ensuring systematic hand-washing with soap (or ash and water) before cooking and eating and feeding infants and after latrine use or handling of babies' faeces. Washing the face everyday helps to prevent trachoma and other eye infections.
- Encourage personal hygiene including clean clothes by providing amenities such as showers and laundering areas and basins. This will also reduce contact with water bodies that have been polluted by excreta and urine, reducing the risk of disease including bilharziasis (schistosomiasis).

81. Communication of key messages on the importance of hygiene will have no effect if they do not reach or are not accepted by the affected community. It is extremely important that messages be discussed with vulnerable groups, especially women and children. The key steps to remember in conveying these messages are (adapted from UNICEF, 2005):

i. Establish and train a team that is familiar with local practices and social structures.
ii. Use the local language or pictograms if possible.
iii. Keep messages clear and simple.
iv. Work through existing social structures.
v. Consider existing culture, practices and gender roles.
vi. Reach people during times of emergency at clinics, feeding centres, distribution centres, water collection points, etc.
vii. Use a variety of ways of reaching people that can include megaphones, radio, broadcasts, announcements, meetings, posters, home visits, large and small group discussions, local newspapers and community newsletters, as well as street theatre, slides, films, video presentations, games, drama, songs, role-play and simulation, if possible and appropriate.

viii. It is important not to blame the community for previous poor hygiene practices.

Disposal of the dead

- Suitable arrangements for disposal of the dead are required from the start of an emergency.
- Action should be coordinated with the national authorities.
- Burial is the simplest and best method where acceptable and physically possible. Arrangements should be made to allow traditional rituals.
- Before burial or cremation, bodies must be identified and the identifications recorded.

82. Suitable arrangements for the disposal of the dead are required from the start of a refugee emergency. The mortality rate may well be higher than under "normal" conditions. The authorities should be contacted from the outset to ensure compliance with national procedures, and for assistance as necessary.

83. Dead bodies present a negligible health risk unless the cause of death was typhus or plague (when they may be infested with infected lice or fleas) or cholera. Funerals for persons dying from cholera should be held quickly, near the place of death. Efforts should always be made to restrict funeral gatherings of persons dying from any of these three diseases, and to restrict feasting and ritual washing of the dead, by intensive health education or by legislation, as appropriate.

84. Health considerations provide no justification for cremation, for which sufficient fuel may often not be available. Whenever possible, the customary method of disposal should be used, and the traditional practices and ritual should be allowed. Material needs, for example for shrouds, should be met. The necessary space for burial will need to be taken into account at the site planning stage, particularly in crowded conditions.

85. Before burial or cremation, bodies must be identified and the identification recorded, and, if possible, cause of death recorded. This is particularly important for the control, registration and tracing of disease. If the whereabouts of relatives are known, the most immediate relation should be notified; and steps must be taken to assure the care of minors who, as the result of a death, are left without an adult to look after them.

86. When handling corpses, workers should protect themselves with gloves, face masks, boots and overalls. The workers should wash thoroughly with soap and water afterwards. Although the HIV virus cannot survive for long in a dead body, care should be taken with bodily fluids.

Potential environmental impacts

87. So as not to cause irreversible or long-term damage to a location or those who are residing in it, listed below are potential environmental impacts, related to sanitation, which should be avoided during an emergency operation:

i. Poor control of excreta can lead to pollution of surface water as well as groundwater. This can result in the spread of disease to a much greater population than that which caused the pollution, with resultant human and financial costs.

ii. Poor management of water distribution points and waste water (i.e. if it is allowed to collect and stand in puddles) can provide breeding grounds for disease carrying vectors.

iii. Inadequate provision of garbage storage near point of use, collection, disposal and stabilization, or reuse and recycling, could lead to contamination of the environment and the potential spread of disease by humans, animals, insects or vermin.

iv. Dust carried in the air can be irritating or harmful to the eyes, respiratory system or skin, can contaminate food

and damage sensitive camp equipment. Under some conditions, dust can be heavily contaminated with faecal matter and may be a direct cause of disease.

v. Smoke generated as a result of deficient cooking practice and wrong design of shelter can be a concern, as it is hazardous to human health and other local biological entities.

vi. Insects and rodents are primary vectors for the spread of disease within the refugee camp and between the refugee and local population. These pests can also contaminate food supplies, either before or after distribution to refugees.

vii. Some of the measures used to control pests (i.e. chemical applications) can be toxic to humans (both beneficiaries and workers), to non-target organisms and to the environment (regarding biodegradability of chemicals).

Key references (* = available on the web, # = available on the TSS toolkit)

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Annex 1: Sanitation Survey Form

Country: Date: ...../...../.....

Camp/Settlement & coordinates: Camp population:

Prepared by:

I. Living areas

A. Excreta disposal Ratio of latrine seats to people: 1/.....

	Total	Basic latrine	V.I.P.	P.F.**	Other
Private latrines					
Public latrines					

Comments: _____

_____

B. Refuse disposal

	Capacity (litres)	Number	Max distance from dwelling (m)
– Individual pits:	☐	☐	☐
– Garbage bins	☐	☐	☐

	Wheel-barrow	Truck	Other
– Transportation:	☐	☐	☐

	Landfill	Incineration	Other
– Final disposal	☐	☐	☐

	Dimensions	Number
Communal refuse pits	long___x Wide___x Deep___x	☐

Comments: _____

_____

* V.I.P. = ventilated improved pit

**P.F. = pour-flush

Annex 1

II. Public places

C. Existing facilities

Schools

*Latrine Type	**P.F.**	**V.I.P.**	**Basic**	**Other**
	☐	☐	☐	☐

1 seat /_____ boys

1 seat /_____ girls

1 urinal /_____boys

Hand washing facilities: Yes No

*Refuse collection Yes No

☐ ☐

Hospitals

*Latrine Type	**P.F.**	**V.I.P.**	**Basic**	**Other**
	☐	☐	☐	☐

Hand washing facilities: Yes No

*Refuse collection Buried Burnt

☐ ☐

Markets & food distribution centres

*Excreta disposal Good Poor None

☐ ☐ ☐

*Refuse collection Good Poor None

☐ ☐ ☐

Comments: _____

_____

D. Drainage

– at water posts Good Poor None

☐ ☐ ☐

– around latrines Good Poor None

☐ ☐ ☐

– camp drainage network Good Poor None

☐ ☐ ☐

Comments: _____

_____

E. General characteristics

– topography	Flat ☐	Moderate ☐	Steep ☐
– soil	Rocky ☐	Clay ☐	Sandy ☐
– water table distance from ground surface	Rainy season _____m	Dry season _____m	

F. Community water supply

– sanitation at source	Good ☐	Poor ☐	None ☐
– sanitation at distribution point	Good ☐	Poor ☐	None ☐
– individual water containers	Capacity	_____litres	
– storage at home	Capacity _____ litres	Clean Y – N	Covered Y – N
– chemical used for water disinfection	Chlorine ☐	Other ☐	None ☐
– points of application of above chemicals	Source ☐	Storage tank ☐	Home container ☐

Annex 2: Sanitation – Resource Inventory Form

Country: Prepared by:

Camp: Population:

Date: ...../...../.....

A. Implementation	**Name(s)**
Governmental authorities	
International organizations	
Private sector	
NGO's	

B. Human resources			**Number of workers**
Is there a spraying team?	Y	N	
Is there a drainage team?	Y	N	
Is there a sanitation team?	Y	N	
Is there an organized workshop?	Y	N	
Number of sanitarians:			
Number of health workers: (assigned to sanitation tasks)			

C. Tools	**Description**	**Specification**	**Quantity**
Axe			
Crowbar			
Iron bar cutter			
Pickaxe			
Shovel			
Spade			
Tape metre			
Other (please specify)			

D. Equipment	**Description**	**Specification**	**Quantity**
Cement mixer			
Mortar bucket			
Mould (latrine slab)			
Mould (brick)			
Wheelbarrow			
Sprayer			
Spraying equipment			
– overall clothing			
– masks			
– gloves			
– boots			
Other (please specify)			

E. Chemicals	**Item**	**Unit**	**Quantity (stock in hand)**	**Comments**
Vector control				
–				
–				
Water treatment				
–				

15 Sanitation and hygiene

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Food and nutrition

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Overview

cont.

Situation

In emergencies, food and nutritional security is often severely threatened and urgent actions are required to ensure adequate provision and intake of food. Refugees will need partial or full food support to meet basic energy and protein requirements, as well as micronutrients. Nutritional rehabilitation will be required for those who are already malnourished.

Objective

To provide the refugees with sufficient quality and quantity of appropriate foods to reaffirm the fundamental right to adequate food in order to maintain their well-being, nutritional status and eliminate protection risks.

Principles of response

- Based on the Memorandum of Understanding (MOU) 2002 between UNHCR and the World Food Programme (WFP), ensure close coordination with WFP and other agencies in relation to joint assessment and consequently the provision of food and non-food needs.
- Every effort should be made to ensure the food-aid items meet nutritional requirements and are culturally acceptable to the population of concern to UNHCR.
- Measures to meet food supply should be adequate to cover the overall nutrition needs of all population subgroups affected in terms of quantity, quality and safety.
- The food distribution system should involve refugee participation, especially women, and provide non-food related needs, such as cooking facilities and fuel.
- Promote breastfeeding and pay particular attention to adequate complementary feeding for older infants and young children, women and those with specific needs who are prone to malnutrition.
- Maintain close coordination with the other vital sectors (health, water, environmental sanitation, HIV and AIDS etc.) and aim for maximum integration with existing services.
- Ensure the active involvement of a nutritionist.
- Every effort should be made to provide cereal in fortified flour form instead of grain; if wholegrain is provided, milling facilities should be made available.

Action

- Ensure an initial nutrition, food and non-food needs assessment is carried out.
- Once the initial emergency phase is stablized, conduct a nutrition survey to establish the nutrition status of the population.
- Ensure the availability of appropriate food and non-food items such as cooking fuel and utensils, including the necessary transport and storage.
- Organize a general feeding programme for all refugees and, based on the nutritional status, organize necessary targeted feeding programmes to meet specific needs such as community-based care for the severely malnourished, supplementary feeding for pregnant and lactating women as well as the moderately malnourished.
- Arrange community education on use of food-aid commodities and promote appropriate infant and young child feeding practices and behavioural changes.
- Provide fortified food items including blended food to meet the general populations micronutrient needs (if the population is fully dependent on food aid).
- Review general food ration composition taking into consideration: environmental temperature, nutritional status, demographic distribution, level of physical activity and self-reliance opportunities.
- Enhance outreach activities and nutrition monitoring.

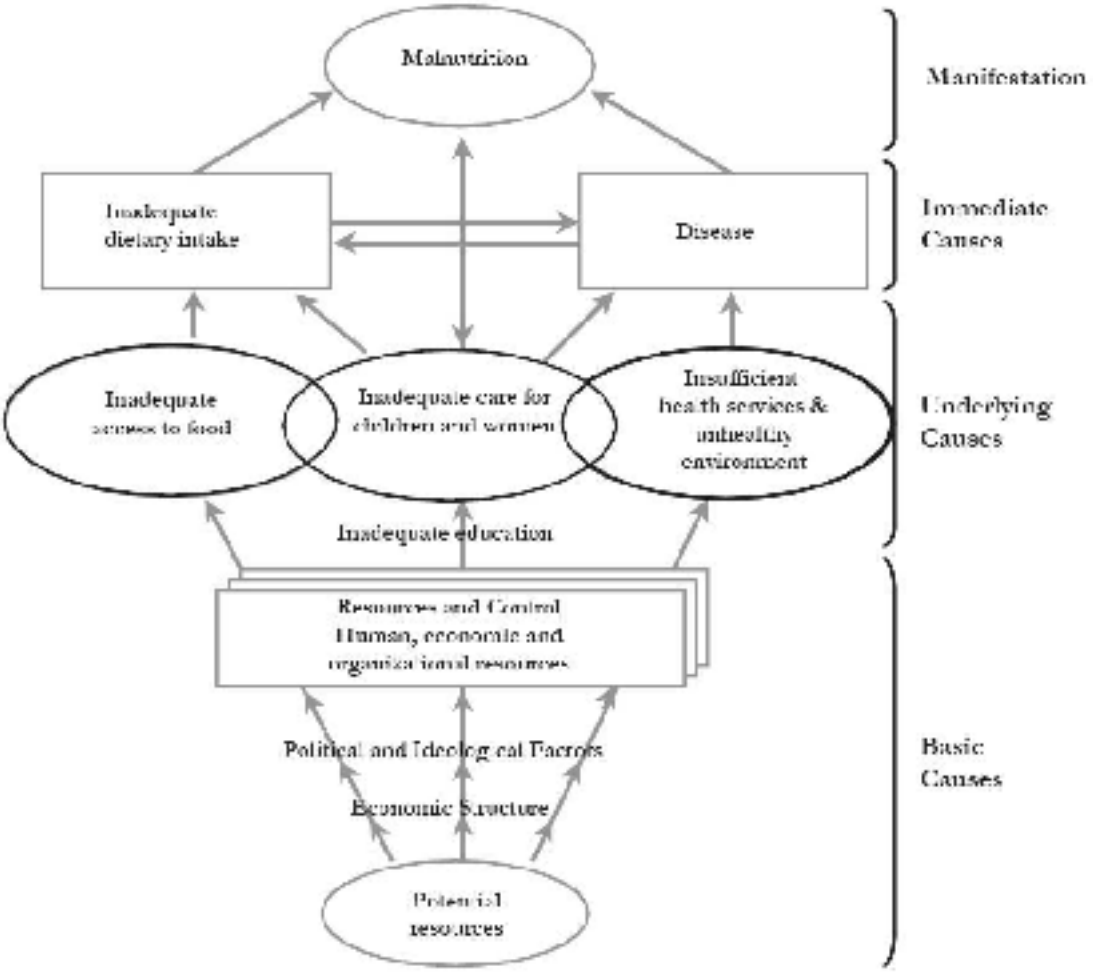
Introduction

1. In an emergency, refugees and people of concern to UNHCR may be completely dependent on the provision of external food sources. An initial assessment of the beneficiary numbers, health and nutritional situation, food security and other related information (e.g morbidity, micronutrient deficiencies) is fundamental for calculating food needs and to make necessary adjustments to the initial planning figure. Continuous monitoring will ensure that the programmes can be adjusted in order to reflect changing conditions.

2. The causes of malnutrition are often complex and multi-sectoral (see Figure 1). Therefore, examining the causes of malnutrition and possibilities for response is essential. Coordinating the food and nutrition programmes with health, water, environment, food security, gender roles and other vital sectors is necessary for informing programme strategies.

3. Assistance must be appropriate to the nutritional needs of the refugees and be culturally acceptable. Infant feeding policies require particular attention.

Figure 1 – The complex causes of malnutrition



4. Certain groups are more at risk of malnutrition than others, such as infants and young children, pregnant and lactating women, the sick and elderly. Special action is required to identify the malnourished and persons with specific needs to meet their additional requirements.

5. If the refugees are already suffering the effects of severe food shortage, immediate action must be taken to provide food available locally which is acceptable to the refugees. However, acceptable food might not be available locally and time may be needed to develop the full response set out in this chapter.

6. This chapter should be read in conjunction with:

i. Food and Nutrition Needs in Emergencies (UNHCR, UNICEF, WFP and WHO, 2002).
ii. Sphere Handbook, (2004).
iii. Management of Nutrition in Major Emergenices (WHO, 2000).
iv. The UNHCR/WFP Joint Assessment Guidelines (UNHCR/WFP, 2004).

Organization of food support

- The World Food Programme (WFP), the food aid arm of the United Nations system, shares with UNHCR responsibility for meeting the food and nutritional needs of refugees.
- The Memorandum of Understanding (MOU) signed between WFP and UNHCR establishes the division of responsibilities and coordination mechanisms for refugee returnee and internally displaced persons feeding operations.
- The aim of the food programme is to ensure the restoration and maintenance of sound nutritional status through a food ration that meets the assessed requirements and is nutritionally balanced, palatable and culturally acceptable.
- In most refugee emergencies a UNHCR food and nutrition coordinator should be appointed, who will have overall responsibility for coordination of all aspects of the food and nutrition programme with WFP.
- The refugees, and in particular refugee women, must be involved in the organization of these programmes.
- Simple nutrition education is an integral part of effective food and nutrition support.

WFP/UNHCR Cooperation

Joint objectives[1]

7. The ultimate goal of the partnership between UNHCR and WFP is to ensure that food security and the related needs of the population that UNHCR is mandated to protect and assist are adequately addressed. Food security is defined as access by all people at all times to enough food needed for an active and healthy life.

8. On the basis of the above principle and through the timely provision of the right quantity of the right food and of related non-food items, UNHCR and WFP seek to contribute to:

i. the restoration and/or maintenance of a sound nutritional status through a food basket that meets the assessed requirements of the different population groups and that is nutritionally balanced and culturally acceptable, as jointly agreed upon and specified in Joint Plans of Action; and
ii. the promotion of the highest possible level of self-reliance among the beneficiaries, through the implementation of appropriate programmes to develop food production or income-generation, which will facilitate a progressive shift from general relief food distribution towards more targeted assistance and sustainable development-oriented activities.

[1] *WFP/HCR MOU 2002, paragraph 2.1*

9. A revised Memorandum of Understanding (MOU) (see Appendix 1) signed between UNHCR and WFP in July 2002 recognizes the importance of examining both food and non-food aspects relevant to food security, and of capitalizing on opportunities to increase self-reliance. Under the terms of the MOU, WFP meets the emergency food needs of refugees (including asylum seekers), returnees, and, in specific situations, internally displaced persons, and provides associated logistical support. The terms of the MOU apply when the beneficiaries in the country of asylum number more than 5,000, irrespective of their country of origin or their location within the country of asylum, unless otherwise determined and agreed upon by WFP and UNHCR on a case-by-case basis. UNHCR and WFP will separately meet the food needs of persons of their concern that lie outside the scope of the MOU.

10. Within the scope of the MOU, WFP has the lead responsibility for mobilizing the following food commodities (whether for general or selective feeding programmes) and the resources to deliver them.

WFP resourced commodities include:

i. **Cereals**
ii. **Edible oils**
iii. **Pulses (or other sources of protein)**
iv. **Blended foods**
v. **Iodized salt**
vi. **Sugar**
vii. **Occasionally high energy biscuits**

11. WFP is responsible for mobilizing the necessary resources for milling and provide milling facilities for the beneficiaries where feasible. Women will be particularly encouraged to play a key role in the management of the milling services. WFP is also responsible for the timely transport and storage of the commodities at agreed extended delivery points (EDPs), and for the operation and management of the EDPs. Unless otherwise agreed, UNHCR is responsible for the transportation of all commodities from the EDP to the final destination and for final distribution to beneficiaries. In targeted operations, UNHCR and WFP may jointly agree to transfer the responsibility for general distribution to WFP.

12. Under the MOU, UNHCR is responsible for mobilizing and transporting complementary food commodities and for the provision of the necessary micronutrients (vitamins and minerals) when they cannot be met through the ration.

UNHCR resourced commodities include:

i. **Complementary foods (including fresh foods)**
ii. **Therapeutic foods**
iii. **Occasionally spices, other condiments, tea**
iv. **Related non-food items**

13. UNHCR, WFP and their partners have developed a common set of guidelines[2] for estimating food and nutritional needs in emergencies and in selective feeding programmes.[3] These guidelines should be used to assess the food needs for both the general and selective feeding programmes.

Joint assessment and planning

14. Contingency planning: UNHCR and WFP will establish early-warning systems, undertake contingency planning and maintain contingency plans for countries where this is deemed appropriate. Each will seek to ensure joint participation of others in the process, and share relevant contingency plans.

15. Joint plan of action (JPA): At the field level, a JPA setting out the agreed upon objectives, the implementation ar-

[2] *Food and Nutrition Needs in Emergencies, UNHCR-UNICEF-WFP-WHO, WHO 2002.*
[3] *UNHCR/WFP Guidelines for Selective Feeding Programmes in Emergency Situations, WFP-UNHCR, 1999.*

rangements for operations and the recommendations of joint assessments shall be developed at the onset of each joint operation and updated regularly, at least anually. The JPA should include strategy, analysis and monitoring of refugee situations and repatriation plans where applicable. In line with the agreed Inter-Agency Standing Committee (IASC) Policy Package and subject to further agreements, the JPA should include any assistance provided to officially recognized internally displaced persons.

16. Joint assessment mission (JAM):[4] In consultation with the relevant government authorities, donor representatives, operational partners, beneficiaries, and experts as appropriate, UNHCR and WFP will jointly assess the overall food aid and related non-food requirements. Both agencies will agree on the modalities of food assistance, the composition of the food basket, ration size, duration of assistance, and related non-food inputs. Special consideration will be given to the needs and views of women, children and vulnerable groups.

17. In a major new emergency, the initial assessment to determine the number of beneficiaries and the most urgent food and non-food needs will normally be carried out within the framework of the emergency response being mobilized by both agencies. This would involve the participation of emergency response teams from UNHCR, WFP and prospective operational partners, as appropriate.

18. Joint assessment activities include the following as part of an integrated process:

- initial assessment (normally starting with a rapid initial investigation) at the onset of a refugee emergency/influx;
- periodic reviews/re-assessments of an ongoing operation;
- in-depth assessments of food security/self-reliance;
- assessment in preparation for repatriation and reintegration;
- nutrition surveys and surveillance; and
- monitoring on an ongoing basis.

The whole process, including the sequence of and relationships among the various activities, in a country of asylum is shown in Figure 2 (which also shows the inter-action with UNHCR's situation analysis and participatory planning processes, where implemented).[5]

Initial assessment

19. In most cases, when new refugees arrive in significant numbers and are in need of prompt assistance, the assessment will be undertaken in two phases:

1. A ***rapid initial investigation*** within the first few days (e.g. 2-3 days) to provide a basis for initiating the immediate delivery and distribution of assistance, and submitting preliminary requests to donors.

2. A ***detailed initial assessment*** following on directly from the rapid assessment and completed within a few weeks (e.g. 2-3 weeks) to provide a basis for the design of assistance programmes with operational plans and budgets for at least 6 months.

20. In some cases, refugees arrive progressively with some possessions and supplies, and for an initial period take care of themselves or are taken care of by local authorities, local communities and/or NGOs already working in the area. In such cases, the government request for international assistance may be delayed and a joint UNHCR-WFP assessment may be organized only several weeks, or

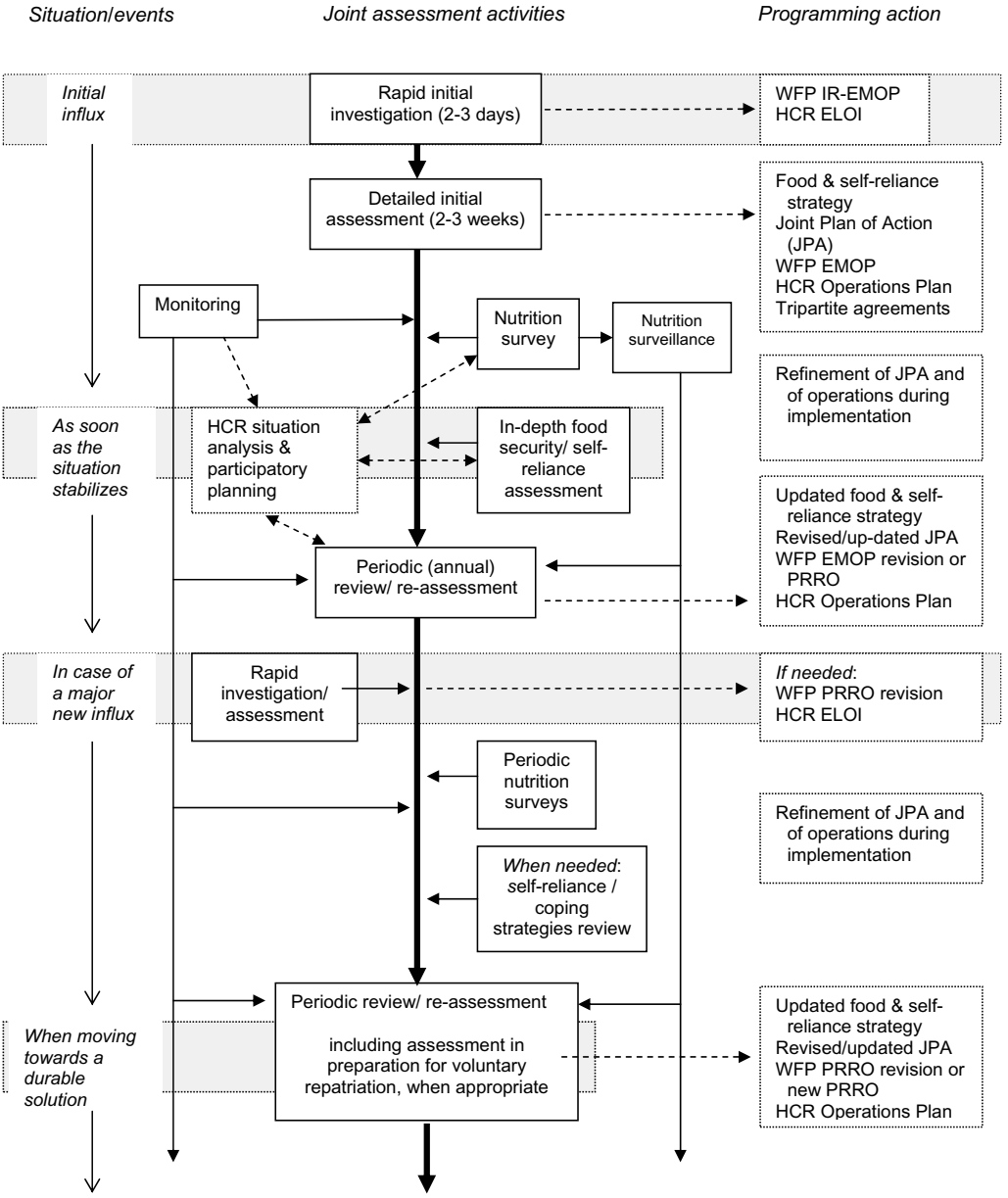
[4] *UNHCR/WFP Joint Assessment Guidelines (with Tools and Resource Materials), UNHCR-WFP, June 2004.*

[5] *See The UNHCR Tool For Participatory Assessment in Operations, 2006.*

even months, after the initial influx.[6] In such cases, a detailed initial assessment may be undertaken without a preliminary rapid investigation phase, if needs are not urgent. However, the 2-phase process is still needed in many cases.

21. A new rapid investigation and follow-on detailed assessment may be required in case of a major new influx in an on-going operation. If needs are urgent and there are no partners or other staff in the locality able to arrange to acquire supplies locally and/or receive supplies sent from elsewhere, and to organize initial distributions, members of the assessment team may have to fulfil these responsibilities while also continuing with the assessment.

Figure 2 - Typical sequence of joint assessment activities



[6] *This was the case for the Sudanese refugees who arrived in Chad in 2003, for example.*

Typical objectives for an initial assessment

Phase-1: Rapid initial investigation (2-3 days)

- To determine whether the refugees need immediate food assistance and/or other forms of assistance to prepare food and ensure their survival and well-being in the short term and, if so, to define (for the next 15-30 days): the number of people to be provided for, the types and quantities of food and related assistance required, how that assistance can be delivered, and how and by whom it should be distributed.
- To begin compiling data that will be required for operational planning, and enable preliminary information to be provided to donors concerning the scale of the assistance that could be required in the coming weeks and months.
- To identify the localities and priority topics on which follow-on more detailed assessment should focus.
- To identify factors that could positively or negatively influence possibilities for self-reliance (e.g. location, proximity of markets, access to water, fuel-wood, etc.), bring constraints to the notice of the authorities who are determining the locations for refugee camps and settlements.

Phase-2: Detailed initial assessment (2-3 weeks)

- To determine what measures are necessary and what assistance is required to ensure that the refugees:
  (i) have access to food that is adequate in quantity and quality to meet their nutritional needs, and to related non-food supplies, services and protection to maintain (or restore) nutritional health in the next 6-12 months; and
  (ii) progressively achieve the maximum possible level of sustainable self-reliance pending a durable solution (avoiding damaging or undesirable survival strategies).
- To define the types of food and related non-food assistance required; the number of people to be provided for; how the food and related assistance should be delivered, targeted and distributed; how initial assistance to self-reliance should be provided.
- To assess the logistic (transport, storage and handling) means and management capacities available to receive imported supplies, acquire in-country supplies, deliver supplies to the refugee sites, and maintain operational reserve stocks, with proper accountability and minimum losses throughout the supply chain, including any logistic constraints to be considered in the design of the overall programme.
- To determine whether immediate measures are necessary and, if so, what assistance is required to: (i) ensure that the food security of the local host population and the natural resource base of the area are not undermined by the self-reliance and fuel-wood collection activities of the refugees; and (ii) address any acute food shortages or malnutrition among the local population.
- To identify and assess the resources and capacities of potential implementing partners to undertake food distribution, self-reliance and monitoring activities.
- To assemble the data required for operational planning and budgeting, and to initiate implementation: this includes data on key indicators necessary to establish a baseline against which programme performance can be measured, to the extent possible.
- To enable specific, credible project proposals (for the next 6-12 months) to be elaborated and submitted to donors for funding.

22. UNHCR and WFP should also consider the food security situation of communities surrounding refugee camps and of individuals and families hosting refugees, and address these needs as appropriate.

Coordination

23. A UNHCR coordinator should be appointed as focal point for food and nutritional issues. In smaller operations, either the programme officer or the logistics officer could be appointed as food coordinator. If technical expertise is not available initially within UNHCR or WFP then assistance should be sought from government nutritionists, UN agencies or NGOs.

24. The food and nutrition coordinator's responsibilities are to establish standard procedures, including procedures for general food distribution, coordinate feeding programmes, monitor and evaluate the feeding programmes, and ensure close coordination and integration with community services, health and other sectors. The coordinator should act as the focal point within UNHCR for coordination with WFP and NGO's. Where the food coordinator is not her/himself a nutrition specialist, an experienced nutritionist will also be needed to provide the food coordinator with the necessary technical advice.

Role of refugees and nutrition education

25. The refugees must be involved from the start in the organization and management of the feeding programmes. Special training will be necessary for refugees.

26. The provision of simple outreach nutrition education and skills for the refugees is necessary when unfamiliar foods or new methods of cooking cannot be avoided. This should be organized in conjunction with providing skills on appropriate infant feeding, community-based therapeutic care, diarrhoea treatment, basic food hygiene and preparation for maximum nutritional benefit.

Related non-food needs and other programming elements

27. Related non-food needs include whatever non-food items, services or other measures may be needed to:

- ensure that refugees are able to prepare and cook their food – e.g. utensils, stoves, cooking fuel, water (for food preparation and cooking), grinding/milling facilities (when needed);
- address other factors that could undermine nutritional status and well-being – e.g. shelter, clothing, blankets, water quantity (for hygiene purposes), water quality (for drinking), sanitation, feeding practices, communicable diseases and psychosocial distress, access to education and health care including essential drugs, personal (in)security; and
- enhance sustainable self-reliance – e.g. the materials, facilities, technical assistance, training, administrative measures, etc.

28. Joint assessment teams must consider all of the above. This will be done largely on the basis of secondary data, especially the reports of surveys, assessments, ongoing monitoring, and evaluations conducted by competent organizations, but will also include discussions with key informants and groups of refugees as well as the team's own observations during visits to refugee sites.

What is expected of joint UNHCR-WFP assessment teams in relation to non-food needs and other programming elements	
Topic	*Approach*
Requirements to store food and water, and to prepare and cook food: ➢ *Utensils* ➢ *Stoves* ➢ *Cooking fuel* ➢ *Water* ➢ *Grinding/milling facilities (where needed)*	□ Examine available secondary data on what is available to households and compare with the standards below. □ Observe food preparation and cooking at household level to confirm the plausibility of the available data. □ Discuss with refugees in focus groups. □ If needed, undertake (or organize) a survey to gather reliable up-to-date data. □ Specify what (if anything) needs to be done to ensure that all households are able to adequately prepare and cook their food.
Factors that affect nutritional status and well-being: ➢ *Shelter, clothing, blankets, water quantity, water quality, sanitation* ➢ *Feeding practices* ➢ *Prevalence of diarrhoea, communicable diseases and psychosocial distress, previously existing micronutrient deficiencies* ➢ *Access to education, health care and essential drugs* ➢ *Personal (in)security*	□ Examine available secondary data on the current situation and compare with the standards below. □ Review the conclusions and recommendations of relevant assessment, monitoring and evaluation reports. □ Observe conditions and practices and discuss with refugee groups, public health workers, nutritionists and NGOs to confirm or update the data and recommendations for action; seek clarification if data are not consistent with your own observations. □ Exceptionally, if no information is yet available from a competent source, gather whatever information you can during your visits, and try to arrange for competent bodies to undertake professional assessments as soon as possible. □ Discuss with refugees in focus groups. □ Summarize available data and the implications for nutritional status and general well-being, including any specifically-identified causes of malnutrition. □ Summarize current recommendations, the status of action on them, and the additional actions required to protect health and nutritional status.
Requirements for self-reliance: ➢ *Materials* ➢ *Facilities* ➢ *Technical assistance* ➢ *Training* ➢ *Administrative measures*	□ Review the findings, conclusions and recommendations of relevant assessment, monitoring and evaluation reports. □ Observe self-reliance activities and discuss with refugee groups, development workers and agencies the effectiveness of activities to enhance self-reliance and confirm or update recommendations for action. □ If needed, organize (or recommend) an in-depth assessment of risks and possibilities for self-reliance (see chapter 5). □ Specify the actions (if any) that need to be taken to enhance self-reliance at household and community levels.

Cooking fuel

29. Particular attention must be paid to the provision of cooking fuel and the control and management of the natural resources in the vicinity of the camp. Failure to deal with this can quickly lead to destruction of the vegetation in and around the site causing lasting damage to the environment, with direct effects on the health and well-being of refugees and local people and friction with the local population. Fuel needs and consumption vary considerably[7]. Factors affecting the use of fuel include:

i. ***Food preparation, cooking techniques, fuel type and preparation***. Soaking beans prior to cooking, ensuring lids are used on pots, ensuring

wood is dry and chopped, and that fires are put out after cooking – all these make considerable fuel savings and can be incorporated into environmental awareness raising and training programmes.

ii. ***Type of stove***. It may be possible to use local technology to modify existing types of wood or charcoal burning stoves in order to make them more fuel efficient. Simple improvements and local technologies are best. Note that the social and economic implications of a new technology are usually more important in determining whether it will be adopted than the effectiveness of the technology itself. The promotion and use of improved stoves must closely involve the refugees.

iii. ***Type of food***. Freshly harvested foods take less cooking time, also using milled rather than whole grain and using pre-cooked food make considerable fuel savings. The environmental implications of the food basket need to be taken into account with WFP.

iv. Availability (or "price") of fuel itself. This is often the most significant factor affecting per capita fuel consumption. The provision of fuel wood and managing and controlling the use of natural resources around a refugee camp is discussed further in chapter 12 on site planning.

Nutrition assessments[8]

- The nutrition assessment should be carried out as soon as possible by an experienced nutritionist.
- A nutrition survey should include anthropometric measurements, morbidity as well as food security information.
- Regular nutrition assessment is necessary both to monitor the nutrition status of the community including identifying individuals who have specific needs.
- Information must be gathered on infant feeding practices, micronutrient deficiencies, morbidity and mortality as well as malnutrition rates, in order to understand the underlying causes of malnutrition.

Introduction

30. An initial assessment of the nutrition status of the refugees should be made as soon as possible and should be carried out by an experienced nutritionist. The extent of malnutrition has important implications for what form the emergency response will take, and will enable early decisions to be taken on the components of the rations and on the requirement for any additional selective feeding programmes.

31. The initial nutritional assessment should be followed by regular nutrition surveys under specialist supervision to monitor the nutrition situation of the population as a whole.

32. Where results of the initial assessment or later surveys indicate a need for selective feeding programmes, individuals will need to be identified and registered for these programmes. Their individual progress should then be monitored regularly.

33. The initial nutrition assessment and the periodic nutrition surveys of the population as a whole should be done by measuring the weight and height of a ran-

[7] *Average fuel-wood consumption per person per day in different refugee camps has varied from 0.9kg to 4kg.*

[8] *WHO released new growth standards in April 2006 which are available at www.who.int/childgrowth. This is accompanied by the release of software which allows calculation of the prevalence of malnutrition using the NCHS/WHO reference data and the WHO 2006 growth standards. UNHCR is in the process of assessing programming implications of these new standards. For more information contact HQTS01@unhcr.org*

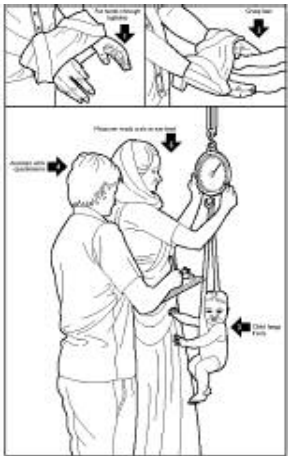
dom sample of the child population (as explained below). Initially such surveys should be carried out every two to three months. When conditions have stabilized, a survey once every six to twelve months is sufficient.

34. In addition, a nutrition surveillance and monitoring system should be established. Any change or trend in nutritional status can thus be detected and appropriate adjustments made in the assistance programmes.

There is a serious nutritional emergency where the acute malnutrition rate is either 15% or more, or 10-14% with aggravating factors (e.g. high prevalence of respiratory infection and diarrhoeal diseases). Such a situation requires urgent action. It is important to try to get information on trends in malnutrition rates which would give a better picture of the situation (deteriorating rapidly but still low might require some rapid action even if the trigger level has not been reached). Please see Appendix 1: Key Emergency Indicators.

Recognizing and measuring malnutrition

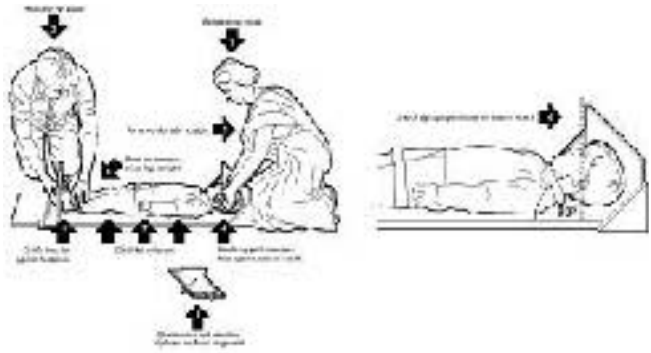
35. Malnutrition can be recognized by clinical signs (such as nutritional oedema or micronutrient defiencies) and by anthropometry (body measurements). Measurements such as weight-for-height are used as an objective assessment of nutritional status, which quantifies the nutritional situation at one point in time, and allows comparisons over time.



36. Mortality and morbidity information will assist in understanding the underlying causes of malnutrition and the relationship characteristic between malnutrition and mortality to determine the focus on specific interventions. Child mortality rates are particularly important.

37. ***Weight-for-height in children***, is the best indicator to assess and monitor nutritional status of populations. The actual weight of a child is calculated as a percentage of the standard weight for a normal child of that height, or as a Z score. Z-scores are the standard and the preferred mode of presenting anthropometric indicators in nutrition surveys. Percentage of the median can be presented in addition to Z-scores in the survey report if there is a specific need for this alternative expression (such as when results will be used as a programmatic tool in selective feeding programs). It is usually young children aged between 6 and 59 months who are measured in nutrition surveys, because young children are the first to show signs of malnutrition in times of food shortage and are the most severely affected. When the ages of children are not known, 65 cm and 110 cm height are used as the cut off points instead of 6 and 59 months.

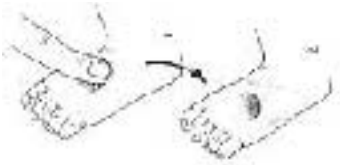
Z-score: The deviation of an individual's values from the mean value of a reference population taking into consideration the standard deviation of the reference distribution. Z-score is used in analysing continuous variables such as the height and weight of a sample of the population in a nutrition survey.



38. ***Body mass index*** (BMI) (Weight in kg)/(Height in m)^2, is used for assessing the nutritional status of adults by assessing the degree of thinness (see table 1).

39. ***Oedema*** is an essential nutrition indicator and may indicate kwashiorkor (see Annex 4). Oedema is characterized by swelling in both feet due to an abnormal accumulation of fluid in intercellular spaces of the body.

Children with nutritional oedema should always be classified as having severe acute malnutrition regardless of their weight-for-height or height-for-age Z-score or percentage of the median.



40. ***Mid-upper arm circumference***. The mid-upper arm circumference (MUAC) is measured on the left arm, at the mid-point between elbow and shoulder. MUAC is not recommended to measure the prevalence of malnutrition in young children in a population. MUAC is more suitable as a screening tool for determining admission to selective feeding programmes and for rapid assessments. If MUAC is included in a population-based nutrition survey of children, it is essential that weight-for-height indices are also included.

41. However, it should be noted that:

i. In addition to WFH <70% of the median and bilateral oedema, MUAC <110 mm is an <u>independent</u> criterion for admission to a therapeutic feeding program for children 6-59 months old.

ii. In infants less than 6 months old, there are no clear anthropometric criteria for admission to a therapeutic feeding program and it is recommended that "severe visible wasting" be used until further studies are undertaken to develop criteria.

iii. MUAC is a simple and practical tool which can be used by minimally trained workers for detecting the severely malnourished in the community and for achieving high program coverage.

42. ***Weight-for-age*** and ***height-for-age*** are not such useful assessment indicators in emergencies as age is often difficult to determine. This can be used for growth monitoring of individual children, and partially in assessing long-term (chronic) malnutrition.

Moderate and severe malnutrition

43. The standard cut-off points to describe malnutrition are:

i. between 70% and 80% weight-for-height of the median NCHS/WHO reference values (or between -3 and -2 Z scores) for moderately malnourished; and

ii. less than 70% weight-for-height of the median NCHS/WHO reference values (or < -3 Z scores) for severely malnourished.

Table 1: Summary of key malnutrition indicators*

Malnutrition	Children under 5 years old			Adults BMI
	Weight-for- height (W/H)% of median NCHS/WHO reference values value[9]	Weight-for- height (W/H) in Z scores or SD's of the median NCHS/WHO reference values[10]	MUAC	
Moderate	70% to 79%	-3 to -2 Z scores	110 mm to<125 mm	16 - <18
Severe	less than 70% or oedema	less than -3 Z scores or oedema	< 110 mm, oedema	less than 16

** Results expressed by different methods are not directly comparable*

General feeding programme

Response to food and nutritional needs

- A mean figure of 2,100 kcal per person per day is used as the planning figure for calculating the food energy requirements of refugees in emergencies in developing countries, except when the population pyramid is not 'normal', e.g. when there is an unusually high number of adolescents amongst the refugees, or only women and young children[11]
- Everyone in the population, irrespective of age or sex, should receive exactly the same general ration (i.e. same quantity and type of foods).
- The food basket should be nutritionally balanced and suitable for children and other groups at risk.
- Every effort should be made to provide familiar foodstuffs and maintain traditional food habits.
- The level of fat intake should provide at least 17% of the dietary energy of the ration. Protein intake should provide at least 10-12% of the total energy.
- The diet must meet essential vitamin and mineral requirements.
- Particular attention should be paid to locally prevalent micronutrient deficiencies.

General food ration

44. To design and anlyse a general food ration, it is advised to use the interactive tool NutVal. Jointly updated by UNHCR, WFP and the Institute of Child Heath, London, *NutVal* is a spreadsheet application for the planning, calculation and monitoring of the Nutritional Value of general food rations.[12]

45. Every effort should be made to provide familiar food items and maintain sound traditional food habits. Expert advice on the ration size and composition is essential and should take full account of local availability of food commodities. Staple food should not be changed simply because unfamiliar substitutes are readily available. Inappropriate foods often lead to waste and lower the morale of the refugees.

46. The first concern is to ensure that energy and protein requirements are met. This requirement is calculated on an average population containing men, women and children of different age groups. However, a complete ration should be provided to each refugee without distinction.

[9] *Percentage below the median "reference" weight-for-height values.*
[10] *Standard deviations (SDs, or Z score) below the median "reference" weight-for-height values.*
[11] *Food and Nutrition Needs in Emergencies, UNHCR, UNICEF, WFP, WHO, 2003.*
[12] *Copies of the NutVal CD and TSS toolkit can be obtained from the UNHCR Technical Suport Section (TSS), HQTS01@unhcr.org*

A minimum requirement of 2,100 kcal per person per day is used as the planning figure for the affected population at the beginning of an emergency.

A population which contains mostly active adults may require considerably higher average energy intakes. In addition, a higher ration is vital for survival in a cold climate.

47. The daily energy requirement can be adjusted when the situation has stabilized[13] and detailed data is available. Factors to be taken into consideration are:

i. age and sex composition of the population;
ii. activity level;
iii. climatic conditions;
iv. health, nutritional and physiological status; and
v. people's access to other food sources e.g. agriculture, trade, labour.

48. The food basket should comprise: a staple food source (cereals), an additional energy source (fats and oils), a protein source (legumes, blended foods, meat, fish), iodized salt and possibly condiments (such as spices). Fresh foods should be included in the food basket for essential micronutrients. The level of fat intake should provide at least 17% of the dietary energy of the ration, and protein intake should provide at least 10-12% of the total energy (see above).

49. When certain food commodities are not available, they can be replaced for a maximum of one month by other available food items in order to maintain the adequate energy and protein level. Substitution in energy value, should an item not be available, is:

Corn soy blend (CSB) for beans	1:1
Sugar for oil	2:1
Cereal for beans	2:1
Cereal for oil[14]	3:1

[14] *Note that oil cannot be used in place of cereal.*

For example, the energy from 20g of sugar can substitute for that from 10g of vegetable oil.

50. Fortified cereal flour, rather than whole grain, should be provided, especially at the beginning of an emergency. Considerable fuel savings are made by using milled rather than whole grain. If whole grains are provided, local milling should be made available and the cost compensated for.

Micronutrients

51. Micronutrient deficiencies represent a less visible, but often devastating, form of malnutrition that can be particularly prevalent among a population affected by an emergency or already lacking sufficient quantity and/or quality of food. There is a close relationship between malnutrition, which is often linked to lack of food, and specific micronutrient deficiency diseases that are associated with the consumption of foods poor in micronutrients. Since populations affected by an emergency often have limited access to a varied diet, a large proportion of these are also likely to suffer from multiple micronutrient deficiencies.

52. Populations that are highly dependent on food assistance, which is not adequate, are often at risk of micronutrient-deficiency diseases. Such micronutrient-deficiency diseases include scurvy (vitamin C deficiency), pellagra (niacin deficiency) and beriberi (thiamine deficiency) have been experienced in previous emergency situations. In addition, anaemia, iodine deficiency and vitamin A deficiency are also the three most common micronutrient deficiencies even in non-emergency situations. For details on the micronutrient

[13] *Food and nutrition needs in emergencies, UNHCR, UNICEF, WFP, WHO, 2003. http://whqlibdoc.who.int/hq/2004/a83743.pdf*

content of selected food-aid commodities, see Annex 1.

53. Micronutrient deficiencies increase the risk of communicable diseases or the risk of dying due to diarrhoea, measles, malaria and pneumonia. In turn, communicable diseases contribute to micronutrients deficiencies.The groups most vulnerable to micronutrient deficiencies are pregnant women, lactating women and young children.

Table 2: Micronutrient needs of groups with specific needs

Groups with specific needs	Micronutrient deficiency risk
Pregnant women	Greater risk of dying during childbirth or of giving birth to an underweight or mentally-impaired baby.
Lactating mothers	Micronutrient status determines the health and development of her infant during the breast feeding period, especially for the first 6 months of life.
Young childeren	Micronutrient deficiencies increase the risk of dying due to infectious disease and contribute to impaired physical and cognitive development.

54. It is essential to ensure that the micronutrient needs of refugees are adequately met through ensuring that the general food aid rations are adequate and well-balanced in content, distributed regularly and in sufficient quantities. In addition, micronutrient fortified foods such as corn soya blend (CSB) should be provided to ensure that recommended daily micronutrient intakes are met. Fortified foods, vegetable oil enriched with vitamin A, and iodized salt, are usually provided as part of food rations in emergencies with a view to preventing micronutrient deficiencies or to protecting against further deterioration of micronutrient status among the targeted population**.**

The prevention and control of micronutrient defiencies and other forms of malnutrition requires an integrated approach with food security and public health components.[15]

For micronutrients deficiency signs and definitions, see Annex 3 (with photos and a table definition of beri-beri, pellagra, scurvy etc.)

55. The risk of specific nutrient deficiencies can be estimated from the composition of the general ration in combination with the access the population has to other food sources. Possible options for providing vitamins and minerals are:

i. provide fresh food products;
ii. promote the production of vegetables and fruits;
iii. add to the ration a food rich in a particular vitamin and micronutrient such as fortified cereals, blended foods, or condiments;
iv. ensure provison of vitamin A supplement; and
v. provide supplements in tablet form, **if necessary.**

56. Wherever possible the refugees should be supported and encouraged to grow vegetables themselves: the production of fresh food by refugees not only improves and diversifies the diet but saves fuel and provides an opportunity to generate some income. Larger plot sizes and the provision of appropriate seeds and skills would facilitate this. It should be taken into consideration, that it can be a challenge to encourage refugees to produce fresh food because of their uncertainty as to the length of their stay and problems of access to land. However, small- scale agrcicultural activities proved to be a success in various refugee situations.

[15] *For more details on micronutrints including prevention and assessement, please see key references.*

Nutrition, food and HIV and AIDS

57. For people living with HIV and AIDS among populations of concern to UNHCR, adequate nutrition is recognized as essential to maintain an individual's immune system and desirable weight for an optimal quality of life, as well as to ensure optimal benefits from the use of antiretroviral treatment which can help prevent mother-to-child transmission of HIV.

Based on current scientific evidence:

a) HIV-infected adults and children have greater energy needs than uninfected adults and children. Energy needs increase by 10% in asymptomatic HIV-infected adults and children, and in adults with more advanced disease, by 20% to 30%. For HIV-infected children experiencing weight loss, energy needs are increased by between 50% and 100%.

b) There is no evidence to support a need for increased protein intake by people infected by HIV over and above that required in a balanced diet to satisfy energy needs (10%-12% of total energy intake).

c) Micronutrient intakes at daily recommended levels need to be assured in HIV-infected adults and children through consumption of diversified diets, fortified foods and micronutrients supplements as needed.

d) WHO's recommendation on vitamin A, zinc, iron, folate, and multiple micronutrient supplements remain the same.

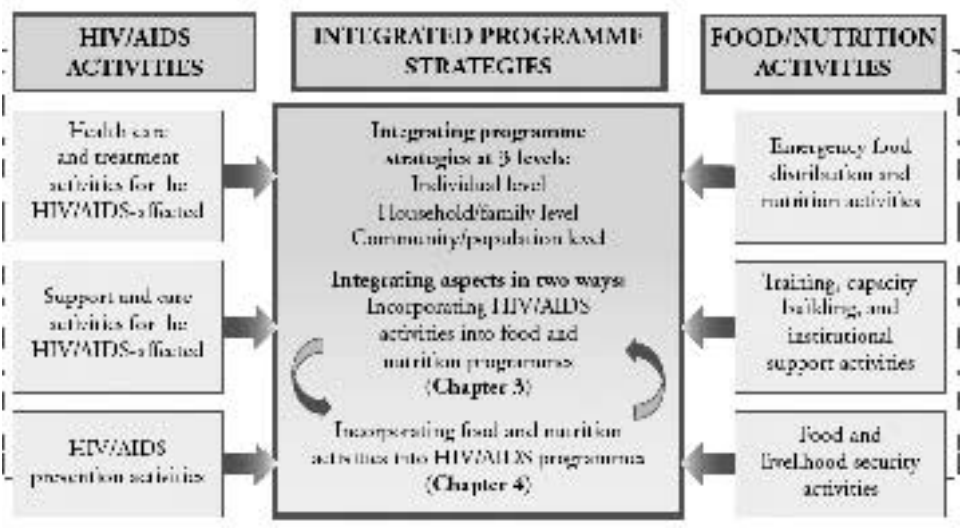
e) Optimal nutrition of HIV-infected women during pregnancy and lactation increases weight gain and improves pregnancy birth outcomes.

Source: World Heath Assembly 2005, Resolution WHA57.14

Figure 3 below outlines the types of food and nutrition as well as HIV and AIDS activities which should be considered for integrated programme strategies at the individual, household and community levels.

For more practical programming strategies on integrating nutrition, food, HIV and AIDS, consult the UNHCR, WFP and UNICEF: Integration of HIV/AIDS activities with food and nutrition support in refugee settings, 2004.

Figure 3 Integrated programme strategies



Food delivery and distribution

58. In countries where the beneficiary caseload exceeds 5,000 people of concern, WFP is responsible for the timely mobilization, transport and storage of sufficient quantities of food commodities at agreed-upon extended delivery points (EDPs). UNHCR is responsible for the timely transport and storage of food that it is responsible for mobilizing (less than 5,000 beneficiaries, complementary food commodities, therapeutic milk etc.). Unless otherwise agreed, UNHCR is also responsible for the transportation of WFP food commodities from the EDPs to the final delivery points (FDPs) and for their final distribution to beneficiaries.

59. Arrangements for the final distribution of food to beneficiaries are agreed upon jointly by the Government, UNHCR and WFP, in consultation with beneficiaries, particularly women's committees, and in conformity with the established commodity distribution guidelines.

60. The final distribution of food commodities will normally be the responsibility of UNHCR through an implementing partner, whose designation shall be jointly agreed upon by UNHCR and WFP. Tripartite agreements will be signed in every joint operation. In the most recent Memorandum of Understanding (MOU) with WFP (July 2002) an agreement has been reached for WFP to take over the responsibility of final food distribution in five jointly selected operations with a view to determining whether this division of labour would be an optimum arrangement for implementation in other situations on a case by case basis. UNHCR maintains its responsibility for distribution of food in all selective feeding programmes.

61. In emergencies, although the preference is on dry distribution, on some occasions there might be a need for distribution of cooked meals. Dry food distribution (which is taken home) has major advantages over cooked food distribution. It allows families to prepare their food and to use their time as they wish, permits them to eat together as a unit and is more culturally and socially acceptable. It also reduces the risk of the spread of infectious diseases. Cooked meal distribution requires centralized kitchens with adequate utensils, water and fuel (the requirement is less than the amount required for family cooking) and trained personnel. Cooked meal distribution to the whole population is therefore only provided under exceptional circumstances when the refugees do not have access to adequate water and/or cooking fuel and in insecure situations.

62. In addition to cooking pots, fuel and utensils, the refugees must have containers and sacks to protect and store their food rations. Oil tins and grain bags will be useful.

Monitoring the general feeding programme:

63. The general feeding programme can be monitored by:

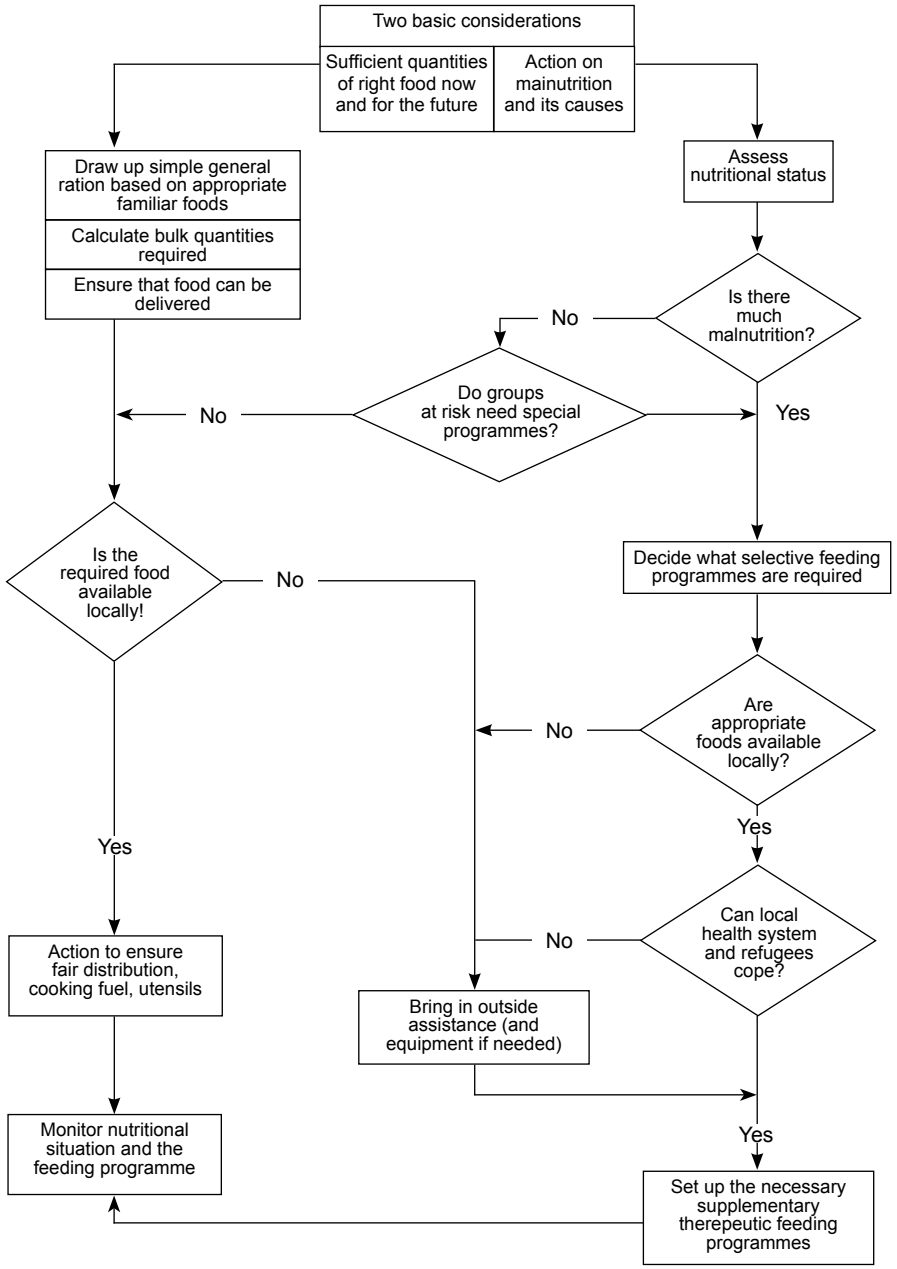
- Food basket monitoring: Comparing the quantity and quality of food collected by the refugees at the distribution site on distribution days with the planned ration. Confirming what beneficiaries actually receive.
- Post distribution monitoring: Monitoring after the distribution at household and/or community levels through visits. Learning about the use made of the food and the length of food aid by beneficiaries and identifying any changes in the food security situation.
- Discussing the quality and quantity of the rations regularly with the refugees.
- Investigating complaints.

For more information on the distribution monitoring report and food distribution monitoring checklist, see the food section of the Technical Support Section's Toolkit, UNHCR 2006.

Selective feeding programmes

- The objective of a selective feeding programme is to reduce the prevalence of malnutrition and mortality among the groups at risk.
- Selective feeding programmes provide extra food for the malnourished and at-risk groups – this food must be in addition to (not a substitute for) the general feeding programme.
- The programme must actively identify those who are eligible for the selective feeding programmes, using criteria described in this chapter.

Figure 4 – Response to food and nutritional needs



General principles of selective feeding programmes

64. Where malnutrition exists or the needs of the groups at risk cannot be met through the general ration, special arrangements are required to provide extra food. This is organized through different types of selective feeding programmes which take into account the degree of malnutrition and associated risks. In the emergency phase of an operation, selective feeding programmes are part of an emergency measure to prevent excess mortality. However, preventing excess mortality should be a combined strategy of selective feeding, public health and emergency health care (see Figure 2: response to nutritional needs).

The organization of these programmes should be integrated from the beginning with community and health services and especially with mother and child health care programmes (MCH).

65. Malnutrition develops particularly among infants, children, pregnant women, nursing mothers, the elderly and the sick. Their vulnerability stems from the greater nutrient requirements associated with growth, the production of breast milk, repair of tissues and production of antibodies. Malnutrition results in lower resistance to infection, which in turn results in further malnutrition. Small children are particularly susceptible to this cycle of infection and malnutrition. Sick children must eat and drink even if they do not have an appetite, are vomiting, or have diarrhoea. Because children are unable to eat a large volume of food, it is necessary to prepare food in a concentrated form (giving the required nutrients in less volume), and to provide more frequent meals.

66. Certain other groups or individuals may be at risk of malnutrition for social or economic reasons. These include unaccompanied children, the disabled, single-parent families, and the elderly, particularly those without family support. In some communities specific social or cultural practices and taboos may put constraints on meeting the nutritional needs of certain persons, for example pregnant women and nursing mothers or even sick children.

67. Even if the overall quantity of food is sufficient there may be other causes of malnutrition such as:

i. inequities in the distribution system reducing access to food for certain groups;
ii. inaccuracies in registration or unfair distribution of ration cards;
iii. infections; and
iv. inappropriate feeding practices or food preparation habits.

Selective feeding programmes are not a substitute for an inadequate general ration.

68. The following types of selective feeding programmes are contemplated:

i. Supplementary feeding programmes (SFP):
   a) targeted SFP
   b) blanket SFP

ii Therapeutic feeding programmes (TFP):
   a) hospital and feeding centers
   b) community-based

To be effective, the extra ration provided in SFP must be additional to, and not a substitute for, the general ration.

Supplementary feeding programmes (SFP)

69. Targeted and blanket supplementary feeding programmes provide extra food to groups at risk, in addition to the general ration, as dry take-home or wet on-the-spot feeding for a limited period of time.

70. A targeted SFP aims to rehabilitate those who are moderately malnourished. These could be children, adults or older persons and/or individuals selected on

medical or social grounds, e.g. pregnant and nursing women and the sick. This is the most common type of supplementary feeding programme.

71. A blanket SFP provides a food (and/or micronutrient) supplement to all members of a certain vulnerable group regardless of their individual nutritional status in order to prevent a deterioration in the nutritional status of those groups most at risk (usually children under five, pregnant women and nursing mothers.

72. Supplementary feeding programmes can be implemented either by giving wet or dry rations.

Therapeutic feeding programmes (TFP)

73. A TFP aims to reduce deaths among infants and young children with severe malnutrition. The forms of severe malnutrition are described in Annex 3. Generally the target group is children under 5 years old with severe malnutrition. Therapeutic feeding can either be implemented in special feeding centers or in a hospital or clinic or at the community level. TFP involves intensive medical and nutritional treatment.[16] Therapeutic foods such as, Therapeutic Milk™, **and/or** ready-to-use therapeutic food (RUTF), are used for treatment of severely malnourished children.

74. The management of severe malnutrition in children can take place as follows:

i. **Facility-based management** refers to treatment in a hospital or center that provides skilled medical and nursing care on an inpatient basis. This includes therapeutic feeding centres.
ii. **Community-based management** refers to treatments that are implemented with some external input, such as the presence of a health worker for diagnosing the condition, instituting treatment and monitoring the condition of the child at home. This applies to the treatment of severe malnutrition when a health worker is involved in identifying a severely malnourished child and in providing treatment that may include a mineral and vitamin supplement or ready-to-use therapeutic food (RUTF).

75. Managemnent of severe malnutrition at the community level using ready-to-use therapeutic foods (RUTF) is a new development. As such, it is highly desirable to manage severe acute malnutrition, with no medical complications, in the community and without an inpatient phase. These are severely malnourished children who are alert, have good appetite, are clinically well, and have reasonable home circumstances who can be rehabilitated at home.

76. The following points should be considered for manamgement of severe malnutrition at the community level:

- Children with severe malnutrition and medical complications should be referred to an inpatient treatment facility with trained staff. These children include severely malnourished children with anorexia, children with severe oedema, or children with any acute severe medical condition.
- Children less than 6 months old who are suspected to be severely malnourished should always be referred for assessment and treatment. Treatment should be based on promotion of breastfeeding (if possible).

77. In addition, the following guiding principles[17] for community-based management of severe malnutrition in children should also be considered:

[16] *Procurement of therapeutic foods and technical advice could be facilitated by UNHCR HQs technical unit (TSS and SMS).*

[17] *The guiding principles for community-based management of severe malnutrition in children were agreed in a consultation meeting (WHO, UNICEF, the UN Standing Committee on Nutrition (SCN) and other partners, including UNHCR in November 2005: http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/CBSM/Meeting_report_CBSM.pdf*

- Identification of severely malnourished children in the community in order to provide for treatment.
- Management of severely malnourished children in the community.
- Community-based management of severe malnutrition in the context of high HIV prevalence.

Identification of severely malnourished children in the community in order to provide for treatment

78. In addition to weight-for-height < 70% or < -3 Z-scores of the median NCHS/WHO reference values and/or bilateral oedema, MUAC < 110 mm can be used independently as a criterion for admission to a therapeutic feeding programme for children aged 6-59 months. Children with a MUAC < 110 mm should be admitted to a programme for the management of severe malnutrition regardless of their weight-for-height.

79. MUAC is a simple and practical tool which should be used by community workers to identify severely malnourished children.

80. In infants less than six months old, it is recommended that "visible severe wasting" and/or oedema, in conjunction with difficulties in breastfeeding be used as admission criteria until further studies are undertaken to develop more precise admission criteria for treatment.

81. High coverage (both temporal and spatial) of the programmes, achieved through active case finding activities, as established in the SPHERE minimum standards must be a key objective for therapeutic feeding programmes.

Community-based management of severe malnutrition in children

82. Programmes for the management of severe malnutrition should usually have a community-based and a facility-based component, so that severely malnourished children, with no complications, can be treated in the community while those with complications are referred to an inpatient treatment facility with trained staff.

It is highly desirable to manage severely malnourished children with no complications in the community without an inpatient phase. These are severely malnourished children who are alert, have good appetite, are clinically well, are not severely oedematous, and have reasonable home-care circumstances.

83. Children with severe malnutrition having mild or moderate oedema and good appetite but who are not severely wasted can also be treated at home, without an inpatient phase.

84. Children with severe malnutrition and complications should be referred to an inpatient treatment facility with trained staff. These children include severely malnourished children with anorexia, children with severe oedema, children with both severe wasting (MUAC < 110 mm or weight-for-height < 70% or < -3 Z-scores of the NCHS/WHO reference) and mild or moderate oedema, or children who are clinically unwell.

85. For those treated as inpatients, after the complications of severe malnutrition are under control, management should normally be continued in the community. Children who deteriorate at home should be referred for assessment and further management.

Ready-to-use therapeutic foods (RUTF) are useful for treating severe malnutrition without complications in communities with limited access to appropriate local diets for nutritional rehabilitation.

86. When RUTF is given to children with severe malnutrition, 150-220 kcal/kg/day should be provided.

87. When families have access to nutrient-dense foods, severe malnutrition without complications can be managed in the community without RUTF, by means of carefully designed diets using low-cost family

foods, provided appropriate minerals and vitamins are given. Efficacy of local therapeutic diets should be tested clinically.

88. Treatment of young children should include support for breastfeeding and messages on appropriate infant and young children feeding practices. Children less than 6 months old should not receive RUTF, nor solid family foods. These children need milk-based diets and their mothers support to re-establish breastfeeding. They should not be treated at home.

89. Monitoring the effectiveness of treatment should be based on a weight gain of at least 5 g/kg/day for severely wasted children,[18] low case fatality, defaulting and treatment failures, and length of stay under treatment.

Community-based management of severe malnutrition in the context of high HIV prevalence

90. The general principles and guidelines for the care of severely malnourished children in areas of high HIV prevalence do not fundamentally differ from those where HIV is rarely seen.

91. In areas where HIV prevalence is high, there should be unfettered access to HIV services (e.g. VCT, cotrimoxazole prophylaxis, nutritional counselling, ART) and seamless articulation from the onset between levels of care (community, health centre and hospital) and between HIV treatment and malnutrition programmes.

92. All therapeutic foods used, including RUTF, should be chosen to be appropriate for HIV infected persons and severely malnourished children, based on current scientific evidence.

Starting a selective feeding programme

93. The decision to start a selective feeding programme is based on the prevalence of malnutrition and other aggravating factors. Aggravating factors include high mortality (more than 1 person per 10,000 per day), measles epidemic, high prevalence of infectious diarrhoea, general ration below minimum requirements. The prevalence of malnutrition is assessed from the initial and on-going nutrition assessments and surveys.

In all situations, remember that it is more important to understand and address the root causes of malnutrition, focusing on prevention in the first place rather than to address symptoms through selective feeding programmes.

94. The effectiveness of these programmes will be severely compromised if an adequate general ration is not provided.

95. Figure 5 provides guidance on deciding when to initiate selective feeding programmes. Clear criteria for the termination of these programmes should be defined from the beginning.

Identifying those eligible

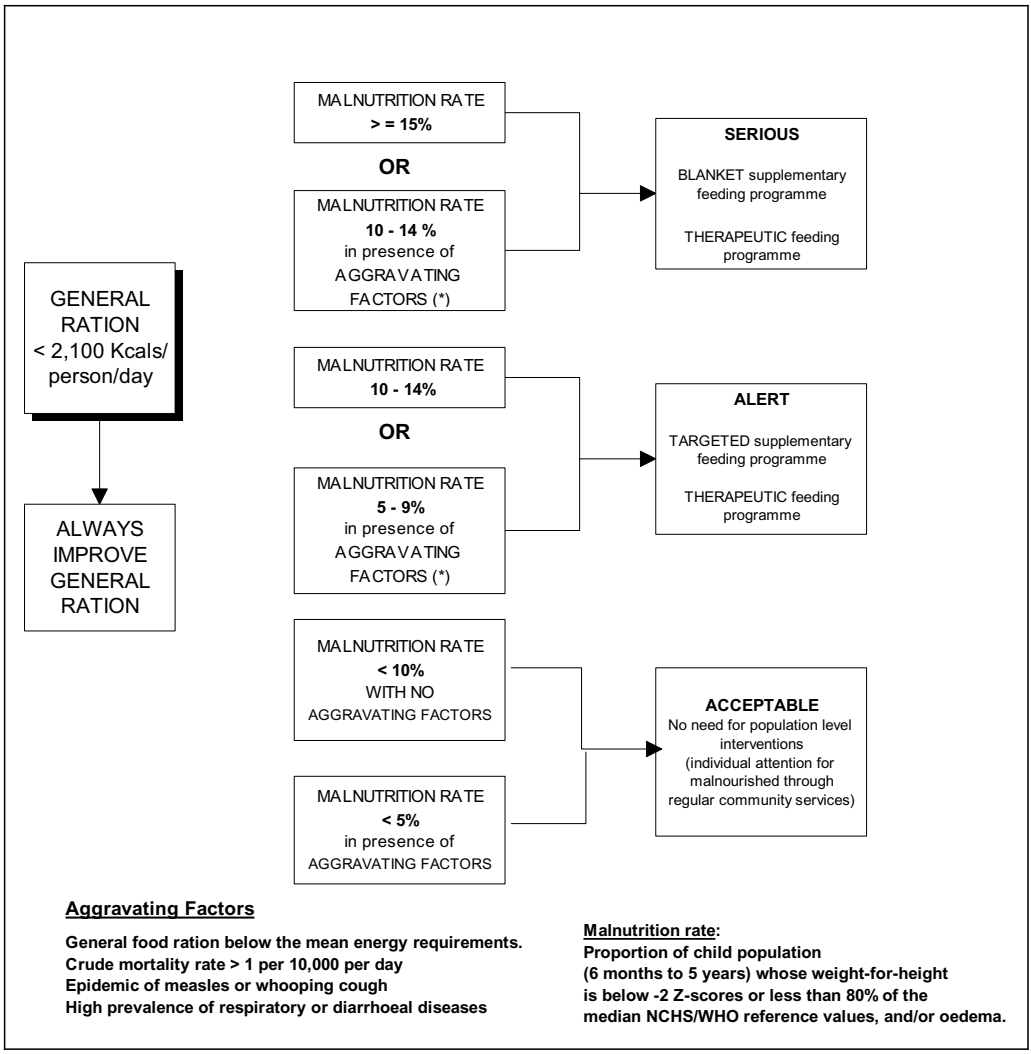
96. Selective feeding programmes must be based on the active identification and follow up of those considered at risk. Beneficiaries can be identified by:

- house to house visits to identify all members of a targeted group (e.g. children under five years old, elderly people);
- mass screening of all children to identify those moderately or severely malnourished;
- screening on arrival (for example with the registration exercise); and
- referrals by community services and health services.

97. Table 3 below summarizes the main objectives, target groups and criteria for selection of beneficiaries of selective feeding programmes.

[18] *Rate of weight gain was deliberately changed to a lower level than the SPHERE minimum standards which referred to inpatient treatment of severe malnutrition.*

Figure 5 – Selective Feeding Programmes



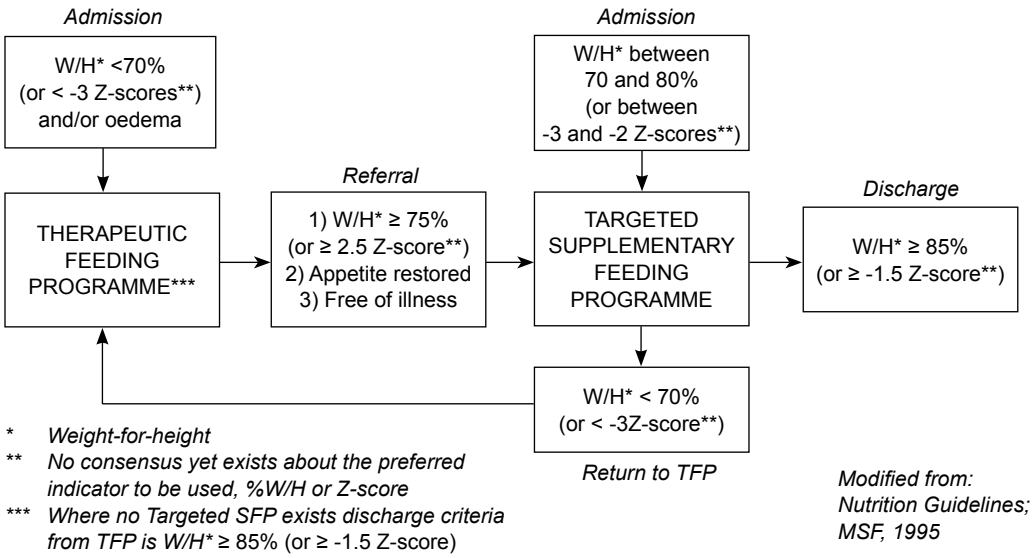
Source: Modified from "Nutrition Guidelines", MSF, 1995

Table 3 – Types of selective feeding programmes

Programme	Objectives	Criteria for selection and target group
Targeted SFP	• Correct moderate malnutrition • Prevent the moderately malnourished from becoming severely malnourished • Reduce the mortality and morbidity risk in children under 5 years old • Provide nutritional support to selected pregnant women and nursing mothers • Provide a follow-up service to those discharged from therapeutic feeding programmes	• Children under 5 years old moderately malnourished: - between 70% and 80% of the median weight-for-height or: - between -3 and -2 Z-scores weight-for-height • Moderately malnourished individuals (based on weight-for-height, BMI, MUAC or clinical signs) including: - older children (between 5 and 10 years old) - adolescents - adults and elderly persons - medical referrals e.g T.B patients • Selected pregnant women (from date of confirmed pregnancy) and nursing mothers (until 6 months after delivery), for instance using MUAC <22 cm as a cut-off indicator for pregnant women • Referrals from TFP • People living with HIV and AIDS (PLWHA)
Blanket SFP	• Prevent deterioration of nutritional situation • Reduce prevalence of acute malnutrition in children under 5 years old • Ensure safety net measures • Reduce mortality and morbidity risk • Reduce excess mortality and morbidity risk in children under 5 years old	• Children under 3 or under 5 years old • All pregnant women (from date of confirmed pregnancy) and nursing mothers (until maximum 6 months after delivery) • Other at-risk groups
TFP	• Provide medical/nutritional treatment for the severely malnourished Note: TFP includes community-based management of severe malnutrition in children	Children under 5 years old severely malnourished: □ < 70% of the median weight-for-height and/or oedema or: □ < -3 Z-scores weight-for-height and/or oedema MUAC <110mm including children with HIV and AIDS • Severly malnourished children older than 5 years, adolescents and adults admitted based on available weight-for-height standards or presence of oedema including PLWHA • Severely malnourished low birth weight babies

98. The links between different selective feeding programmes and the criteria for entry and discharge from a programme are shown in figure 6 below.

Figure 6 – Admission and discharge Criteria



Planning and organizing a selective feeding programme

Organizing a supplementary feeding programme (SFP)

99. Supplementary feeding programmes (SFP) can be implemented either by providing wet rations or dry rations.

i. Wet rations are prepared in the kitchen of a feeding centre and consumed on-site. The beneficiary, or child and caregiver, have to come for all meals to the feeding centre every day.
ii. Dry rations are distributed to take home for preparation and consumption. Rations are usually distributed once a week.

100. In most situations dry take-home SFP programmes are preferable. The advantages of dry instead of wet rations for SFP include:

i. much easier to organize;
ii. fewer staff are needed;
iii. lower risk of transmission of communicable diseases;
iv. less time-consuming for the mother; and
v. the mother's responsibility for feeding the child is preserved.

The ration for dry feeding however has to be higher than for wet feeding in order to compensate for sharing and substitution. Wet rations are typically given in situations where insecurity prevents dry rations from being taken home safely or where access to cooking facilities are limited. See Table 4 below for some of the main considerations when organizing a selective feeding programme.

Table 4: Organization of selective feeding programmes

Organization of Selective Feeding Programmes			
	Supplementary Feeding Programme		Therapeutic Feeding Programm (facility-based)
Organization	• On site wet feeding • Some medical care On site feeding would usually only be considered for targeted SFP	• Take home dry feeding This is the preferred option for both blanket and targeted programmes	• On site wet feeding (only for those who are severely malnourished with medical complications) + • Intensive medical care + • Psychological stimulation during rehabilitation phase
Size of extra ration	• 500 - 700 kcal/ person/day, and • 15-25 g protein	• 1,000 - 1,200 kcal/person/day, and • 35-45 g protein	• 150 kcal/kg body-weight/day/patient. and • 3-4 g protein per kg body-weight/ day/patient
Frequency of meals	Minimum 2 meals/day	Ration distributed once per week	Frequent meals. Phase 1: 8-10 meals over a 24 hour period Rehabilitation phase: 4-6 meals Note: In addition, see guiding principles for community-based management of severe malnutrition in children[19]

Organizing a therapeutic feeding programme (TFP)

101. Therapeutic feeding programmes (TFP) are either implemented in specially organized feeding centers, hospitals, clinics or at community level. They involve medical and nutritional treatment as well as rehydration. The programme should be easily accessible to the population, near to or integrated into a health facility. The treatment should be carried out in phases (see Table 4), the length of which depend on the severity of malnutrition and/or medical complications. For complicated cases in an inpatient facility, at least during the first week of a TFP, care has to be provided on a 24-hour basis.

102. One of the main constraints to the implementation of a TFP is the lack of experienced or insufficient staff to manage the programme. Proper training of both medical and non-medical personnel is essential before starting the programme. The refugees, particularly the mothers of patients, must be involved in managing the TFP centres. Management of severe malnutrition for cases with no complications as mentioned above can be organized as outpatient and be treated in the community using RUTF. Inputs including RUTF supply, community mobilization, monitoring of progress indicators and follow-up are essentials for the success of the programme.

Planning the quantity of food needed for selective feeding

103. The amount of food needed for the selective feeding programme will depend on:

i. the type of selective programme;
ii. the type of commodities; and
iii. the expected/eligible number of beneficiaries.

104. This information should be based on precise demographic information and on the prevalence of malnutrition taken from the results of the nutritional survey. The

[19] *The guiding principles for community-based management of severe malnutrition in children were agreed in a consultation meeting (WHO, UNICEF, the UN Standing Committee on Nutrition (SCN) and other partners including UNHCR in November 2005: http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/CBSM/Meeting_report_CBSM.pdf.*

nutritionist will advise on the appropriate commodities and type of programme.

105. However, in some circumstances, estimates on the prevalence of malnutrition and expected number of beneficiaries may need to be made for planning purposes, when for example a registration and nutrition assessment have not yet been carried out. See Table 5 below for a projected demographic breakdown for a typical population.

106. If it is apparent that there is, or is likely to be, a major nutritional emergency, the following assumptions can be made for planning purposes:

i. 15 to 20% may suffer from moderate malnutrition.
ii. 2 to 3% may be severely malnourished.
iii. The breakdown of a typical population, by age, is as follows:

Table 5: Projected demographic breakdown

Projected breakdown by age	
Age groups	**% Total population**
0-4 or under 5	15-20%
Pregnant	1.5 - 3%
Lactating	3-5%

107. For example, to estimate the number of beneficiaries for a targeted SFP and TFP, both for children under 5 years old:

If the total population = 30,000

Estimated number under 5 years old = 4,500 – 6,000 (15-20%)

Estimated prevalence of moderate malnutrition (15%) gives 675-900 children

Estimated prevalence of severe malnutrition (2%) gives 90-120 children

With these numbers the estimated food requirements can be calculated by multiplying the estimated number of beneficiaries for each programme by the ration scale appropriate for each beneficiary, as follows:

Quantity of commodity required = ration / person / day X number of beneficiaries X number of days

Monitoring selective feeding programmes

108. The effectiveness of impact of the selective feeding programme should be monitored at regular intervals.

109. Selective feeding programmes should be monitored and evaluated to assess their performance in relation to the established objectives.[20] Monitoring and evaluation will involve the regular collection and analysis of:

- process indicators such as attendance, coverage and recovery rates, to evaluate the success in implementation and trends in the programme over time; and
- impact indicators such as malnutrition prevalence, mortality rate and numbers served, to evaluate the effectiveness and efficacy of the programme.

110. The effectiveness of selective feeding programmes can be measured through nutrition surveys and the regular collection of feeding centre statistics. Specific forms for monthly reporting on supplementary and therapeutic feeding programmes are attached as Annexes 4 and 5. A nutrition survey results form (weight-for-height) is also attached (Annex 7).

111. Trends in health and nutrition indicators can be related to many different factors.

Actions in other sectors such as water, shelter, or community services may help explain a positive outcome.

Criteria for closing programmes

112. Once the number of malnourished is significantly reduced, it may be more ef-

[20] *For further reference, consult Chapter 8: Evaluation of Feeding Programmes in the MSF Nutrition Guidelines.*

ficient to manage the remaining severely malnourished individuals through health facilities and through community-based programmes. The specific criteria for closing each selective feeding programme will depend on the degree of success in reducing the main aggravating factors mentioned in Figure 5 and on the degree of integration between these feeding programmes and mother and child health (MCH) activities and other support services offered by the refugee community.

113. After closing selective feeding programmes, any deterioration of the situation should be detected by nutrition surveys undertaken at regular intervals and review of morbidity and mortality data. This is especially important if the overall situation remains unstable.

Infant and young child feeding and use of milk products [21] [22]

- The protection, promotion and support of breastfeeding and appropriate complementary feeding are essential to the well-being of infants and young children.
- Inappropriate handling of milk products in situations of concern to UNHCR, can negatively impact on infant feeding practices and directly contribute to increased morbidity and mortality in infants and young children.
- UNHCR supports the policy of the World Health Organization (WHO) concerning safe and appropriate infant and young child feeding, in particular by protecting, promoting and supporting exclusive breastfeeding for the first six months of life and continued breastfeeding for 2 years or beyond, with timely and correct use of adequate complementary foods.
- The use of milk products in refugee settings must conform with the International Code of Marketing of Breast Milk Substitutes and the Operational Guidance on Infant and Young Child Feeding in Emergencies, as well as the revised UNHCR policy on the acceptance, distribution and use of milk products in refugee settings.[23]
- Breastfeeding and infant and young child feeding support should be integrated into other services for mothers, infants and young children.
- Foods suitable to meet the nutrient needs of older infants and young children must be included in the general ration for food aid dependent populations.
- Breast milk substitutes, other milk products, bottles or teats must never be included in a general ration distribution. These products must only be distributed according to recognised strict criteria and only provided to mothers or caregivers for those infants who need them.
- UNHCR will actively discourage the inappropriate distribution and use of breast milk substitutes (BMS) in refugee settings. UNHCR will uphold and promote the provisions of the *International Code of Marketing of Breast milk Substitutes and subsequent relevant WHA resolutions*.
- For infants requiring infant formula in emergencies, generic (unbranded) formula is recommended as first choice, after approval by a senior staff member and the coordinating body.

[21] *Infant and Young Child Feeding in Emergencies, Operational Guidance for Emergency Relief Staff and Programme Managers, Inter-Agency Working Group on Infant and Young Child Feeding in Emergencies/Infant Feeding in Emergencies Core Group , version 2.0.*

[22] *Policy of the UNHCR related to the Acceptance, Distribution, and use of Milk Products in Refugee Settings, Revised Edition, 2006.*

[23] *Other relevant publications are: WHO Guiding Principles for Feeding Infants and Young Children in Emergencies, relevant World Health Assembly (WHA) resolutions and the Sphere Project.*

- In refugee settings and in accordance with UNHCR policy as well as operational guidance, UNHCR will source infant formula after review and approval by its HQ technical units.
- Breastfeeding and infant and young child feeding support should be integrated into other services for mothers, infants and young children.
- Foods suitable to meet the nutrient needs of older infants and young children must be included in the general ration for food aid dependent populations.

114. Human milk is the best and safest for infants and children under two years old. Breastfeeding provides a secure and hygienic source of food, initially the only source of food, as well as antibodies giving protection against some infectious diseases. Mothers may need to receive extra food to encourage breastfeeding and provide the additional calories and nutrients required. This should be done through the feeding programmes.

Careful attention to infant feeding and support for good practice can save lives. Preserving breastfeeding, in particular, is important not just for the duration of any emergency, but may have lifelong impacts on child health and on women's future feeding decisions. Every group of people has customs and traditions about feeding infants and young children. It is important to understand these and work with them sensitively while promoting best practice.

115. The problems associated with infant formulae, milk products and feeding bottles are exacerbated in a refugee emergency. Clean boiled water is essential but rarely available, careful dilution of the feeds is of critical importance but difficult to control; mothers are unlikely to be familiar with the use of infant formulae, and the instructions are often in a foreign language. Infant formulae, if unavoidable, should be distributed from health or feeding centres under strictly controlled conditions and proper supervision. Infant feeding bottles must never be distributed or used; they are almost impossible to sterilize and keep sterile under emergency conditions and are therefore dangerous. Babies should be fed by clean cup and spoon if necessary.

Key definitions

Infant and young child feeding: key definitions

Infant: a child aged less than 12 months.

Young child: a child aged 12-<24 months (12-23 completed months). *This age group is equivalent to the definition of toddler (12-23 months) as defined in the World Health Report 2005, p.155 (http://www.who.int/whr/2005/en/).*

Optimal infant and young child feeding: early initiation (within one hour of birth) of exclusive breastfeeding, exclusive breastfeeding for the first six months of life, followed by nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years old or beyond.

Exclusive breastfeeding: an infant receives only breast milk and no other liquids or solids, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

Complementary feeding (previously called 'weaning' and more accurately referred to as '**timely complementary feeding**'): the child receives age-appropriate, adequate and safe solid or semi-solid food in addition to breast milk or a breast milk substitute.

Replacement feeding: Feeding infants who are receiving no breast milk with a diet that provides the nutrients infants need until the age at which they can be fully fed on family foods. During the first six months, replacement feeding should

be with a suitable breast milk substitute. After six months the suitable breast milk substitute should be complemented with other foods.

Note: This terminology is used in the context of HIV/AIDS and infant feeding. The current UN recommendation states that "when replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended during the first months of life." If these criteria are not met, exclusive breastfeeding should be initiated, and breastfeeding should be discontinued as soon as it is feasible ('early cessation'), taking into account local circumstances, the individual woman's situation and the risks of replacement feeding (including infections other than HIV, and malnutrition).

International Code: The International Code of Marketing of Breast Milk Substitutes, adopted by the World Health Assembly (WHA) in 1981, and subsequent relevant WHA resolutions, referred to here as 'the International Code' *(4)*. The *aim* of the International Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast milk substitutes when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. The Code sets out the *responsibilities* of the manufacturers and distributors of breast milk substitutes, health workers, national governments and concerned organizations in relation to the marketing of breast milk substitutes, bottles and teats.

Supplies: In the context of the International Code, supplies means quantities of a product provided for use over an extended period, *free or at a low price,* for social purposes, including those provided to families in need. In the emergency context, the term supplies is used generally to describe quantities of a product irrespective of whether they have been purchased, subsidized or obtained free of charge.

Breast milk substitute (BMS): any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose.

Note: In practical terms, foods may be considered BMS depending on how they are marketed or represented. These include infant formula, other milk products, therapeutic milk, and bottle-fed complementary foods marketed for children of up to 2 years old and complementary foods, juices, teas marketed for infantsof under 6 months old.

Infant formula: a breast milk substitute formulated industrially in accordance with applicable Codex *Alimentarius* standards [developed by the joint Food and Agriculture Organization (FAO) / World Health Organization (WHO) Food Standards Programme]. *Commercial* infant formula is infant formula manufactured for sale, branded by a manufacturer and may be available for purchase in local markets. *Generic* infant formula is unbranded and is not available on the open market, thus requiring a separate supply chain.

Follow-on/follow-up formula: These are specifically formulated milk products defined as "a food intended for use as a liquid part of the weaning diet for the infant from the sixth month on and for young children" (Codex Alimentarius Standard 156-19871). Providing infants with a follow-on/follow-up formula is not necessary (See WHA Resolution 39.28, 1986, para 3 [2]). In practice, follow-on formula may be considered a BMS depending on how they are marketed or represented for infants and children of under 2 years old and fall under the remit of the International Code.

Note: Acceptable milk sources include expressed breast milk (heat-treated if the mother is HIV-positive), full-cream

animal milk (cow, goat, buffalo, sheep, camel), Ultra High Temperature (UHT) milk, reconstituted evaporated (but not condensed) milk, and fermented milk or yoghurt. (See ref (9)).

Home-modified animal milk: a breast milk substitute for infants up to six months old prepared at home from fresh or processed animal milk, suitably diluted with water and with the addition of sugar and micronutrients.

Note: Acceptable milk sources include full-cream animal milk (liquid or powdered), Ultra High Temperature (UHT) milk, or reconstituted evaporated (but not condensed) milk. These milks must be adapted/modified according to specific recipes, and micronutrients should also be given (22b). It is difficult to obtain nutritional adequacy with such milks, even with added micronutrients. ***Thus, home-modified animal milks should only be used as a last resort to feed infants when there is no alternative.***

Infant complementary food: any food, whether industrially produced or locally prepared, used as a complement to breast milk or to a breast milk substitute and that should be introduced after six months of age.

Note: The term 'infant complementary food' is used in the Operations Guidance to distinguish between complementary food referred to in the context of infant and young child complementary feeding, and complementary food used in the context of Food Aid (i.e. foods, beyond the basic food aid commodities, given to an affected population to diversify their dietary intake and complement the ration, e.g. fresh fruit and vegetables, condiments or spices. Infant complementary foods should not be marketed for infants under six (completed) months old. Supplementary foods are commodities intended to supplement a general ration and used in emergency feeding programmes for the prevention and reduction of malnutrition and mortality in vulnerable groups.

Commercial baby foods (industrially produced infant complementary foods)**:** branded jars, packets of semi-solid or solid foods.

Milk products: dried whole, semi-skimmed or skimmed milk; liquid whole, semi-skimmed or skimmed milk, soya milk, evaporated or condensed milk, fermented milk or yogurt.

Ready-to-use therapeutic food (RUTF): RUTF are specialized products for use in the management of severe malnutrition, typically in community and home based settings. They may be locally produced or manufactured at national or international level.

Note: Infants do not have the reflex to swallow solid foods before 6 months old and should never be given RUTF before that age. Also, marketing or otherwise representing RUTF as a partial or total replacement for breast milk in infants under six months old would mean they would fulfil the definition of a breast milk substitute and come under the remit of the International Code.

Therapeutic milk: Term commonly used to describe formula diets for severely malnourished children, e.g. F75 and F100. Strictly speaking, these are not milks – F100 comprises only 42% milk product, and F75 less so. Therapeutic milk may be pre-formulated or prepared from dried skimmed milk (DSM), with the addition of a vitamins and minerals complex.

Note: Therapeutic milks should not be used to feed infants and young children who are not malnourished. The standard dilution of F100 has too a high a solute load for infants under six months old. Therapeutic milks contain no iron and long term use will lead to iron deficiency anaemia.

Infant feeding equipment: bottles, teats, syringes and baby cups with or without lids and/or spouts.

World Health Assembly (WHA) resolutions: see definition for International Code.

HIV and infant feeding

- Emphasize primary prevention of HIV/AIDS through such means as provision of condoms.
- Where the HIV status of the mother is unknown or she is known to be HIV negative, she should be supported to exclusively breastfeed. Exclusive breastfeeding is recommended for HIV-infected women for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) for them and their infants before that time. When replacement feeding is acceptable, feasible, affordable, sustainable and safe avoidance of all breastfeeding by HIV-infected women is recommended.
- Where a mother is HIV positive, UNHCR will support **replacement feeding** (see key definitions).

In all circumstances, because of the existing research and experience gaps, consult relevant senior staff for up-to-date advice.[24]

Protect, promote and support optimal infant and young child feeding with integrated multi-sectoral interventions

Basic interventions

116. Ensure that the nutritional needs of the general population are met, paying special attention to access to commodities suitable as infant complementary foods for young children. In situations where nutritional needs are not met, advocate for a general ration, appropriate in quantity and quality. In situations where supplementary foods are available but sufficient food for the general population is not available, consider pregnant and lactating women as a target group.

117. Complementary feeding for older infants (over six months old) and young children (12-<24 months old) in emergencies may comprise:

i. basic food-aid commodities from general ration with supplements of inexpensive locally available foods;
ii. micronutrient fortified blended foods, e.g. corn soya blend, wheat soya blend, (as part of general ration, blanket or supplementary feeding); and
iii. additional nutrient-rich foods in supplementary feeding programmes.

118. In all situations, special attention should be given to the nutritional value of the food ration distributed to infants and young children, whose particular nutritional requirements are often not covered by the general ration. Nutrient dense foods for children, whether fortified or non-fortified, should be chosen, taking into account possible micronutrient deficiencies.

119. Where a population is dependent on food aid, a micronutrient fortified food should also be included in the general ration for older infants and young children. Ready-to-Use Therapeutic Food (RUTF) are formulated for the management of malnutrition and are not an appropriate infant complementary food (see key definitions above).

120. Before distributing an industrially produced infant food during an emergency, the cost compared to local foods of similar nutritional value and the risk of undermining traditional complementary feeding practices should be considered. As a rule, expensive industrially produced commercial baby foods have no place in an emergency relief response.

[24] *For most up-to-date scientific evidence, refer to http://www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm*

121. Establish registration of new-borns within two weeks of delivery to ensure timely access to additional household ration entitlement.

122. Ensure rest areas in transit and establish, where culturally appropriate, secluded areas for breastfeeding. Screen new arrivals to identify and refer any mothers or infants with severe feeding problems and refer for immediate assistance.

Train health/nutrition/community workers to promote, protect and support optimal infant and young child feeding as soon as possible after emergency onset. Knowledge and skills should support mothers/caregivers to maintain, enhance or re-establish breastfeeding.

123. Ensure easy and secure access for caregivers to water and sanitation facilities, food and non-food items.

Targeting and use, procurement, management, and distribution of breast milk substitutes (BMS), milk products, bottles and teats should be strictly controlled, based on technical advice, and comply with the International Code and all relevant World Health Assembly Resolutions.

UNHCR's policy related to the acceptance, distribution and use of milk products:

1. UNHCR will not accept *unsolicited* donations of breast milk substitutes, bottles and teats and commercial 'baby' foods (see definitions). UNHCR will work with the coordinating agency to limit the risks of unsolicited donations that end up in circulation in refugee settings.
2. UNHCR will only accept *solicited* donations or source infant formula when based on infant feeding needs assessment by trained personnel using established and agreed criteria, where key conditions are met (see sections 5.5-5.8) of the UNHCR policy, in consultation with the designated coordinating body, UNICEF and WHO, and after review and approval by UNHCR HQ technical units.
3. UNHCR will discourage the distribution and use of infant-feeding bottles and artificial teats in refugee settings. In any instance where an infant or young child is not breastfed, cup feeding is encouraged.
4. UNHCR will only accept, supply and distribute pre-formulated therapeutic milk products (see definitions) or dried skimmed milk (DSM) to prepare therapeutic milk for treatment of acute severe malnutrition, or combined mineral and vitamin mix (CMV) in accordance with the WHO guidelines, and in line with Memorandum of Understanding (MOU) with the World Food Programme (WFP), in consultation with the coordinating body, with UNICEF and WHO, and after review and approval by UNHCR HQ technical units.

Guidelines for the safe use of milk products

Dried milk powder

124. Milk powder, both dried skimmed milk (DSM) and dried whole milk (DWM), may be used in reconstituted form **only** where it can be mixed carefully with other foods[25] and hygienically in a supervised environment for on-the-spot consumption, e.g. as a therapeutic milk in a therapeutic feeding programme. On-the-spot feeding programmes, e.g. supplementary wet feeding programmes, should be conducted in enclosed areas under supervision, where the carrying away of reconstituted milk can be prevented. Unreconstituted DSM should be mixed with other foods to make it suitable for feeding older infants.

[25] *DSM, if not mixed with other foods, has a very high solute load and is not suitable for infant feeding.*

125. DSM should always be mixed with oil in order to supply sufficient energy. Both DSM and DWM should be prepared with sugar to increase their energy content.

UHT liquid milk

126. UHT liquid milk should not be included in general distributions in refugee settings.

Breast milk substitutes (BMS)[26]

127. UNHCR will only handle BMS in refugee settings when based on infant feeding needs assessment by trained personnel using established and agreed criteria, where distribution can be targeted, where the supply chain is secure, where conditions for safe preparation and use can be met, and in strict accordance with the International Code, in consultation with UNICEF and WHO, and after review and approval by UNHCR HQ technical units.

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Acceptance, distribution and use of milk products in feeding programmes in refugee settings, UNHCR,1989 (Currently under revision,contact: HQTS01@unhcr.org).

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[26] *When indicated, an appropriate BMS must be regularly supplied until each infant is six months old or has established re-lactation, together with clear instructions in the local language for safe mixing and for feeding with a cup and a spoon, and conditions established for safe preparation and use.*

Glossary

Anthropometry	The technique that deals with measurements of the size, weight, and proportions of the human body.
Baseline data	Data collected at the beginning of a programme that can be compared with similar data collected later and so used to evaluate the impact of interventions or to monitor trends.
Body mass index (BMI)	Anthropometric measure defines weight in kilograms divided by height in meters squared. (weight in kg)/ (height in m).^{2} It is used for assessing the nutritional status of adolescents and adults.
Fortified blended food	A flour composed of pre-cooked cereals and a protein source, mostly legumes, fortified with vitamins and minerals, e.g. corn soya blend (CSB), wheat soya blend (WSB) used for general and selective feeding programmes.
Fortification	Adding micronutrients to foods, e.g. iodized salt and fortified blended food.
Kilocalorie	Unit of energy used in nutrition, 1 Kcal = 4.17 kilojoules.
Kwashiorkor	Severe form of malnutrition characterized by oedema (swelling) particularly of the lower parts of the arms and legs.
Marasmus	Severe form of malnutrition in which the person becomes wasted.
Micronutrients	Minerals and vitamins.
Mid-upper arm circumference (MUAC)	Circumference at the mid-point of the left upper arm, which is an indicator of malnutrition and used as a tool for screening.
Nutrients	Those parts of food that are absorbed and/or used by the body i.e. carbohydrate, protein, fat, alcohol, vitamins and minerals.
Oedema	An abnormal accumulation of fluid in intercellular spaces of the body. In case of nutritional oedema this is oedema due to a deficiency in the diet.
On-site feeding	Cooked meal eaten at the feeding centre.
Ready-to-use therapeutic foods (RUTF)	RUTFs are specialised products for use in the management of severe malnutrition, typically in community and home based settings. They may be locally produced or manufactured at national or international level.
Therapeutic milk	Specialized milk products indicated for use in the management of severe malnutrition e.g. F75, F100. Therapeutic milk may be pre-formulated or prepared from dried skimmed milk (DSM), with the addition of a vitamins and minerals complex.
Stunting	Low height for age. Comparing the height of a child of a certain age with the height of reference (healthy) children of the same age indicates the level of chronic malnutrition.
Take-home rations	Dry rations that are given to people to take and prepare at home.
Therapeutic milk	Special milk used for rehabilitation of severely malnourished persons.
Wasting	Abnormal loss of fat and/or muscle tissue which is indicated by a low weight for height, a low body mass index or observation (thinness).
Xerophthalmia	Clinical signs in the eye caused by vitamin A deficiency.
Weight-for-height	The weight of a person at a certain height compared with the reference weight for that height.
Z-score	Z-score is statistical term. It indicates the deviation of an individual's values from the mean value of a reference population taking into consideration the standard deviation of the reference distribution. Z-score is used in analysing continuous variables such as heights and weights of a sample in a nutrition survey
Wasting (acute malnutrition)	Percentage of children under the age of five suffering from moderate or severe wasting (below -2SD from the medina weight for height of reference population.
Stunting (chronic malnutrition)	Growth failure in a child that occurs over a slow cumulative process. Stunting can occur even before birth and it is not possible to reverse it later. Stunted children are short for their age. It is measured by the height for age index

Annex 1 – Basic facts about food and nutrition

All foods are made up of five basic types of nutrient in addition to variable amounts of water.

Carbohydrates, the main source of energy, provide 4 kcal/g. They are mostly starches and sugars of vegetable origin, and are a major component of cereals and tubers.

Fats and oils provide the most concentrated source of energy, and have more than twice the energy content per weight of carbohydrates and proteins (9/kcal/g).

Proteins are body-building substances required for growth and tissue repair. Protein is found in foods of animal origin and in cereals and legumes and provide 4 kcal/g.

Vitamins and minerals are needed in small quantities for the adequate functioning of the body and protection against disease. Fresh vegetables and fruits are a good source of vitamins. Water soluble vitamins are fragile and cannot be stored (Vitamins Bs and C), whereas fat soluble vitamins can be stored in the body (Vitamin A and D). Important minerals are iron, sodium, iodine, zinc, magnesium, potassium, etc. Individual vitamins and minerals or combinations are found in all foods in very variable amounts.

Energy and protein intakes

If the energy intake is inadequate, some protein will be burnt to provide energy. That is, it will be used in the same ways as carbohydrate or fat. More than 20% of the energy requirement should be supplied from fats and oils which greatly enhance the palatability of the diet and increase energy density (important for younger children). Energy requirements vary widely even in normal individuals. They are also increased by physical activity. Much higher energy and protein intakes are required for the treatment of malnutrition, when the aim is rehabilitation rather than maintenance.

Food and Diets

Most diets in most countries contain adequate amounts of all the nutrients required for good health if enough of the diet is taken to satisfy the individual's energy requirements. Even a growing child, if healthy, requires no more than 10% of total calories to be supplied from protein sources.

Annex 1 (cont.) – Prices , nutritional value and unit cost of World Food Programme (WFP)-supplied commodities (for project costing and general planning) March 2006

	Nutritional value				Cost per unit (US cents)	
	FOB Price (US$/MT)	ENERGY (Kcal)	PROTEIN (g)	FAT (g)	ENERGY (1000 Kc)	PROTEIN (100 g)
CEREALS						
Wheat	160	330	12.3	1.5	4.8	13.0
Rice	245	360	7.0	0.5	6.8	35.0
Sorghum/Millet	120	335	11.0	3.0	3.6	10.9
Maize	150	350	10.0	4.0	4.3	15.0
Cereals, General (EMOPs)	180					
PROCESSED CEREALS						
Maize meal	220	360	9.0	3.5	6.1	24.4
Wheat flour	250	350	11.5	1.5	7.1	21.7
Bulgur wheat	260	350	11.0	1.5	7.4	23.6
BLENDED FOODS						
Corn soya blend	300	380	18.0	6.0	7.9	16.7
Wheat soya blend	320	370	20.0	6.0	8.6	16.0
Soya-fortified maize meal	220	390	13.0	1.5	5.6	16.9
MILK AND CHEESE						
Dried skim milk (enriched)	2,500	360	36.0	1.0	69.4	69.4
Dried skim milk (plain)	2,100	360	36.0	1.0	58.3	58.3
Dried whole milk	2,600	500	25.0	27.0	52.0	104.0
MEAT & FISH						
Canned meat	2,500	220	21.0	15.0	113.6	119.0
Canned fish	1,550	305	22.0	24.0	50.8	70.5
OILS & FATS						
Vegetable oil	900	885	0	100	10.2	0.0
Edible fat	740	900	0	100	8.2	0.0
PULSES						
Beans	475	335	20.0	1.2	14.2	0.0
Peas	310	335	22.0	1.4	9.3	0.0
Lentils	430	340	20.0	0.6	12.6	0.0
MISCELLANEOUS						
Sugar	300	400	0.0	0	7.5	0.0
Iodized salt	80	0	0.0	0	0.0	0.0
High energy biscuits	875	450	12.0	15	19.4	0.0

Note: The prices quoted are free-on-board (FOB) and therefore do not include transportation costs. The prices shown are as of 2006 and will vary over time. This information is regularly updated and published by WFP and is available from WFP HQ's or from their offices in the field.

Annex 1 (cont.) – Micronutrient content of selected food-aid commodities

	Micronutrients per 100 g edible portion							
	Calcium (mg)	**Iron** (mg)	**Vitamin A** (µg)	**Thiamine B1** (mg)	**Riboflavin B2** (mg)	**Niacin B3** (mg)	**Folate** (µg)	**Vitamin C** (mg)
Cereals								
Wheat	36	4	0	0.3	0.07	5.0	51	0
Rice (parboiled)	7	1.2	0	0.2	0.08	2.6	11	0
Sorghum	26	4.5	0	0.34	0.15	3.3	U	0
Maize whole yellow	13	4.9	0	0.32	0.12	1.7	U	0
Wheat flour	15	1.5	0	0.10	0.03	0.7	22	0
Processed Cereals								
Maize flour	10	2.5	0	0.3	0.10	1.8	U	0
Wheat flour*	29	3.7	0	0.28	0.14	4.5	U	0
Bulgur wheat	23	7.8	0	0.30	0.10	5.5	38	0
Blended Foods								
Corn-soya blend (CSB)	513	18.5	500	0.65	0.5	6.8	U	40
Wheat-soya blend (WSB)	750	20.8	498	1.50	0.6	9.1	U	40
Soya-fortified bulgur wheat	54	4.7	0	0.25	0.13	4.2	74	0
Soya-fortified maize meal	178	4.8	228	0.70	0.3	3.1	U	0
Soya-fortified wheat flour	211	4.8	265	0.66	0.36	4.6	U	0
Soya-fortified sorghum grits	40	2.0	-	0.2	0.10	1.7	50	0
Dairy Products								
Dried skim milk (DSM)	1257	1.0	1,500	0.42	1.55	1.0	50	0
Dried whole milk (DWM)	912	0.5	280	0.28	1.21	0.6	37	0
Canned cheese	630	0.2	120	0.03	0.45	0.2	U	0
Meat & Fish								
Canned meat	14	4.1	0	0.20	0.23	3.2	2	0
Dried salted fish	343	2.8	0	0.07	0.11	8.6	U	0
Canned fish	330	2.7	0	0.40	0.30	6.5	16	0
Oil & Fats								
Vegetable oil	0	0	0	0	0	0	0	0
Butter oil	0	0	0	0	0	0	0	0
Pulses								
Bean (kidney-dry)	143	8.2	0	0.5	0.22	2.1	180	0
Peas	130	5.2	0	0.6	0.19	3.0	100	0
Lentils	51	9.0	0	0.5	0.25	2.6	U	0
Miscellaneous								
Sugar	0	0	0	0	0	0	0	0
Dates	32	1.2	0	0.09	0.10	2.2	13	0

U: unknown
**: medium extraction*
Reference: Adapted from Food and Nutrition in the Management of Group Feeding (Revision 1) FAO, Rome 1993 (Annex 1, p. 149-54).

Annex 2 - Characteristics of common foods

	Food type	Vitamins and minerals	Comments
1.	Cereal grains (rice, corn, sorghum, oats, etc.)	Contain vitamin B and iron. However these are reduced by milling, i.e. the whiter the flour the greater the loss of vitamins.	The main source of both energy and protein in most diets.
2.	Legumes / oilseeds (beans, peas, soya, groundnuts, etc.)	B complex vitamins. Most contain significant quantities of iron and calcium.	Legumes are particularly useful when eaten with cereals as the proteins complement each other
3.	Whole tubers and roots (yams, taro, cassava, sweet potato, potato, etc.)	Variable but generally low, except for potatoes which are rich in vitamin C.	Bulk and low protein content makes them unsuitable as staple foods in emergencies.
4.	Vegetables and fruits	Important source of vitamins and minerals. Variable quantities of B and C vitamins. Dark green leaves or yellow/red pigmentation usually indicates vitamin A compounds.	
5.	Meat, milk and dairy products, eggs, etc	Good sources of B vitamins. Whole milk and eggs also good source of vitamin A. Milk and eggs provide significant amounts of calcium.	Usually consumed in very small quantities in normal times. They are more readily used by the body than proteins of vegetable origin. Therefore small quantities useful to improve the quality and palatability of diet.
6.	Fish, dried	Rich source of calcium and iron. Contains B vitamins.	A concentrated source of protein for those who like it. Therefore acceptability trials essential before use.
7.	Fats and oils	Fats derived from milk are sources of vitamin A and D, while vegetable fats contain no vitamin A and D, except for red palm-oil.	Useful way to increase energy intake without increasing bulk of diet. Improves palatability and helps in food preparation.

Examples of adequate full rations in terms of energy, protein and fat for populations entirely reliant on food assistance

Source: *Food and nutrition needs in emergencies, UNHCR, UNICEF, WFP, WHO, 2003*

ITEMS	**RATIONS (quantity in g)**				
	Example 1	**Example 2**	**Example 3**	**Example 4**	**Example 5**
Cereal	400	450	350	400	400
Pulses*	60	60	100	60	50
Oil (vit. A fortified)	25	25	25	30	30
Fish/meat	-	10	-	30	-
Fortified blended foods	50	40	50	40	45
Sugar	15	-	20	-	25
Iodized salt	5	5	5	5	5
Energy: kcal	**2,113**	**2,075**	**2,113**	**2,146**	**2,100**
Protein (in g and in % kcal)	58 g; 11%	71 g; 13%	65 g; 12%	55 g; 10%	65 g; 12%
Fat (in g and in % kcal)	43 g; 18%	43 g; 18%	42 g; 18%	42 g; 17%	39 g; 17%

Five types of rations are shown to illustrate differences due to factors such as the food habits of the population, the acceptability and availability of the commodities in the region.

Reference: Food & Nutrition Needs in Emergencies (UNHCR, UNICEF, WFP and WHO, 2002)

Annex 3 – Main nutritional deficiency disorders in emergencies[15]

Protein-energy malnutrition (PEM) is likely to be the most important health problem and a leading cause of death during an emergency. There are several forms:

Marasmus is marked by the severe wasting of fat and muscle, which the body has broken down for energy, leaving "skin and bones". It is the most common form of PEM in nutritional emergencies.

Kwashiorkor is characterized essentially by oedema (swelling which usually starts in the feet and legs), sometimes accompanied by a characteristic skin rash and/or changes in hair colour (reddish). The hair becomes sparse.

In ***Marasmic kwashiorkor*** there is a combination of severe wasting and oedema. Children under 5 years old are usually the most affected, but older children and adults are also often at risk or affected. The treatment of severe forms of acute malnutrition is presented in the section on selective feeding programmes.

Vitamin and mineral deficiencies can cause long-lasting or permanent disabilities and can be fatal. The deficiencies most likely to occur include:

Iron *deficiency* (1) causes ***anaemia***. (signs: pallor of skin and eyelids, fatigue, weakness and shortness of breath); (2) increases the risk of haemorrhage, infection and death associated with childbirth; (3) increases rates of low-birth-weight and (4) impairs the cognitive development of infants and children.

Iron Deficiency Anaemia

Pale mucous membranes in the eye and the tongue are signs of anaemia. You may see these signs in males and females of all ages.

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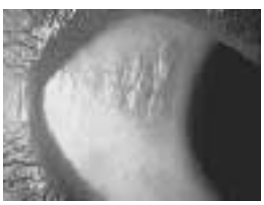
Iodine *deficiency* causes not only ***goitre*** but also some impairment of intellectual development in children and of reproductive performance in women (see illustrations below). Severe maternal deficiency can cause cretinism in the offspring. Best prevented in emergencies by the use of iodized salt.

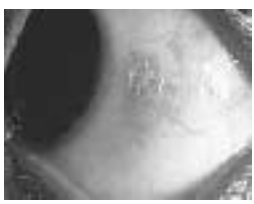
Photo taken by Internal Displacement Division (IDD)

[15] *Adapted from: The management of nutrition in major emergencies. WHO, Geneva 2000.*

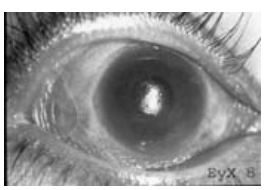
Vitamin A *deficiency* causes ***xerophthalmia***, blindness and death (see illustrations below). Eye signs: poor vision in dim light, dryness of conjunctiva or cornea, foamy material on the conjunctiva or clouding of the cornea itself. These signs may appear after several months of an inadequate diet, or following acute or prolonged infections, particularly measles and diarrhoea.

Vitamin A Deficiency Xeropthalmia





Bitots spots *X1B(are foamy white areas on the white of the eye. Be careful not to confuse them with other types of eye problems. These signs will most often be seen in children.



Corneal Xerosis (X2)

Keratomalacia (X3)

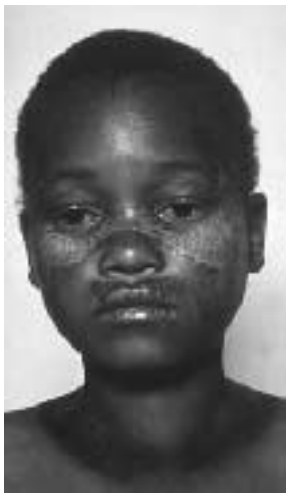
ICH/UNHCR MNDD Slide 20

Vitamin B1 (thiamine) deficiency causes ***beri-beri***. Symptoms and signs: loss of appetite, malaise and severe weakness, especially in the legs; may also lead to paralysis of the limbs or swelling of the body, heart failure and sudden death. Beri-beri occurs when the diet consists almost exclusively of white polished rice or starchy staple such as cassava.

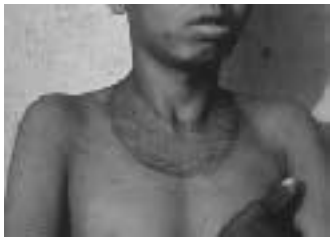
Vitamin C *deficiency* causes ***scurvy***. Signs: swollen gums which bleed easily, swollen painful joints, easy bruising. This occurs due to a lack of fresh vegetables and fruits.

Niacin *deficiency* causes ***pellagra***. Signs: skin rash on parts of body exposed to sunlight; diarrhoea; and mental changes leading to dementia. This occurs especially where maize and sorghum are the staples and there is a lack of other foods.

Niacin Deficiency – Pellagra



Butterfly sign



Casal's collar

A rash (dermatitis) which is on both sides of the body, and on skin normally exposed to sunlight is a sign of pellagra.

Check the face, neck, hands, arms and legs.

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Prevention involves ensuring that people receive or have access to a variety of foods that contain sufficient quantities of essential vitamins and minerals. This also includes fortified food items distributed in food aid, access to local markets, and produce from home gardens.

Treatment consists of administering therapeutic doses of the missing nutrients. The distribution of multi-vitamin tablets to the entire refugee population is a waste of time and money, since they contain insufficient quantities of individual vitamins to correct deficiencies.

Annex 4 – Reporting form: supplementary feeding programme

Country:
Location:
Agency:

Period:

Total population:
Under (<) 5 population
Moderate malnutrition rate:
Target <5 (moderate malnutrition rate *<5 pop):
Theoretical coverage <5 (new total (J)/Target):

CATEGORIES							
	< 5 years		≥ 5 years		Pregnant women	Lactating women	TOTAL
	M	F	M	F			
Total at end of last month (A)							
New admissions: < 80% WFH or < -2 Z-score Others							
Total new admissions (B)							
Re-admissions (C)							
Total admissions (D=B+C)							
Discharged in this period: Discharges (E) Deaths (F) Defaulters (G) Referrals (H)							
Total discharged (I=E+F+G+H)							
New total at end of this month (J=A+D-I)							

Average length of stay in the programme

(from all or a sample of 30 recovered children) (target <60 days) =

$$\frac{\text{Total number of days of admission of all (or 30) recovered children}}{\text{No of recovered children (or 30)}}$$

Comments:

Annex 5 – Reporting form: therapeutic feeding programme

Country:
Location:
Agency:

Period:

Total population:
Under (<) 5 population
Moderate malnutrition rate:
Target <5 (moderate malnutrition rate *<5 pop):
Theoretical coverage <5 (new total (J)/Target):

Total at end of last month (A)	< 5 years		≥ 5 years		Adults		TOTAL
New admissions: < 70% WFH or < -3 Z-score Kwashiorkor Others	M	F	M	F	M	F	
Total new Admissions (B)							
Re-admissions (C)							
Total admissions (D=B+C)							
Discharged this month: Discharged (E) Deaths (F) Defaulters (G) Referrals (H)							
Total discharged (I=E+F+G+H)							
New total at end of this month (J=A+D-I)							

Causes of death:

Average weight gain during last month (from all or a sample of 30 children) (target: >8 g/kg/day) =

$$\frac{\text{weight at end of month (or on exit)} - \text{lowest weight recorded during month}}{\text{lowest weight recorded in last month} \times \text{number of days between lowest weight recorded and end of month (or on exit)}}$$

Average weight gain for ***marsmus*** (include only children in phase II) =

Average weight gain for ***kwashiorkor*** (include only children in phase II after complete loss of oedema) =

Average length of stay in the programme (from all or a sample of 30 recovered children) (target <30 days) =

$$\frac{\text{Total number of days of admission of all (or 30) recovered children}}{\text{Number of recovered children (or 30)}}$$

Annex 6 – Example of anthropometric nutrition survey format (source: Emergency Nutrition Assessment, Save the Children, 2004).

Distribution of age and sex of sample

	Boys no.	%	Girls no.	%	Total no.	%	Ratio boy:girl
6–17 months							
18–29 months							
30–41 months							
42–53 months							
54–59 months							
Total							

Prevalence of acute malnutrition by age based on weight-for-height z-scores and/or oedema

		Severe wasting (< –3 z-score)		Moderate wasting (>= –3 and < –2 z-score)		Normal (> = –2 z-score)		Oedema	
Age (mths)	Total no.	No.	%	No.	%	No.	%	No.	%
6–17									
18–29									
30–41									
42–53									
54–59									
Total									

Prevalence of acute malnutrition by sex based on weight-for-height z-scores and/or oedema

	Boys n =	Girls n =
Prevalence of global malnutrition (< –2 z-score and/or oedema)	XX % (95% CI XX–XX)	XX % (95% CI XX–XX)
Prevalence of moderate malnutrition (< –2 z-score and >= –3 z-score)	XX % (95% CI XX–XX)	XX % (95% CI XX–XX)
Prevalence of severe malnutrition (< –3 z-score and/or oedema)	XX % (95% CI XX–XX)	XX % (95% CI XX–XX)

The prevalence of oedema is XX%

Prevalence of acute malnutrition based on the percentage of the median and/or oedema

	6–59 months **n =**
Prevalence of global acute malnutrition **(<80% and/or oedema)**	XX % (95% CI XX–XX)
Prevalence of moderate acute malnutrition **(<80% and >= 70%)**	XX % (95% CI XX–XX)
Prevalence of severe acute malnutrition **(<70% and/or oedema)**	XX % (95% CI XX–XX)

The prevalence of oedema is XX%

Prevalence of malnutrition by age, based on weight-for-height percentage of the median and/or oedema

		Severe wasting (<70% median)		**Moderate wasting (>= 70% and <80% median)**		**Normal (> = 80% median)**		**Oedema**	
Age (mths)	**Total no.**	**No.**	%	**No.**	%	**No.**	%	**No.**	%
6–17									
18–29									
30–41									
42–53									
54–59									
Total									

Annex 7: Rapid assessment: measuring malnutrition

There are 3 major clinical forms of severe protein energy malnutrition - marasmus, kwashiorkor and marasmic kwashiorkor. There are various clinical signs useful for diagnosis, but most obviously a marasmic child is extremely emaciated and a child with kwashiorkor has bilateral oedema. However, clinical assessment is not practical for managing nutritional programmes and monitoring and comparing large-scale food crises. Most standardized indicators of malnutrition in children are based on measurements of the body to see if growth has been adequate.

- Height for age (H/A), is an indicator of chronic malnutrition. A child exposed to inadequate nutrition for a long period of time will have a reduced growth rate - and therefore a lower height compared to other children of the same age (stunting).
- Weight for age (W/A), is a composite indicator of both long-term malnutrition (deficit in height/"stunting") and current malnutrition (deficit in weight/ "wasting").
- Weight for height (W/H), is an indicator of acute malnutrition that tells us if a child is too thin for a given height (wasting).

For all 3 indicators (W/H, W/A, H/A), we compare individual measurements to international reference values for a healthy population (NCHS/WHO/CDC reference values).

In emergencies, W/H is the best indicator as:

- it reflects the present situation;
- it is sensitive to rapid changes (problems and recovery);
- it is a good predictor of immediate mortality risk; and
- it can be used to monitor the evolution of the nutritional status of the population.

Bilateral oedema is an indicator of kwashiorkor. All children with oedema are regarded as being severely acutely malnourished, irrespective of their W/H. Therefore, it is essential to assess W/H and the presence of bilateral oedema to define acute malnutrition.

Middle upper arm circumference (MUAC), is another anthropometric indicator. MUAC is simple, fast and is a good predictor of immediate risk of death, and can be used to measure acute malnutrition from 6-59 months (although it overestimates rates in the 6-12 month age groups).

However, the risk of measurement error is very high, therefore MUAC is only used for quick screening and rapid assessments of the nutritional situation of the population to determine the need for a proper W/H random survey.

Adapted from:
UNHCR/UNICEF/WFP/WHO Estimating Food & Nutrition Needs in Emergencies, 2001

Annex 8: Emergency phase action plan

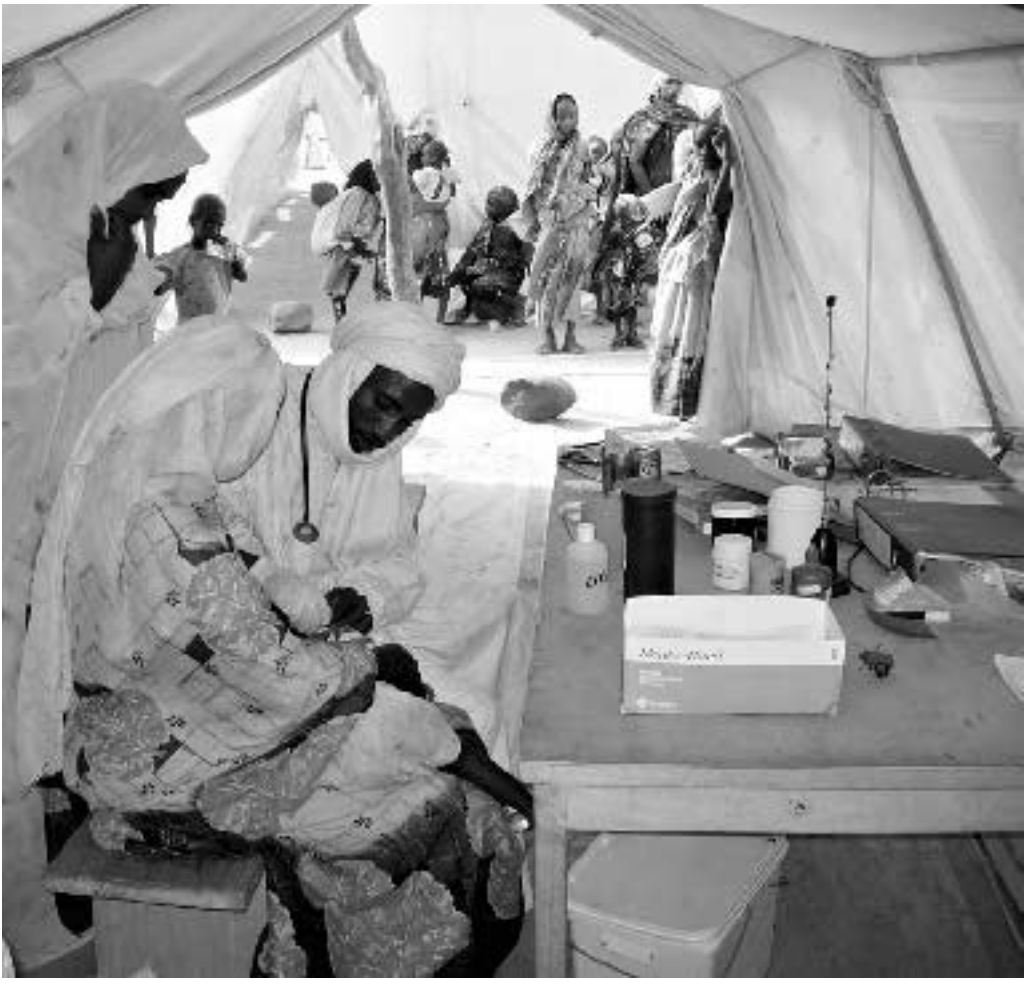
PHASE I OF THE EMERGENCY	
From the outset and during initial stages of the emergency (i.e. during initial rapid assessments).	⇒ Adopt the 2,100 kcal/person as a reference figure. ⇒ Adjust 2,100 kcal figure based on information available immediately using the factors outlined in Section V. ⇒ Ensure that food ration is adequate to address the protein, fat and micronutrient requirements of the population. ⇒ Ensure that food ration is adequate to address the nutritional needs of all sub-groups of the population. ⇒ Outline strategies for collecting information for making further adjustments. ⇒ Food management issues are considered. ⇒ Food-related conditions are considered. ⇒ Monitoring system is established to ensure adequacy of the ration.
PHASE II OF THE EMERGENCY	
Situation stabilized	⇒ Through periodic reassessment, further revision and adjustment of the reference figure based on additional information about all the factors affecting energy requirements specific to the situation (outlined in Section V). ⇒ Plan for longer term assistance or phase out strategies.

ANNEX 9: Checklist for adjustments to the initial reference figure of 2,100 kcal

- **Are the majority of the population undertaking strenuous physical activities such as carrying heavy loads over long distances?**
- **Is the average temperature significantly lower than 20°C?**
- **What is the prevalence of malnutrition among the population?**
- **Is the crude mortality rate (CMR) significantly higher than normal?**
- **Are there significant public health risks for the affected population?**
- **Is the demographic profile of the affected population as expected?**
- **Is the population receiving a regular supply of some food from other sources?**
- **What is the percentage of energy from protein in the ration?**
- **Is the energy obtained from fat at least 17%?**

16 Food and nutrition

17
Health



CONTENTS

Situation

It is well known from experience that emergencies result in excess loss of life (high mortality) and increased incidence of diseases (high morbidity). In developing countries, the diseases mainly responsible for high mortality and morbidity are measles, diarrhoeal diseases (including cholera), acute respiratory infections (pneumonia), malnutrition and malaria. The factors which increase the risk of disease and which should be addressed in any emergency response include an unfamiliar environment, poverty, insecurity, overcrowding, inadequate quantities and quality of water, poor environmental sanitation, inadequate shelter and inadequate food supply.

Objectives

• To prevent and reduce excess mortality and morbidity and to promote a return to normalcy to ensure refugees' right to the highest attainable standard of physical and mental health.[1]

Principles of response

- Priority should be given to a Primary Health Care (PHC) strategy which includes preventive and basic curative health services and integrate a multisectoral response with a strong vital sectors component including water, food, sanitation, shelter and physical planning.
- Refugee participation, in particular women, in the development and provision of health services is essential.
- All members of the population including groups with specific needs, women and men, girls and boys, ethnic and other minorities should have access to health services.
- Services provided for refugees should be at a level equivalent to that appropriate to host country nationals, i.e. there must be parity - providing that minimum international and UNHCR standards are met.
- The health services must be of a quality that ensures that programmes, providers and institutions respect patients' rights and comply with nationally and internationally accepted health standards and principles of medical ethics.
- The health programme should also be sustainable. It is sometimes better not to start activities which cannot be maintained, than to cease supporting activities which both implementing partners and beneficiaries have taken for granted (of course this does not apply to vital activities or urgent life saving measures).
- Many countries will not have sufficient human and material resources to respond adequately to the extraordinary needs generated by an emergency. Experienced national and international Non-governmental Organizations (NGOs) should be mobilized to initiate urgent life saving measures and rapid integration with the Ministry of Health (MOH) is essential.
- Health services should take into account the particular vulnerability of children under five years old during emergencies. Priority should be given to the prevention and management of the five main causes of excess mortality and morbidity: malaria, acute respiratory infections, measles, malnutrition, diarrhoeal diseases.
- Health services should also take into account the special needs of women who play a central role as primary health care providers and also bear a disproportionate share of suffering and hardship. It includes a minimum package of reproductive health services, aiming in particular at reducing maternal and newborn mortality and morbidity and reducing the transmis-

[1] *International Covenant on Economic, Social and Cultural rights, 1966, Article 12.*

sion of Human Immunodificiency Virus (HIV)[2]. It should be implemented immediately.

- A UNHCR Health Coordinator should be appointed with responsibility for the health programme and for ensuring that national and international standards and best practices are adhered to, in close coordination with the national health authorities and other organizations.

Action

- Assess the health and nutritional status of the population by age and sex and identify the critical health risk factors in the environmental conditions.
- Establish priority needs, define the required activities to meet those needs and determine the required human, material and financial resources to perform these activities.
- In accordance with these activities, set up community-based health services and devise the appropriate organizational and coordination mechanisms with both the health partners and other relevant sectors of assistance.
- Promote basic health education for the refugees and train refugee health workers (50% women) and ensure female to female health services (including community health workers and midwives).
- Monitor and evaluate the effectiveness of the services and adjust as necessary.
- Ensure that decisions about the health services are based on proper assessment and surveillance, including participatory assessment.
- Communicate information about the emergency situation and the health services for advocacy purposes.
- Establish an early warning and surveillance system to detect outbreaks and prepare rapid response actions.

Introduction

1. Good health, depending as it does on so many non-medical factors, is too big a subject to be left only to medical workers. This chapter is directed at non-specialist staff in the field. It does not pretend to give "medical answers" to health problems. It does, however, seek to show that proper assessment of problems, needs and resources, appropriate organization and coordination of public health and medical services based on a Primary Health Care (PHC) strategy are more important to the overall health status of refugees than curative medicine alone. These crucial organizational factors are often the responsibility of non-medical UNHCR staff.

2. During an emergency, many refugees will be exposed to insecurity, poor shelter, overcrowding, a lack of sufficient safe water, inadequate sanitation, inadequate or inappropriate food supplies and a possible lack of immunity to the diseases of the new environment. Furthermore, on arrival, refugees may already be in a debilitated state from disease, malnutrition, hunger, fatigue, harassment, physical violence and grief. Poverty, powerlessness and social instability, conditions that often prevail for persons of concern to UNHCR, can also contribute to increased sexual violence and spread of sexually transmitted diseases including HIV.

3. The World Health Organization (WHO) has summarized the concept of Primary Health Care as follows: "PHC is essential health care made accessible to everyone in the country. It is given in a way acceptable to individuals, families and the community, since it requires their full participation. Health care is provided at a cost the community and the country can afford. Though no single model is applicable everywhere, Primary Health Care should include the following:

[2] *Please refer to Chapter 19 for more information on HIV and Sexually Transmitted Diseases (STD)*

i. promotion of proper nutrition;
ii an adequate supply of safe water;
iii basic sanitation;
iv reproductive and child care, including family planning;
v appropriate treatment for common diseases and injuries;
vi immunization against major infectious diseases;
vii prevention and control of locally endemic diseases; and
viii education about common health problems and what can be done to prevent and control them.

At the heart of such a strategy there is an emphasis on preventive, as against curative care alone.

Health assessment, planning, monitoring and surveillance

- An assessment of the health and nutritional status is an essential start to the provision of health services.
- This must be done by experts with experience of emergencies and, if possible, local knowledge.
- The factors affecting the health of the refugees must be identified and a surveillance and reporting system established.

Initial assessment

4. First, information should be obtained on the number of refugees[3] segregated by age (percentage of children under five years old) and sex (male/female ratio). See chapter 10 on registration for more information on estimating the total number of refugees.

Age/sex breakdown can be estimated from:

i. information collected during surveys;
ii. information collected during mass immunization campaigns;
iii. mass health screening on arrival; and
iv. information collected by community health workers.

5. The aim of the initial health assessment is to first define the level of the emergency, identifying basic problems and needs to establish priorities. It should be carried out by people with appropriate qualifications and relevant experience. There are obvious advantages in using national or locally-based personnel, but appropriate outside expertise can be made available quickly and should be requested through the Technical Support Section at Headquarters if necessary. Attention should be paid to gender balance among health staff.

6. The priority should be to evaluate the incidence of the major causes of excess mortality and morbidity – measles, diarrhoeal diseases, pneumonia, malaria and malnutrition; the availability and access to basic and emergency care and resources (in particular basic emergency obstetric care) and to identify the level of risk of a possible outbreak (cholera, malaria, meningitis, AHI (avian/human flu), VHF (viral haemorrhagic fever).

7. Relevant information can be obtained from:

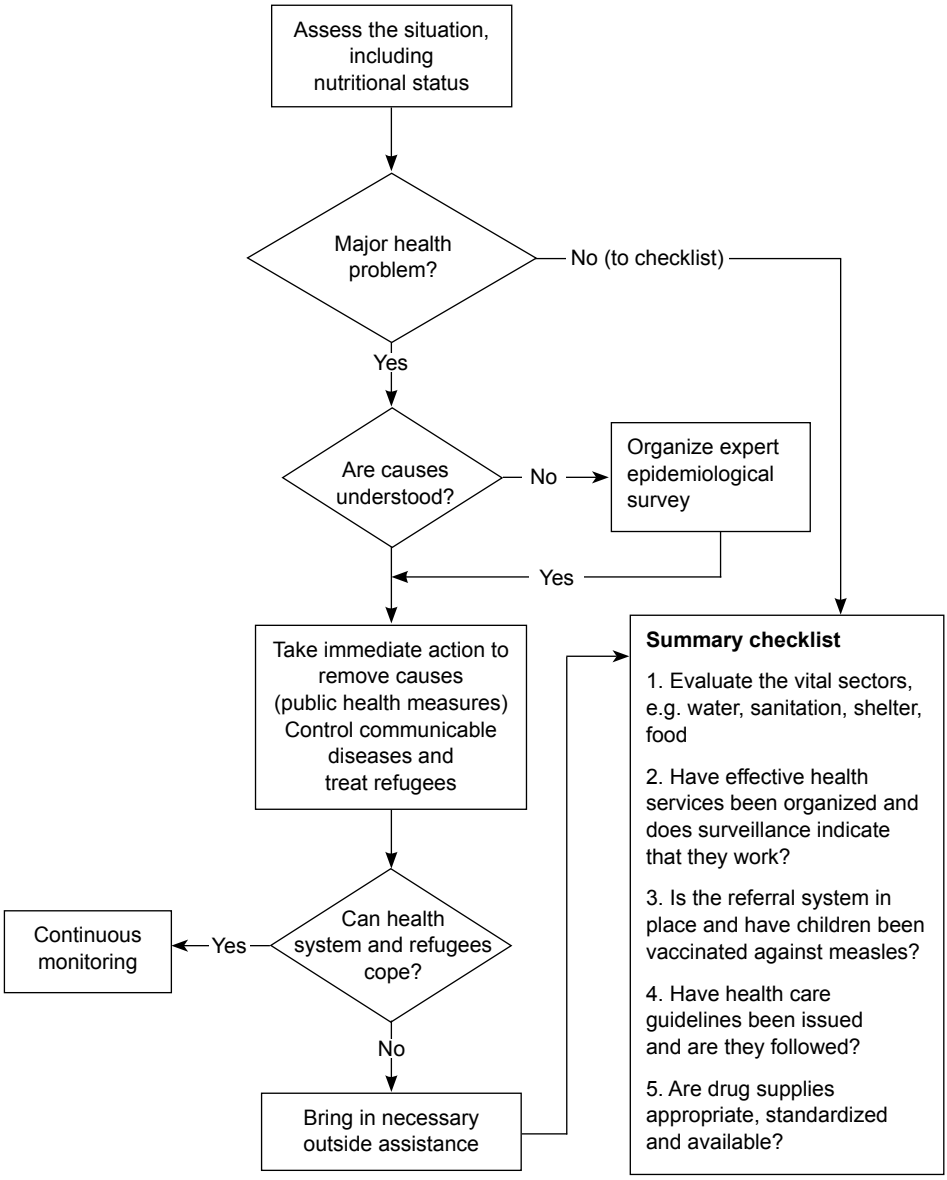
i. direct observation;
ii. reviewing baseline information regarding the country/areas of origin and asylum;
iii. analysing records at health facilities and interviewing health workers;
iv. undertaking sample surveys (nutrition and mortality, i.e. retrospective mortality surveys) which must be done by experts;
v. population estimation and registration (see chapter 10 on population estimation and registration); and
vi. mass health and nutrition screening on arrival. This should focus on: (i) nutrition screening through visual inspection and measurement of the

3 Health experts sometimes call this number "the denominator".

Mid Upper Arm Circumference ("MUAC"), (see chapter 15 on food and nutrition), (ii) checking for communicable diseases and vaccination coverage, and (iii) identifying patients in need of urgent referral. It is usually impractical to try to provide treatment in the screening line itself.

8. Figure 1 illustrates key management considerations for action in light of the initial assessment.

Figure 1 – Assessment and Response



Monitoring and surveillance: the health information system

9. The role of the health information system is to generate, analyse and disseminate health data. This is a continuous activity, conducted regularly and closely linked to public health decision-making and the implementation of programme activities. From the earliest stages of an emergency, a health information system should be put in place under the responsibility of the UNHCR Health Coordinator.

The objectives of any health information system are to:

i. rapidly detect and respond to health problems and epidemics;
ii. monitor trends in health status and continually address health-care priorities;
iii. evaluate the effectiveness of interventions and service coverage;
iv. ensure that resources are correctly targeted to the areas and groups of greatest need; and
v. evaluate the quality of health interventions.

10. UNHCR website (www.unhcr.org/health) provides a number of tables and forms for collecting health related information. This chapter also contains reporting forms on mortality and morbidity. However, to have a more comprehensive idea of the situation, information regarding water, food, sanitation, shelter and availability of soap should also be collected and analysed (see the relevant chapters on water, nutrition, sanitation, and physical planning).

11. The health information system should be simple, reliable, and action oriented. The information to be collected should be adapted to suit the collectors' qualifications. Training in collection of information should be organized in a standard manner. Overly detailed or complex reporting requirements will result in non-compliance. In addition, only data that can and will be acted on should be collected. Communication and exchange of views among all the actors in the health information system are essential to secure the functionality of the system.

12. A reporting calendar is essential to the function of the health information system. It should be standardized among all health partners at all levels of health management. Copies should be distributed throughout each camp and made easily visible to all staff. This calendar should specify the dates on which each week begins and ends; the last day of the week should represent the date on which daily information sources (daily sheets and registers) are compiled and reported using a Weekly Report Form.

13. Health information in the initial stages of an emergency should concentrate on:

i. demography
ii. mortality and its causes
iii. nutritional status
iv. morbidity

14. Only when the situation stabilizes can the system be made more comprehensive. After the emergency phase is declared over, the health information system should be expanded to include more detailed reporting and from a greater number of primary health sections (e.g. Inpatient Department and Referral Services, Expanded Program on Immunization (EPI), and more detailed Reproductive Health and HIV/AIDS information).

Information on mortality and morbidity should be collected as follows:

Mortality (death)

15. Each health facility should keep a log of all patient deaths with cause of death and relevant demographic information. This information should be summarized in tables (see tables 2.1 and 2.2 of Annex 1), reported centrally and consolidated with other data.

16. Because many deaths occur outside the health-care system, a community-based mortality surveillance system should also be established. This system requires identification of sites used as cemeteries, employing grave watchers on a 24 hours basis, routinely issuing burial shrouds, and using community informants. Deaths that occur outside hospitals, by unknown causes, should be validated through verbal autopsy by health workers specifically trained for this task.

17. Depending on the requirements of the health partner, certain primary causes of death should invoke a more detailed investigation of the exact cause and circumstances surrounding the death (see table 2.2 in Annex 1). The investigation should be led by a multi-disciplinary team comprised of health agency staff, UNHCR, government counterparts and community leaders. Guidance on when to begin an investigation into a death, the team composition, methods of enquiry, and the procedure for producing a final report should be clearly stated by each agency. The outcome should be documented in a narrative report, covering terms of reference that have been established in advance. Depending on the cause of death under review, the investigation may also be linked with wider outbreak alerts and response efforts [see paragraph on morbidity (illness)].

18. Death certificates should be issued by the health agency for every death reported within the camp. This acts as both a legal record of death and as a means of triangulating data within the hospital and community mortality sources. No burial should take place without evidence of a death certificate that has been issued by the main camp hospital/dispensary. This will help to prevent under-reporting of deaths that occur in the community but might not otherwise be reported to a health agency.

Morbidity (illness)

19. Each health facility providing out-patient services should report age, sex, and cause-specific data for each consultation. Information should be recorded systematically, using data sources and guidance that are standardized between health agencies.

Monitoring and surveillance

20. The principal source of routine monitoring in the out-patient department should be a daily tally sheet (see www.unhcr.org/health). Before any record is made, the clinical officer must first determine whether a patient is presenting with a new health problem ('New visit'), or is seeking treatment for a pre-existing health problem ('Revisit'). This distinction is critical to the correct calculation and interpretation of morbidity indicators at the end of each month. The definitions of these terms should be specified for each disease and health event under surveillance, and stated in clear, written guidelines that are available to all clinical officers.

21. Case definitions are an essential tool to any surveillance system. They state clear and objective criteria that must be met, before a diagnosis is reported. This guarantees consistency of reporting and helps to ensure that accurate and comparable morbidity data is collected and reported by all health partners. Definitions should be simple, clear and adapted to available diagnostic means. They should be adhered to by all agencies, and used by staff in all reporting facilities (including outpatient department [OPD], inpatient department [IPD] and laboratory). The case definitions of the Ministry of Health should be adopted where available; in their absence, standard WHO case definitions can be used but should be adapted according to the local context.

No diagnosis should be recorded unless it meets the case definition.

Health information systems

22. An early warning system for detection of outbreaks should be established within the routine health information system. All diseases of outbreak potential should be assigned a corresponding alert threshold, which defines the basis upon which an outbreak should be reported. As for all conditions under surveillance, the decision on which diseases are selected should be based upon epidemiological priorities in each country.

23. To promote a predictable and timely intervention once these thresholds are exceeded, the alert thresholds should be visible and easily referenced by all clinical officers. The number of reported cases should also be plotted in a graph at the end of each week. This graph is known as an epidemiological curve, and uses "Number of Cases" on the vertical axis and time in "Weeks" on the horizontal axis.

24. Trends in morbidity should be observed over time and monitored for any rapid or unusual increases that could signal instability and/or possible outbreaks. Historical data should be used to generate and update baseline information regularly in the graphs (e.g. for malaria and meningitis) to watch to see if these alert thresholds are exceeded.

25. Alert thresholds should be monitored per health facility on a daily and/or weekly basis, and an outbreak alert form (Annex 2) should be completed for each threshold that is exceeded. The triggering of an outbreak alert should lead to a number of pre-determined actions, which are familiar to all clinical officers and facility supervisors.

Outbreak preparedness plans should be established, including a system for early detection, investigation and response should be established, identifying key actors.

26. The daily Outpatient Department (OPD) Tally Sheet is a useful tool for condensing large volumes of consultation and diagnosis data, and for facilitating the reporting of statistics each week. However, it does not replace the need to maintain detailed history and examination notes. These should be written legibly, in longhand, in the individual patient records that are maintained by each health agency.

27. A summary of case-based information from each consultation should also be logged in an OPD Register. One register book should be kept in each consultation room within the outpatient department and should record information on the identity of the patient, presenting signs and symptoms, diagnosis and treatment, and necessary follow-up / admission details (see Annex).

28. The centralized summary of case-information within each register acts as a useful monitoring and evaluation tool. Health Managers should periodically audit the registers, to review diagnosis and prescription practices in each OPD and certify adherence to Standard Treatment Guidelines. The case-based information collected in the register also plays a crucial role in tracing individuals in the event of an outbreak and is an important reference for the completion of the line listing in the Outbreak Alert Form (see Annex 2).

29. In addition, the patient should be issued a health record card (or "Road to Health" card) on which the date, diagnosis, and treatment are recorded. The 'Road to Health' card provides a useful medical summary of a child's health in the first five years of life. These are most important in a child's development, and should be closely monitored to ensure timely detection of problems and early diagnosis and treatment. The card is given to mothers when their infant is born and should be updated regularly at the health unit, until the child is five years old.

30. The health information system should be periodically assessed to determine its accuracy, completeness, simplicity and timeliness. The way programme planners

and key decision-makers use the information should also be assessed. The system should evolve as the need for information changes (flexibility).

31. Camp and centrally controlled monitoring of health and nutritional status is essential if problems are to be identified in time to allow preventive and/or corrective actions to be taken and to adjust resource allocation. The refugees' health status should improve as public health services start to function adequately and the refugees adjust to their new environment.

32. However, a vigilant surveillance system must be maintained. Seasonal changes will affect health (for example temperature changes, and especially the rainy season) so seasonal variations in the incidence of disease will remain. The UNHCR Health Coordinator and her/his counterparts in the government and other partners will be responsible for the quality of this surveillance, the data required, who will interpret it and how, to ensure action on the results and feed-back to all actors.

Indicators
Mortality (death)

33. The most important and specific indicators of the overall status of the refugee population are the Crude Mortality Rate (CMR), for the whole population and Under-5 Mortality Rate (U-5MR) for children under five years old. These indicators are of crucial importance to managers of the operation and are also of great interest to the media, donors and relief agencies. A priority for the health surveillance system is to produce reliable information on death rates.

Crude Mortality Rate is deaths/10,000/day.
This is calculated as follows:

$$\frac{\text{Number of deaths} \times 10{,}000}{\text{Number of days} \times \text{total population}}$$

35. An emergency is defined by mortality rates double that of the baseline. Where baseline mortality of the population prior to displacement, or of the population in the host country, is known, then this figure should be used.

Table 1 – Crude Mortality Rate Benchmarks

Average rate in most developing countries	0.5 deaths/10,000/day
Relief programme: under control	<1.0 deaths/10,000/day
Relief programme: very serious situation	>1.0 deaths/10,000/day
Emergency: out of control	>2.0 deaths/10,000/day
Major catastrophe	>5.0 deaths/10,000/day

36. Where baseline mortality is not known, the figure of 0.5 deaths /10000/day (1/10,000/day under five) is used in developing countries. In this case, the objective of the overall assistance programme in the emergency phase should be to achieve CMR of <1/10,000/day and U-5MR of <2/10,000/day as soon as possible. These rates still represent approximately twice the "normal" CMR and U-5MR for non-displaced populations in most developing nations and should not signal a relaxation of efforts. Other situations are given in table 1A below (the Sphere Project, 2004 edition, page 261).

Table 1A: Baseline Reference Mortality Data by Region

Baseline Reference Mortality Data by Region				
Region	**CMR (deaths/ 10,000/day)**	**CMR emergency threshold**	**CMR (deaths/ 10,000 U5s/day)**	**CMR emergency threshold**
Sub-Saharan Africa	0.44	0.9	1.14	2.3
Middle East and North Africa	0.16	0.3	0.36	0.7
South Asia	0.25	0.5	0.59	1.2
East Asia and Pacific	0.19	0.4	0.24	0.5
Latin America and Caribbean	0.16	0.3	0.19	0.4
Central and Eastern European Region/CIS and Baltic States	0.30	0.6	0.20	0.4
Industrialised countries	0.25	0.5	0.04	0.1
Developing countries	0.25	0.5	0.53	1.1
Least developed countries	0.38	0.8	1.03	2.1
World	0.25	0.5	0.48	1.0

Source: UNICEF's State of the World's Children 2003 (data from 2001).

37. Age and sex-specific mortality rates have to be collected systematically and may indicate the need for targeted interventions. Table 1 below shows some benchmarks for developing countries where baseline data is not known against which the daily Crude Mortality Rate (CMR) can be compared. Under-5 Mortality Rate benchmarks are usually twice the CMR.

Morbidity (illness)

38. Knowing the major causes of illness and the groups at greatest risk helps efficient planning of intervention strategies and the most effective use of resources. Morbidity incidence is the number of new cases of a given disease among the population over a certain period of time, usually expressed 1,000/population. It is more useful to follow this than to keep a simple tally of cases, as trends can be followed over time, or compared with other situations. Morbidity incidence should be recorded as set out in Tables 3.1 and 3.2 of Annex 3.

39. The more common diseases are outlined in table 2 below which illustrates the environmental impact on disease and indicates those improvements in living conditions which will bear directly on the health of the refugees.

Table 2 – Common diseases

Disease	Major contributing factors	Preventive measures
Diarrhoeal diseases	Overcrowding, contamination of water and food Lack of hygiene	• adequate living space • public health education • distribution of soap • good personal and food hygiene • safe water supply and sanitation
Measles	Overcrowding Low vaccination coverage	• minimum living space standards as defined in chapter 12 on site planning • immunization of children with distribution of vitamin A. Immunization from 6 months up to 12-15 years (rather than the more usual 5 years) is recommended because of the increased risks from living conditions
Acute respiratory infections	Poor housing Lack of blankets and clothing Smoke in living area	• minimum living spcae standards and • proper shelter, adequate clothing, sufficient blankets
Malaria	New environment with a strain to which the refugees are not immune Stagnant water which becomes a breeding area for mosquitoes	• destoying mosquito breeding places, larvae and adult mosquitoes by spraying. However the success of vector control is dependent on particular mosquito habits and local experts must be consulted • provision of mosquito nets • drug prophylaxis (e.g. pregnant women according to national protocools)
Meningococcal meningitis	Overcrowding in areas where disease is endemic (often has local seasonal pattern)	• minimum living space standards • immunization only after expert advice when surveys suggest necessity
Tuberculosis	Overcrowding Malnutrition High HIV prevalence	• minimum living space standards (but where it is endemic it will remain a problem) • immunization
Typhoid	Overcrowding Poor personal hygiene Contaminated water supply Inadequate sanitation	• minimum living space standards • safe water, proper sanitation • good personal, food and public hygiene and public health education WHO does not recommend vaccination as it offers only low, short-term individual protection and little or no protection against the spread of the disease
Worms especially hookworms	Overcrowding Poor sanitation	• minimum living space standards • proper sanitation, good personal hygiene • wearing shoes
Scabies*	Overcrowding Poor personal hygiene	• minimum living space standards • enough water and soap for washing
Xerophthalmia Vitamin A deficiency	Inadequate diet Following acute prolonged infections, measles and diarrhoea	• adequate dietary intake of vitamin A. If not available, provide vitamin A fortified food. If this is not possible, vitamin A supplements. • immunization against measles. Systematic prophylaxis for children, every 4 - 6 months
Anaemia	Malaria, hookworm, poor absorption or insufficient intake of iron and folate	• prevention/treatment of contributory disease • correction of diet including food fortification
Tetanus	Injuries to unimmunized population Poor obstetrical practice causes neo-natal tetanus	• good first aid • immunization of pregnant women and subsequent general immunization within EPI • training of midwives and clean ligatures, scissors, razors, etc.
Hepatitis	Lack of hygiene Contamination of food and water	• safe water supply • effective sanitation • safe blood transfusions
STD's/HIV	Loss of social organization Poor transfusion practices Lack of information	• test syphilis during pregnancy • test all blood before transfusion • ensure adherence to universal precautions • health education • availability of condoms • treat partners

** Scabies: skin disease caused by burrowing mites*

40. It is not possible to monitor everything to the same level of detail in a health information system. Each country must identify the priority diseases and health events that present the most significant threat to the health of the refugee and host population. The selection process must be done in coordination with UNHCR, Ministries of Health, and health implementing partners, and should take into account the following factors:

i. Does it result in high disease impact?
ii. Does it have a significant epidemic potential?
iii. Is it a specific target of a national, regional, or international control program?
iv. Will the information collected lead to public health action?

41. All health conditions selected for inclusion in the surveillance list should be assigned a case definition, and each should be mutually exclusive of one another.

Main health programmes

- The main causes of death and diseases in emergency situations in developing countries are measles, diarrhoeal diseases (including cholera), acute respiratory infections, malnutrition and malaria (where prevalent), in particular but not only among children.
- However reproductive health problems (in particular pregnancy and obstetric complications) are the leading cause of life loss among women 15 to 44 years old. Experience underlines the importance of meeting the reproductive health needs of refugees, and most particularly of women and adolescents.
- Priority should therefore be placed on programmes targeting the issues mentioned above.
- Other causes of morbidity include tuberculosis, meningitis, vector-borne diseases, sexually transmitted infections, HIV/AIDS.
- The psychological stress of displacement, often compounded by harassment, violence, fear and grief will impact on the mental and psychosocial health of the affected population.
- Early emphasis should be placed on correcting environmental factors which adversely affect health.

Priority health and nutrition activities are outlined in Box 1 (adapted from *Refugee Health*, MSF, 1997).

Curative care

42. Curative medical care is extremely important at the early stage, when refugees are most vulnerable to their new environment with the health hazards it poses and before it has been possible to achieve any major public health improvements. Curative services contribute to reduce the excess of loss of lives and create confidence among the refugees towards the health services.

Priority health and nutrition activities in emergencies

1. **Measles immunization:** at least 90% coverage for children aged 6 months to 14 years.
2. **Nutritional support:** including selective feeding programmes (Therapeutic Feeding Programmes for severely malnourished and Supplementary Feeding Programmes for moderately malnourished) where the prevalence of acute malnutrition is >10% among children 6-59 months (5% in the presence of aggravating factors) on baseline survey.
3. **Control of communicable diseases and epidemics:** outbreak response planning, controlling diarrhoea, measles, acute respiratory infections and malaria.
4. **Minimum initial services package for reproductive health:** nomination of a coordinator; prevention and response to gender-based violence; ensure adherence to universal precautions against HIV/AIDS; condom distribution; clean delivery and midwife kit distribution; planning for comprehensive RH services.
5. **Public health surveillance:** monitoring and reporting standardized health data using UNHCR's Health Information System; and core indicators as outlined in the UNHCR Standards and Indicators Guide.

43. Appropriate diagnosis and treatment protocols of major diseases must be defined in accordance with national protocols, if they are suitable to the refugee context. There may be some exceptions to this rule, but implementation of refugee specific protocols should always be previously agreed upon with national authorities.

44. Remember to take into account deaths occurring outside the health care system. A commonly documented error, committed by even excellent clinicians who have become absorbed in a health facility, is to fail to notice that cemeteries are being filled by refugees dying in their shelters, without having been identified or referred to receive appropriate curative services.

Immunization

45. Measles has been documented as being responsible for excess loss of lives, particularly but not exclusively among children under five years old. Measles has a high potential of outbreaks and mortality, mass vaccination of children against this disease is therefore a high priority: risk of outbreak is higher in crowded emergency settings, in large population displacement and in case of high malnutrition levels.

46. In some settings older children may have escaped immunisation campaigns and measles disease. This is the reason why immunization of all children under the age of 15 is recommended.

Immunization against measles for young children is the only essential immunization in the early stages of an emergency. Children 6 months to 15 years should be vaccinated in emergencies (rather than the more usual 5 years old). Infants vaccinated at 6 months old will need to be revaccinated once over 9 months old.

47. The decision as to whether to undertake a measles vaccination campaign at the onset of an emergency should be the responsibility of an expert. The campaign should ideally be associated with, but not delayed by, distribution of vitamin A. The decision will be based on the vaccination coverage reported in the country and area of origin and its reliability, and if there has been a recent epidemic or vaccination campaign.

48. If there is a need for a measles vaccination campaign, it should not be delayed until other vaccines are available, and it should have appropriate mechanisms to ensure new arrivals are vaccinated. The provision of vaccines, vitamin A, cold chain and other equipment should be discussed with UNICEF (see the Memorandum of Understanding [MOU] between UNICEF and UNHCR, Appendix 3).

49. There are strong reasons, both medical and organizational, not to have a mass immunization programme with all vaccines. The most common causes of disease and death in the emergency phase cannot be cured or prevented by immunizations (except measles). Mass immunization programmes require a large number of workers, and vaccines need to be carefully handled and controlled, in refrigerated conditions. Therefore undertaking such a campaign may represent a misuse of time and resources in an emergency.

Expanded programme of immunization

50. As soon as the emergency has stabilized there should be a complete Expanded Programme of Immunization (EPI), which should form an integral part of the ongoing long-term health programme. A standard EPI includes diphtheria, pertusis and tetanus toxoid (DPT), oral polio (OPV), and BCG (Bacille Calmette-Guerin) vaccines as well as measles. However, there should not be a vaccination campaign against any of these (apart from measles), nor should there be a complete EPI, unless the following criteria are met: the population is expected to remain stable for at least 3 months; the operational capacity to administer vaccine is adequate, and the programme can be integrated into the national immunization programme within a

reasonable length of time (see the MOU between UNICEF and UNHCR).

Immunization records

51. It is essential that adequate immunization records be kept. At the very minimum, personal immunization (or "Road to Health") cards should be issued. In addition, an independent central register of all immunizations is desirable, to enable analysis of vaccination coverage.

Communicable disease control[4]

- Emergency conditions, particularly overcrowding, poor sanitation and deficient water supply etc. will facilitate the spread of communicable diseases.
- The aim is to prevent, detect, control and treat diseases.
- Refugees are at greatest risk if they might be exposed to a disease against which they have not acquired immunity (e.g. measles, malaria etc.).
- During an emergency situation measures that may be put in place for preparation and response to a sharp increase in the number of cases of a disease are:
  - a surveillance system to ensure early warning;
  - close coordination of the response with the national authorities, WHO and partners as appropriate;
  - outbreak response plan;
  - standard treatment protocols;
  - stockpiles of essential treatment supplies;
  - operative laboratory; and
  - relevant vaccines identified if a mass vaccination campaign is required.

52. The main communicable diseases causing illness and death among refugees in emergencies are:

i. measles
ii. diarrhoeal diseases
iii. acute respiratory infections
iv. malaria (where prevalent)

Moreover, the interaction between malnutrition and infection, particularly among young children, contributes to increased rates of mortality.

53. Other communicable diseases – meningococcal meningitis,[5] tuberculosis, sexually transmitted infections (STIs), hepatitis, typhoid fever, lassa fever and other haemorrhagic fevers, typhus and relapsing fever – have also been observed among refugee populations. However, the contribution of these illnesses to the overall burden of disease globally among refugees has been relatively small.

Diarrhoeal diseases

54. Diarrhoeal diseases represent a major public health problem and acute epidemics of shigellosis (causing bloody diarrhoea dysentery) and cholera,[6] have become common in refugee emergencies and have resulted in excess loss of lives. In risk areas, it is essential to set up appropriate preventive measures as soon as possible. These measures include:

i. adequate supply of potable water and an appropriate sanitation system;
ii. provision of soap and education on personal hygiene and water management;
iii. promotion of food safety and breastfeeding;

[4] *Communicable disease control in emergencies, a field manual, 2005 WHO, Geneva.*

[5] *See World Health Organization. Control of Epidemic Meningococcal Disease: WHO Practical Guidelines 2nd edition, 1998.*

[6] *First steps for managing an outbreak of acute diarrhoea, 2003. WHO, Geneva; Acute diarrhoeal control in complex emergencies, critical steps, 2004. WHO, Geneva; Cholera outbreak: assessing outbreak response and improving preparedness, 2004. WHO Geneva.*

iv. reinforced home visiting and early case detection; and
v. identification of an area ("cholera management unit") to manage patients with cholera in case an epidemic occurs.

It is essential to stockpile the basic medical supplies for a rapid response (Ringer lactate, SROs, adequate antibiotics…)

55. It is not possible to predict how a cholera outbreak will develop. If proper preventive measures are taken less than 1% of the population should be affected. Usually however, 1 to 3% are affected but in extreme cases it can be more – even as much as 10%.

56. To be prepared to respond quickly to an outbreak, the above preventive measures should be accompanied by the establishment of appropriate protocols on case management. These protocols should be based on National or WHO protocols and should be founded on rehydration therapy, continued feeding and appropriate antibiotics (especially for shigellosis).[7] In addition, there should be a reliable surveillance system for early detection of cholera cases, to follow trends and determine the effectiveness of specific interventions.

57. A significant amount of material, financial and experienced human resources are likely to be needed to respond to a cholera outbreak and reduce the case fatality rate.

58. To facilitate an immediate response, cholera kits can be obtained from the Supplies Management Service at Headquarters at short notice. Each kit can cover the overall management of some 500 cases. There is some experience in using an oral cholera vaccine to prevent outbreaks in emergency settings, but its use is only appropriate in specific circumstances and expert guidance should be sought.

[7] *See World Health Organization. Guidelines for the control of Epidemics due to Shigella Dysenteriae Type 1, 2005*

Measles

59. WHO has classified refugees and displaced populations, especially in camps, as groups at highest risk for measles outbreaks. Indeed, this disease has been devastating in many refugee situations. Measles vaccination coverage should be as close as possible to 100% (and must be greater than 90% to be effective). If not, measures should be taken immediately to control the situation (see the MOU between UNICEF and UNHCR and paragraphs on immunization above).

Malaria

60. Malaria is one of the major causes of illness and death in populations coming from, passing through, or arriving in a malarious area. Effective treatment and prevention will require expert advice.[8]

61. **Treatment**

i. The mainstay of response in an emergency is prompt access to effective treatment. Health education to the population on seeking care in time should be a priority.
ii. In emergency settings endemic for falciparum malaria,[9] first-line treatment should usually be with artemesinin-based combination therapy (ACT). These drugs are rapidly effective in most settings. If the national protocol is not based on recent efficacy data, interim protocols will need to be established for the emergency setting, in collaboration with the national health authorities.
iii. Diagnosis of falciparum malaria should be laboratory confirmed (except during confirmed malaria epidemics). Rapid tests should be used in most settings.

[8] *Malaria control in complex emergencies: An Inter-Agency Field Handbook 2005, WHO*
[9] *Falciparum malaria is the most dangerous form of malaria and is the most common form in most sub-saharan African countries.*

iv. All pregnant women, severely malnourished children, and those with suspected HIV/AIDS attending health facilities should be actively screened for malaria (usually using rapid tests).

v. Active fever case findings in the community should be instituted for all pregnant women and children under five as soon as possible.

62. **Prevention**

i. Sites should be selected away or upwind from potential breeding sites, and site planning should ensure adequate drainage to prevent the development of breeding sites for malaria transmitting mosquitoes.

ii. Insecticide treated nets (preferably long-lasting insecticidal nets that do not need retreatment) should be fitted to all inpatient beds in clinics, hospitals and therapeutic feeding centres.

iii. Other chemical control measures such as insecticide treated nets, or indoor residual spraying, may seem quite attractive but should only be taken upon expert advice as several factors must be considered such as: the habits of the refugees, seasonal variations, mosquito biting habits, transmission levels, national protocols about chemicals and registered lists of chemicals and cost. Please see chapter 15 on sanitation and hygiene for guidance on vector control.

iv. During an emergency in sub-Saharan Africa, insecticide treated nets could be considered for distribution among the beneficiary population provided that: good access to diagnosis and treatment is already in place; transmission intensity is moderate to high; nets are stockpiled in advance; the community is already familiar with sleeping under nets; indoor residual spraying is not being conducted in the same shelters; and there is adequate access to food. Coverage of greater than 60% of households will have a protective effect for the community, less than this the nets will have an individual protective effect.

v. During an emergency in sub-Saharan Africa, indoor residual spraying can be considered provided that: there is adequate insecticide, water, equipment, trained staff, a well organized implementation plan, training and supervision; and adequate time for implementation ahead of the rainy season. Experience from UNHCR programmes shows that implementation is usually too late to be effective following the onset of the malaria transmission season.

vi. Intermittent preventive treatment in pregnancy should be implemented according to national policy. Where there is moderate to high transmission intensity, antenatal services are established and the drug ("sulfadoxine-pyrimethamine") remains moderately efficacious.

vii. Prevention strategies not usually recommended for malaria control in emergencies are larvaciding, brush cutting and space spraying.

viii. New tools including other insecticide treated materials (e.g. plastic sheeting) are under investigation but are not yet accepted for use as standard emergency response.

63. In the early stages of an emergency, those most at risk of severe illness and death should be targeted first:

i. Priority 1: pregnant women, severely malnourished (admitted to Therapeutic Feeding Programme) and children under 2 years old.

ii. Priority 2: children under 5, moderately malnourished (admitted to Supplementary Feeding Programme) and people with known HIV infection or clinical suspicion of AIDS.

Acute respiratory infections

64. Pneumonia is the acute respiratory

infection that has been documented as a cause for excess mortality, most particularly in the under five population. It is therefore essential to make sure that refugees are provided with adequate shelter and blankets as soon as possible. Health staff must be appropriately trained to diagnose and treat respiratory infections.

Reproductive health[10]

65. Reproductive health care in refugee situations should be provided by adequately trained and supervised staff and should be guided by the following principle:

- **Reproductive health care should be available in all situations and be based on refugee, particularly women's, needs and expressed demands.**
- **The various religious, ethical values and cultural backgrounds of the refugees should be respected, in conformity with universally recognized international human rights.**

66. The provision of quality reproductive health services requires a collaborative effort by a number of sectors (health, community services, protection, education) and organizations, which should provide reproductive health services based on their mandates.

67. While resources should not be diverted from addressing the problems of the major killers (measles, diarrhoeal diseases, acute respiratory infections and malaria), there are some aspects of reproductive health which must also be dealt with in the initial phase of an emergency. The Minimum Initial Service Package (MISP) is a series of objectives and actions needed to respond to the reproductive health needs of populations in the early phase of a refugee situation. Documented evidence of its efficiency justifies its use without prior needs assessment. The major objectives of reproductive health care in an emergency are to:

i. ensure a coordinated response to reduce reproductive health related morbidity and mortality by identifying an organization and a person responsible to facilitate the coordination and implementation of reproductive health activities;

ii. prevent excess neonatal and maternal morbidity and mortality by providing clean home delivery kits, ensuring clean and safe deliveries at health facilities and managing emergency obstetric complications by establishing a referral system;

iii. prevent and manage the consequences of gender-based violence;

iv. reduce HIV transmission, by enforcing respect of universal precautions[11] and guaranteeing the availability of free condoms; and

v. plan for the provision of comprehensive reproductive health services to be integrated into primary health care, as soon as possible.

68. As soon as it is feasible, when the situation has stabilized, comprehensive reproductive health services based on the needs of refugees should be put in place. These services should be integrated within the primary health care system and should address the following aspects:

Safe motherhood

69. Maternal and neonatal deaths can be prevented:

- by reducing delays in (1) recognising a complication, (2) seeking care, and (3) reaching a facility;

[10] *See: United Nations High Commissioner for Refugees: An Inter-Agency Field Manual on Reproductive Health in Refugee Situations, 1999.*

[11] *"Universal precautions" means procedures and practices by health workers to limit transmission of disease.*

- by having access to skilled attendants[12] and comprehensive emergency obstetric care;
- by supporting breast-feeding and essential newborn care; and
- by preventing unwanted and mistimed pregnancies.

Services should cover antenatal care, delivery care, post-natal care as well post-abortion care.

70. All pregnant women should receive antenatal care services at least 3 times during pregnancy. Antenatal services should include routine medical assessment, detection and management of complications, preventive medical treatments, tetanus immunization, nutritional and health promotion, as well as systematic syphilis screening.

71. All deliveries should be accompanied by a trained health care provider (nb: Traditional Birth Attendants [TBAs] are not considered as trained health care providers and their intervention should be limited to community-based preventive and support services) and a referral system to manage obstetric emergencies should be put in place.

72. Within the first 4-6 weeks, mothers and their newborn should visit the health services and receive nutritional supplements, support for breast-feeding, counselling on infant health and nutrition and family planning (see paragraph on family planning). Women who have complications, such as spontaneous or unsafe abortion should be cared for by the referral system.

[12] *Traditional Birth Attendants (TBAs) are not considered as a skilled attendant. They should not be supported to attend deliveries. However they should be supported and trained to perform health and hygiene promotion, immunization promotion, breast feeding support, and other activities to promote healthy and health seeking behaviour.*

Family planning

73. Women who give birth more than 4 times face dramatic higher maternal risks.

Family planning can prevent 25-30 percent of all maternal deaths fighting the 4 too rule: too young, too old, too many, too close together. Furthermore, spacing pregnancies more than 2 years increases child chances of survival.

74. Family planning services should be initiated as soon as feasible, the first intervention being to ensure continuity of family planning supplies for those men, women and couples already using a method.

75. Information, education and communication should be designed by and for the refugees according to their culture and knowledge, but without taboo and in an open and respectful manner.

76. Family planning methods need to be easily and confidentially accessible, and diversified ensuring that refugees can make an informed and free choice in child spacing matters.

Prevention and response to sexual violence

77. Sexual and gender-based violence (SGBV) prevention and management requires a coordinated multi-sectoral team approach involving refugees. Education, information, communication, protection and comprehensive response are paramount in addressing the different SGBV issues in a culturally sensitive manner, and respect of children, women and men's rights prevail. Please refer to chapter 18 on SGBV.

78. **In situations which may give rise to SGBV, the following measures may be considered in addition to actions to address the specific causes of the problem**:

Policy and management:

- Include SGBV management in health coordination meetings and ensure that refugees are informed of the availability of services.

Medico-legal:

- Document case respecting survivor wishes and confidentiality (including medical report).
- Collect, label and store forensic evidence.

Medical:

- Prevent unwanted pregnancy through emergency contraception.
- Prevent HIV transmission with PEP.
- Provide wounds and injuries care.
- Prevent sexually transmitted infections (STIs) transmission with medical treatment.
- Prevent tetanus and hepatitis B through vaccination.
- Provide follow-up care.

Psychosocial support:

- Provide counselling and treatment for psychological trauma.

Other reproductive health concerns

79. Programmes to eradicate harmful traditional practices, including female genital mutilation, should be implemented once the situation has stabilized. It is crucial to work closely with the refugee community in tackling this issue.[13]

80. Culturally appropriate sanitary supplies should be distributed to women as soon as possible. Inadequate sanitary protection may prevent women from collecting material assistance.

81. Health workers should pay particular attention to meeting the reproductive health needs of young people as they may be at greater risk and have more limited access to appropriate services.

82. It is important to ensure that sufficient female health workers are trained in reproductive health in order to provide culturally appropriate health services, including education within the community and at the health facilities. At least some of these health workers should be recruited from among the refugee community.

Tuberculosis control [14]

83. The prevalence of tuberculosis (TB) has significantly increased world-wide, however, a TB control programme is not a priority in the early stages of an emergency when mortality and malnutrition rates are very high and the situation is still unstable.

84. Expert advice and involvement of the national TB control programme (often supported by WHO) are needed before starting a TB programme. Bad planning and poor implementation could result in more harm than good.

85. TB treatment takes many months. To increase the chances of success, TB programmes should only be started in stable situations, that is, when Directly Observed Therapy[15] can be implemented, and when funds, drugs, reliable laboratory services and trained staff are available. Programmes should be expected to remain stable for at least 9 months. Interruption to treatment creates drug resistance, a public health menace.[16]

Mental health[17]

86. The psychosocial needs of refugees have often been neglected or even forgotten. However, health services should aim

[13] *See IOM/FOM (83/97; 90/97), Policies on Harmful Traditional Practices, UNHCR, 1997.*

[14] *World Health Organization and United Nations High Commissioner for Refugees: Guidelines for Tuberculosis Control in Refugees and Displaced Populations, 2006.*

[15] *Directly Observed Therapy is where the health worker is able to observe the treatment including that the medication is taken correctly.*

[16] *Guidelines for TB control among refugees and displaced populations, 2005, WHO, Geneva.*

[17] *World Health Organization and United Nations High Commissioner for Refugees Manual of Mental Health of Refugees, 1996.*

to promote the highest standard of both physical and mental health. It is easy to recognize that there is a heavy burden placed upon refugees from, for example, physical violence, grief and bereavement, fear and stress, an uncertain future and a sense of powerlessness.

87. During the acute emergency phase,[18] mental health issues should be addressed primarily through social interventions and linkages should be made with protection and community services sectors. Interventions should not interfere with basic service provision. Adequate, culturally appropriate and gender sensitive provision of food, water, shelter, clothing, and primary health care services should be ensured. Shelter should be safe and arranged to keep family groupings intact (see chapter 12 on site selection, planning, and shelter). Communities must be consulted in decisions about camp layout, which should include cultural, religious and recreational spaces. Appropriate recreational activities should be introduced (avoid distribution of goods that were not available before the emergency such as teddy bears or plastic toys). Community members should be involved in common activities such as food distribution, vaccination programmes, organizing shelter.

88. Social interventions during the emergency phase may include:

i. re-establishment of cultural and religious events, including grieving rituals;
ii. avoidance of disposal of dead bodies in an unceremonious manner. In most settings, dead bodies will not carry risks of communicable disease transmission;
iii. dissemination of simple and empathic information about the emergency, relief efforts, and if possible location of relatives;
iv. family tracing;
v. briefing of field officers, health workers, food distribution workers, community services workers, and registration workers on grief, disorientation and the need for active participation (including vulnerable groups); and
vi. dissemination of empathic information on normal stress reactions and expectation of natural recovery (avoiding mention of abnormal reactions as this may have negative consequences).

89. The health sector should provide:

i. essential psychotropics at the primary health centre level in the management of urgent psychiatric complaints (e.g. dangerousness to self or others, psychoses, severe depression, mania);
ii. 'psychological first aid' (empathetic listening, provide company, encourage but do not force social support) and individual psychological debriefing that pushes people to talk may have negative consequences and should be avoided.

90. As the situation stabilizes, outreach psychosocial activities can be expanded (including engagement of community leaders and traditional healers), community workers trained in core psychosocial and mental health skills, referral networks established, and health workers trained and supervised in basic mental health knowledge and skills.[19]

Capacity building: health education

91. The importance of health education is widely recognized. However, there are significant difficulties in persuading those most at risk to change long-established habits.

In the emergency phase, the priority topics should be those directly related to the immediate public health problems.

[18] *WHO Mental Health in Emergencies, Mental and Social Aspects of Health of Populaitons Exposed to Extreme Stressors, 2003.*

[19] *Mental Health of Refugees, 1996. WHO/UNHCR, Geneva.*

92. Health education should therefore focus on the disposal of human excreta and refuse, water management and personal hygiene. Many governments and organizations produce simple health education materials that may be useful. Trained refugee teachers and respected elders are likely to be more effective than outsiders in communicating the basic principles and practices of health to their own people. At a later stage, information, education and communication should also be a major tool for the prevention and reduction of sexually transmitted diseases, including HIV.

Training

93. As suggested by the definition of an emergency, extraordinary mobilization of resources, including human, will be needed to cope with the situation. Annex 4 sets out a suggested structure of the health service and numbers and qualifications of staff needed. Full staff support including health workers, doctors and nurses at health centres, community health workers and health posts and clinics, with the necessary qualifications and experience, will not be instantly available.

Training will be a cornerstone of an effective health and relief programme.

94. Training activities must be well targeted to meet the objective of the programme, and this is dependent on the definition of roles and responsibilities among various levels of health care and identifying the necessary qualifications. Training must be part of the main health programme.

Medical supplies

95. Decisions concerning drug and medical supplies procurement should follow UNHCR guidelines.[20] The Technical Support Section and the Supplies Management Section at Headquarters issued an essential drugs list, which is used to order drugs for UNHCR operations. The essential drug list and the procurement guideline aim to ensure a supply of safe, effective and affordable drugs to meet priority needs of the refugees.

96. In order to foster the appropriate use of drugs, standard treatment protocols should be established. This will help rationalize prescription habits among the various partners and organize training activities. Protocols are usually based on national standards.

97. In the early stage of an emergency, it is often useful to resort to pre-packaged emergency health kits. The best known is the Inter-Agency Emergency Health Kit which has been developed through collaboration among many agencies (WHO, UNICEF, MSF, ICRC, UNHCR and others, see www.who.int/medicines for updates). The contents of the kit are intended to cover the needs of 10,000 people for 3 months during an emergency. The kit can be obtained at short notice through the Supplies Management Section at Headquarters and can be used at the community level of health care and at health centres. The emergency health kit should only be used at the early stage of an emergency and not relied on for longer term needs.

98. Reproductive Health Kits for Crisis Situations also exist . These have been designed by members of the Inter-Agency Working Group on Reproductive Health to complement the Emergency Health Kits. The Reproductive Health Kits are available through the United Nations Population Fund (UNFPA) [see Reproductive Health Kits for Crisis Situations, UNFPA, updated 2005 or www.unfpa.org for more details]. In many situations UNFPA will provide these supplies free of charge to UNHCR operations as part of the Memorandum between UNHCR and UNFPA through the national UNFPA office or the HIV/AIDS Unit at Headquarters.

99. As soon as possible, arrangements should be made for a regular supply of

[20] *UNHCR Drug Management Guideline, 2005.*

appropriate quantities of essential drugs from the UNHCR essential drugs list. The requests should be based on epidemiological surveillance and disease patterns. The Supplies Management Section can also provide support for the purchase of quality assured drugs and their transport to the field. Local purchase is usually not indicated unless drug quality procedures are followed.[21]

100. It is of utmost importance to establish a system to monitor drug consumption and ensure drug quality. In major operations, a full-time pharmacist may be needed to work with UNHCR. Over-prescription of medicines by health workers following pressure by refugees is not uncommon in refugee emergencies.

101. Donations of unsolicited drugs are often a problem during emergencies. A number of agencies (UNDP, UNHCR UNICEF, WHO, MSF and others) have jointly developed guidelines on drug donations[22] that provide donors and users with a list of drugs and supplies, which can be sent to emergency situations. This is to help ensure that personnel in the field do not waste time sorting out "useless" donations (small quantities of mixed drugs, free samples, expired medicines, inappropriate vaccines, and drugs identified only by brand names or in an unfamiliar language). UNHCR's policy is that overseas medical supplies should be sent only in response to a specific request or after expert clearance. The WHO Representative, local diplomatic missions and all others concerned should be briefed accordingly.

Laboratory services

102. Refugees are often remote from laboratory facilities. However, very simple laboratory services at the site level are usually adequate. Simple to use rapid tests should be used to aid in the diagnosis of important diseases. Rapid tests are available for diseases including malaria, typhoid, meningitis and hepatitis.

103. Reference laboratory services are required for epidemic management and control, (e.g., meningitis, shigellosis, cholera, hemorrhagic and relapsing fevers, high malarial endemicity, hepatitis etc.) to confirm/clarify diagnosis and perform antibiotic sensitivity. This should be discussed with the national authorities and WHO. Where blood transfusions are provided, laboratory services will be absolutely essential to test all blood for HIV, syphilis and hepatitis before transfusion.

Organization of refugee health care

- There is no single model for organizing health services in refugee situations, but it is usually structured on three levels: community health posts and clinics, health centres, and referral hospitals.
- It is of the utmost importance to ensure good communication and feed-back between the various levels of health care.
- Priority should be given to using host country health facilities as referral centres and support should be agreed upon and provided to the facilities (see MOU between WHO and UNHCR).

Introduction

104. The four levels of health care are summarized in Annex 4. The first level is at the community level with outreach services. At the second level is a health centre with basic facilities for outpatient departments, dressings and injections, and a pharmacy. At the third level is a central health facility with outpatient and inpatient departments. At the fourth level is a referral hospital for emergency obstetric care and surgery, management of very complicated cases, performance of

21 UNHCR Essential Drugs Manual, 2006.
22 WHO, Guidelines for Drug Donations, May 1996.

laboratory tests etc. Referral hospitals are usually national facilities at the district, regional or national level.

105. The refugees must have easy and equitable access to effective treatment for diseases of public health importance. If the local national health facilities cannot be strengthened to meet the needs, alternative arrangements will be required. Unless treatment is provided at the right level, the hospitals or health centres will be swamped by refugees demanding treatment for simple conditions. Thus, a community-based health service is required that both identifies those in need of health care and ensures that this is provided at the appropriate level. Close coordination with community services is essential.

106. Health services utilization and quality should be monitored. Key indicators are:

i. **Consultation rate:** number of new visits/refugee/year to outpatient services, usually around 4 in an emergency setting. If higher this may suggest over-utilization, if lower this may suggest that services are not readily accessible.
ii. **Number of consultations per clinician per day (outpatient care):** If the number exceeds 50 consultations per clinician per day, corrective measures should be taken.

Community level health care

107. Whether refugees are in camps or spontaneously settled among local villages, community level services are essential.

Community-level health care must be the mainstay of health services from the very beginning of the emergency.

108. Outreach services can be delivered by Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs). TBAs might be recruited among traditional midwives in the community. Evidence shows that to decrease maternal deaths, deliveries should be conducted in health facilities with trained health assistants and not by TBAs. In order to be effective, CHWs and TBAs must be trained, supported and closely supervised. The role of CHWs and TBAs includes:

i. home visiting, identification and referral of sick people and malnourished children;
ii. identification of pregnant women and referral for antenatal, delivery and post natal care;
iii. basic health and nutrition education (including breast-feeding support);
iv. data-gathering for the health information system (deaths and their causes and the incidence of major communicable diseases); and
v. responding to the needs of refugees who have been sexually assaulted, referring promptly for medical and other care.

As a guide, 1 CHW per 500-1,000 population and 1 TBA per 2,000 population should be the goal. Ideally, 50% of those trained should be women as same sex care is often preferred.

The primary health centre

109. There should be a health centre for each refugee settlement (approximately 10,000 people). Very large settlements may require more than one. The health post centre should be a simple building with facilities for consultation, basic curative care (drugs from the New Emergency Health Kit), oral rehydration therapy, clinical procedures such as dressings (but not injections because of the risks of HIV transmission), a small lock-up pharmacy, simple equipment and sterilization facilities (electricity may not be available), data collection (log books to record patients and activities). Water and sanitation and equipment for universal precautions are essential in all health facilities.

110. An indication of the number and qualifications of health staff required is given in Annex 4.

The central health facility

111. A central health facility providing 24 hour service, inpatient and outpatient facilities should serve each population of approximately 50,000. Adequate infection control must be ensured. Basic laboratory facilities may be available. Indicative staffing levels are given in Annex 2. The central health facility should also organize the main health programmes (EPI, reproductive health) and the supervision and training of staff (at both first and second level).

Referral services

112. The health centre must be able to refer patients to hospitals for treatment. Referral hospitals should provide emergency obstetric and surgical care, treatment for severe diseases, laboratory and x-ray services as well as supply and support for nationally controlled programmes (TB, leprosy, HIV/AIDS).

113. Refugees should have access to treatment equivalent to that of the majority of the local host population. Expensive interventions that are inaccessible to the majority of the population or of limited success should not be supported.

114. Only a small proportion of patients will require referral services. These services will usually be organized in national health facilities at the district, regional or national level, and ideally, referral should be made to the nearest national hospital. This has obvious advantages, not least the fact that the infrastructure already exists.

Community-level health care must be the mainstay of health services from the very beginning of the emergency.

115. The hospital(s) should be expanded or supported as necessary, for example with tents and additional health personnel as well as some financial and/or material support (drugs, supplies, food). Care must be taken not to swamp the local hospital. Close and direct coordination with the district or regional medical officer is essential.

116. An agreement should be signed between the parties, under the aegis of the Ministry of Health, which clarifies the conditions of assistance including cost per patient per treatment, conditions to be referred and in-kind support (food and drugs). A written agreement is essential to avoid controversies.

117. It is only in certain circumstances that special refugee hospitals will need to be established, but generally this should be avoided. They should only be established when the needs cannot be met by existing or strengthened national hospitals, for example when refugee numbers are very large (much larger than the local population), when the nearest national hospitals are too far away, or for security reasons. The Supplies Management Section and the Technical Support Section should be consulted prior to establishing or acquiring refugee specific field hospitals.

118. Whatever arrangements are made for hospital treatment and referral, there must be suitable transport to and from the referral hospitals. Facilities at the hospital must also provide for the needs of relatives and allow parents to be with young children.

119. Arrangements for referral must be such that only those patients specifically referred from the health centres are attended to, with no refugees presenting themselves directly to the hospital.

120. Refugee emergencies are not usually characterized by large numbers of injured persons. However, when this is the case, there may be an initial requirement for the rapid deployment of a surgical unit which is normally quickly available. Prepackaged (expensive) surgical kits can be

obtained through Supplies Management Section at short notice.

121. The UNHCR Health Coordinator should ensure that there is a system to record referrals and subsequent treatment and follow-up of the patients.

Human resources and coordination

- The health services must be developed with and not just for the refugees and in accordance with their needs and demands.
- The early appointment of a suitably experienced health coordinator to UNHCR's staff has proved essential. A reproductive health focal point should also be identified as early as possible.
- While the use and development of local expertise is preferable, it is often necessary to mobilize outside assistance in an emergency.
- The issue of staff salary and incentives should be discussed and solved from the outset.
- The Ministry of Health at all levels must be as closely involved as possible.

The refugees

122. Participation by women and men, girls and boys is essential from the outset . From the beginning, health services should be developed and operated together with, rather than for, refugees or displaced populations. Health programmes must address and incorporate community knowledge, attitudes, behaviours and practices. Outside health workers must understand the refugees' own concepts of health and disease. If not, the services will be less effective, may be distrusted and poorly used, and are unlikely to be sustainable.

123. In emergencies preventive and curative health services should be provided free of charge to refugees and displaced populations. Evidence has shown that systems of 'cost recovery' in developing countries at best recover 5% of costs, and act as barriers to those most in need of health services. Local populations living nearby may also be extended free-of-charge services, and this should be negotiated with the health authorities in line with national policy.

Staffing needs

124. As a general principle, the order of preference for selecting health personnel, in cooperation with the national authorities, is:

i. refugees
ii. experienced nationals or residents
iii. outsiders

Most emergencies will require some combination of these sources. Efforts should be made to ensure gender balance and same sex services.

125. Strong emphasis should be placed on the training, supervision and upgrading of medical skills of selected refugees, particularly in their former roles within the community. When selecting refugees, care must be taken to include women who may not come forward as readily as men. Full account should be taken of the experience of the traditional healers and midwives. Refugees may seek traditional treatments and experience has demonstrated the advantages of encouraging traditional methods of health care which complement other organized health services.

126. An important consideration may be the government's attitude to foreign medical personnel, including, for example, recognized qualifications and permission to practice medicine.

127. The issue of staff salary and incentives should be addressed at the onset. All agencies and organizations involved in the refugee programme should adhere to the same standards. The determination of salaries and incentives should be based on the national (or country of origin) stand-

ards and due account should be taken of assistance (free food, water, shelter etc.) received by refugees. In principle, all staff performing work on a daily basis, with clearly identified responsibilities and strict working hours, should receive a salary or an incentive.

128. Special attention should be given to the recruitment of local staff. The salary or incentive offered to them should be in line with national standards. Very frequently refugee emergencies attract national personnel working in the public and private sector (commonly referred to as "brain drain") to the detriment of these services which can create serious tension.

The national health authorities

129. Early involvement of the host government's central, provincial, and district health services is essential. To the extent possible, services provided to refugees should be integrated with national services. It will be particularly important to ensure integration and compatibility with certain treatment protocols, immunization programmes, communicable disease control and surveillance practices. Promoting good health for the refugees is clearly in the interest of the local population. In addition, supporting existing structures will help ensure that health services for refugees are sustainable and are at a standard equivalent to that of the host country nationals.

130. In major emergencies, (e.g. when there are disease outbreaks/many partners/large population numbers involved) UNHCR must ensure that a Refugee Health Coordinator is appointed. The Health Coordinator should be a key member of the UNHCR programme staff. The person should take the lead role in this sector, or play a key supporting role to the national institution which takes the lead role.

131. The Health Coordinator's primary responsibility will be to ensure that the level and quality of services provided adhere to nationally and internationally accepted standards and medical ethics.

Other main tasks and duties include:

i. participating and facilitating the consultation process among all concerned parties in order to carry out an appropriate problem, needs and resources assessment;
ii. participating in, and facilitating the creation of, health and nutrition committees with the Ministry of Health, other UN agencies and non-governmental organizations (NGOs) where coordination will take place to jointly identify priority activities, and to plan for their implementation by defining needed human, material and financial resources;
iii. facilitating cooperation among all partners to ensure an appropriate implementation and monitoring of the programme as agreed upon at the coordination committee meetings;
iv. setting up and participating in the implementation of an effective Health Information System;
v. ensuring that joint protocols for medical treatment, staffing and training are established and that implementing partners adhere to them;
vi. ensuring the identification of a qualified and experienced person to coordinate reproductive health activities at the start of the relief programme;
vii. facilitating inter-sectoral coordination;
viii. consolidating the reporting about the refugees' health and nutritional status; and
ix. assisting in setting up a medical evacuation plan for UNHCR staff.

132. Experience shows that it is in the first days and weeks of an emergency that excess mortality is recorded.

It is vital that a UNHCR Health Coordinator is fielded immediately, at the very start of the emergency.

133. The quickest and most practical way to deploy a Health Coordinator is usually to send UNHCR staff or consultants. Headquarters should be consulted immediately on this. At a later stage, posts can be created or staff seconded from other UN agencies (UNICEF or WHO), or from the Ministry of Health.

Other specialized staff

134. The need for specialized staff should be carefully assessed by the UNHCR Health Coordinator or by the Health and Community Development Section at Headquarters. Such specialists include epidemiologists, specialists in public, reproductive and mental health, nutrition, tropical medicine, paediatrics, midwifery, pharmacy etc.

Experienced personnel with the right personality are more important than highly trained specialists, whose skills are often inappropriate.

135. Familiarity with the local culture, patterns of disease and the public health services and previous experience in emergencies are equally important as an advanced knowledge of medicine and medical techniques.

Role of the UN and specialized agencies

136. **WHO.** The World Health Organization works directly with the Ministry of Health in almost every country in the world. The response to the health needs of the refugees and surrounding local populations should be closely coordinated with WHO. Details of this collaboration are described in the WHO and UNHCR Memorandum of Understanding.

137. **UNICEF.** Collaboration with UNICEF in emergencies will focus on supply of measles vaccines and delivery/midwifery kits, as well as on health education (see Memorandum of Understanding between UNICEF and UNHCR for more details, Appendix 3)

138. **UNFPA**. Collaboration with UNFPA focuses on reproductive health matters and demography and there is a Memorandum of Understanding between UNFPA and UNHCR which details this collaboration.

139. **UNAIDS.** UNAIDS is an inter-agency mechanism created in 1995 to support national HIV/AIDS programmes. Refugee health services must be integrated in these national programmes.

140. Through a standby arrangement with UNHCR, the Centre for Disease Control and Prevention (CDC Atlanta, USA) can supply, at short notice, experts for rapid health and nutritional assessment, improvement of epidemic preparedness and response in emergencies and set up Health Information Systems. Deployments are usually limited from four to eight weeks and can be arranged upon request through the Health and Community Development Section at Headquarters.

Role of NGOs

141. Operational and implementing partners are essential collaborators for UNHCR. All collaborators in the emergency health programme must be brought together to form health sub-committees at the central and field level as appropriate. Initially, these committees may have to meet daily or at least weekly, usually under the chairpersonship of a representative of the Ministry of Health, supported by the UNHCR Health Coordinator. Ideally, members of the committee should have been identified at the contingency planning stage.

142. Activities of the health sub-committee include: allocation of tasks, exchange and pooling of information on health activities and other sectors (e.g. food, water, sanitation etc.), setting up jointly agreed

protocols for medical procedures, staffing levels and training, and problem-solving in general.

143. During emergencies, urgent outside assistance in the health sector is almost invariably necessary. This is because the immediate and specialized attention needed represents a burden that existing local structures are not designed to bear. District health services will almost never have the needed reserve capacity in terms of staff at all levels, infrastructure, medical supplies and technical expertise. This capacity can be developed over time, with support from the central government and other UN agencies.

144. NGOs (international, regional or national) must be chosen with care and this is usually done by the government of the country of asylum. However, it is also the responsibility of UNHCR to advise the government on which organizations have proven competence in emergencies. Some agencies have experience in long-term situations but less in emergencies; others may be too narrow in focus, preferring to do purely curative work to the exclusion of public health, prevention, sanitation etc.

145. Small NGOs, especially those created in response to a specific situation, should first demonstrate appropriate competence before being engaged in the emergency phase.

The number of agencies involved should be kept to a minimum.

146. During the early stages of an emergency it is essential that the number of NGOs involved should be kept to the minimum necessary, and that those chosen should be professional, capable of deploying experienced personnel and with proven past experience in collaborating with both governments and UNHCR in the effective management of an emergency.

Organization of response

147. A possible hierarchy of health services is outlined in Annex 2. It is based on a large-scale emergency involving a great number of health staff, both national and international. A smaller emergency will require fewer levels of organization. Note that the numbers and qualification of staff suggested is no more than an indication. Actual needs will depend on the health problems, the degree of isolation of the area and so on.

All organizations providing health care to the refugees should be involved in the preparation and be required to observe standard guidelines.

148. Once the pattern of disease and overall needs have been determined, situation-specific guidelines on standard procedures for health workers should be prepared, based on national or internationally recognized standards. These should cover all aspects of the services, including subjects such as:

i. basic principles (how the services are to be organized, including any selective feeding programmes);
ii. standardized treatment protocols;
iii. drug lists and supply; and
iv. vaccination and reporting.

The guidelines should be prepared by the UNHCR Health Coordinator in consultation with all concerned, issued under the aegis of the Ministry of Health if possible, and reviewed periodically, for example by a health coordination sub-committee. At least part of the guidelines should be translated into the language of the community health workers.

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Annex 1: Weekly Reporting Form – Mortality

Health Information System

Weekly Reporting Form

Name of Organisation _____

Name of Camp _____

Current Week & Month _____

2.0 Mortality

2.1 Mortality by Age

	Refugee			National	
	< 1	≥ 1 to < 5	≥ 5	< 5	≥ 5
Male					
Female					

2.2 Mortality by Cause

	Refugee				National	
	< 5		≥ 5		< 5	≥ 5
	Male	Female	Male	Female		
Malaria						
ARI						
Watery diarrhoea						
Bloody diarrhoea						
Tuberculosis						
Measles						
Meningitis						
AIDS						
Maternal death						
Neonatal death						
Acute malnutrition						
Other						

Health Information System

3.0 Outbreak Alert Form

Name of Organisation _____

Name of Camp & Unit _____

Date _____ / _____ / _____

Name of reporting officer:

Suspected Disease / Syndrome *(Tick **ONE** box only)*	**Symptoms and Signs** *(You can tick several boxes)*
❑ Malaria ❑ Watery diarrhoea ❑ Cholera ❑ Bloody diarrhoea ❑ Polio (Acute Flaccid Paralysis) ❑ Measles ❑ Meningitis Total number of cases reported (refer to weekly thresholds): ☐	❑ Watery or loose stool ❑ Visible blood in stool ❑ Acute paralysis or weakness ❑ Fever ❑ Rash ❑ Cough ❑ Vomiting ❑ Neck stiffness ❑ Other (describe): _____ _____

Line listing (continue on separate sheet)

Serial No.	Age	Sex (M / F)	Address	Date of onset	Lab. specimen taken (Y / N)	Treatment given	Outcome (I / R / D)*	Final Classification (S / C)**

** Outcome:*
I = currently ill
R = recovering or recovered
D = died

*** Final Classification:*
S = suspected case with clinical diagnosis
C = confirmed case with laboratory diagnosis

Annex 3: Weekly Reporting Form – Morbidity

Health Information System

Weekly Reporting Form

Name of Organisation _____

Name of Camp _____

Current Week & Month _____

3.0 Morbidity

3.1 Consultation

	Refugee		National
	M	F	
New Visits			
Revisits			

Number of full-time trained clinicians[§]	
Number of full days OPD functioning	

[§] *enter average number holding OPD consultations on each day of the week*

3.2 Morbidity

	Refugee						National		
	< 5			≥ 5		Total			Total
	M	F	Total < 5	M	F	< 5 + ≥ 5	< 5	≥ 5	< 5 + ≥ 5
* Malaria									
ARI									
* Watery diarrhoea									
* Bloody diarrhoea									
Skin disease									
Eye Disease									
Intestinal worms									
Tuberculosis									
Leprosy									
* Acute Flaccid Paralysis / Polio									
* Measles									
* Meningitis									
HIV/AIDS									
** STI (non-HIV/AIDS)									
Acute malnutrition									
Anaemia									
Angular Stomatitis									
Iodine deficiency									
*** Injuries									
Dental									
Gastritis									
Surgical									
Gynaecological									
Hypertension									
Diabetes									
Mental illness									
Other									
Total									

* *Disease with outbreak potential. Refer to weekly alert thresholds (see reverse)*

** *Also enter information on syndromic diagnosis; < 18 / ≥ 18 age group; and treatment of contacts in STI table (see r*

*** *Includes SGBV. Ensure incident report form has been completed each case*

3.3 Outbreak Alert and Response

Number of outbreaks reported	
Number of reported outbreaks investigated within 48 hours	

3.4 Sexually Transmitted Infection (STI)

	Refugee							National
	< 18		Total < 18	≥ 18		Total < 18 + ≥ 18	Contacts Treated	
	M	F		M	F			
Urethral Discharge Syndrome (UDS)								
Vaginal Discharge Syndrome (VDS)								
Genital Ulcer Disease (GUD)								
Pelvic Inflammatory Disease (PID)								
Opthalmia Neonatorum								
Congenital syphilis								
Others								
Total								

Weekly Alert Thresholds for each Health Facility:

Malaria	1.5 times the baseline *
Watery Diarrhoea	5 cases in the > 5 years age group
Suspected Cholera	1 case
Bloody Diarrhoea	5 cases
Acute Flaccid Paralysis / Polio	1 case
Measles	1 case
Meningitis	5 cases or 1.5 times the baseline *

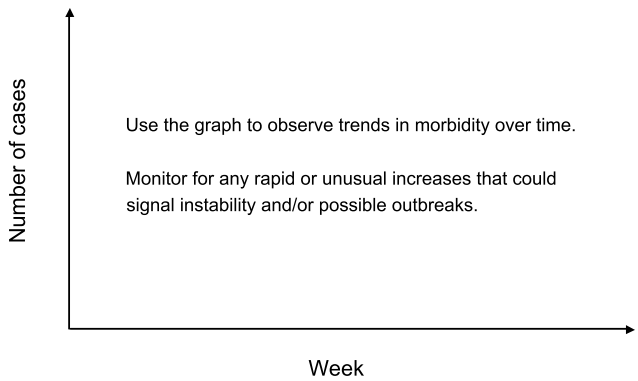
If weekly thresholds are exceeded:

1. Report to Health Coordinator

2. Complete Outbreak Alert Form

* *Baseline = average weekly number of cases of the disease calculated over the past 3 weeks.*

Also present weekly data in a graph (see below). This should include the most commonly reported diseases and those with outbreak potential.



Use the graph to observe trends in morbidity over time.

Monitor for any rapid or unusual increases that could signal instability and/or possible outbreaks.

Annex 4: Indicative health staffing levels (adapted from *The Sphere Project, 2004*)

Community level	Community health worker	One per 500 -1,000 population
	Traditional birth attendant (not for midwifery/obstetrical tasks)	One per 2,000 population
	Supervisor	One per 10 home visitors
	Senior supervisor	One
Primary health facility (for approximately 10,000 population)	Total staff	Two to five
	Qualified health worker	At least two, maximum 50 consultations per worker per day
	Non-qualified staff	At least one for oral re-hydration therapy (ORT), dressings, registration, administration etc
Central health facility (for approximately 50,000 population, 24 hour service, 25-30 in-patient beds)	Qualified health workers	At least five, maximum 50 consultations per worker per day (out-patient care), 20- 30 beds per worker per shift (in-patient care)
	Midwife	At least one
	Doctor	At least one
	Laboratory technician	At least one
	Pharmacist	At least one
	Non-qualified health worker	At least one for ORT; at least one for pharmacy; at least one for dressings, injections, sterilization etc
	Non-qualified staff	Registration, security, etc
Referral hospital	Variable	
	Doctor with surgical skills	At least one
	Nurse	At least one: 20-30 beds per shift

Annex 5 – Rapid health assessment (Source: Communicable disease control in emergencies, a field manual. 2005. WHO, Geneva)

2A. RAPID HEALTH ASSESSMENT

Date of visit:_____| _____| _____ (dd mm yyyy)	Compiled by:	Organization:
Name of location:	Urban / Rural (circle one)	Province/Governorate:
District/Area and subdistrict:	Name of town or city:	Quarter/Neighbourhood:
Reference code:	Other location information:	

1. Access

Routes to location: _____ Distance from nearest airfield? _____ km

Distance from hard surface road? _____ km Routes passable with lorry: Yes / No

Are there security problems? Yes / No – If yes, specify, providing the source: _____

_____

Other information about access: _____

_____

Telephones working? Yes / No – If yes, can call: locally / capital / international

2. Population

Source of information: Name: _____ Title: _____

Total population (approximate or estimate): _____ Number of displaced people: _____

Estimated sex ratio of current adult population: _____ % women

Estimated number of children < 5 years: _____ OR estimated % of total population < 5 years _____

Estimated number of pregnant women: _____

Are there other especially vulnerable population groups in the area (for example, in institutions):

_____

3. Main health concerns

What are the main health concerns currently?

As reported by the population: _____

As reported by health staff: _____

_____

4. Death rates in recent time period (days, weeks or months)

Source of information: Name: _____ Title: _____

Overall mortality rate (all ages): _____ deaths per _____ persons per _____ (recent time period)

Mortality rate in children < 5: _____ deaths per _____ children < 5 years per _____ (recent time period)

5. Health facilities

Source of information: Name: _____ Title: _____

No. of hospitals in this area: _____ No. of primary health centers (with doctor) _____

No. of primary health centres (without doctor): _____ No. of private clinics: _____

No. of other health facilities in this area: _____
(fill out tables below with description of individual health facilities)

If no hospitals in the area, where are patients referred for specialized medical/surgical care?

_____

Is there an ambulance service: Yes / No

If yes, how many working ambulances? _____

Have the health facilities been looted? Yes / No

If yes, what medical equipment has been stolen/destroyed? _____

_____

6. Maternal and child health and nutrition

Source of information: Name: _____ Title: _____

Is there access to an emergency obstetric care centre in the area assessed? Yes / No

If yes, which? _____

If no, where is the closest one? _____

What % of children 1–4 years of age have been vaccinated for measles: _____ %

Is there a community child care unit in this location: Yes (No._____) / No

If yes, how many children are enrolled in all units? _____

Is there a therapeutic feeding centre? Yes (No._____) / No

If yes, how many children enrolled? _____

Has there been a recent assessment of malnutrition in this location? Yes / No

If yes, prevalence of acute malnutrition: _____ %

How measured? Weight-for-age / Weight-for-height / MUAC / Other _____

7. Outbreaks of disease

Have there been any infectious disease outbreaks (unusual numbers of cases) in recent days/weeks?

If yes, describe symptoms, place, number of people affected: _____

_____

8. Mine/UXO injuries

Have there been any injuries in recent months from mines or unexploded ordnance: Yes / No

If yes, describe and identify location: **(Do not visit the location!)** _____

_____

9. Other health problems/issues

_____

_____

12. Review of outpatient register

Health facility: _____ Type of facility: _____

Time period (collect data of a recent period, preferably of the week preceding the visit)

Beginning date: _____ Ending date: _____

Diagnosis of outpatients	< 5 years	5+ years	Total
Acute lower respiratory infection			
Acute watery diarrhoea (including cholera)			
Bloody diarrhoea (dysentery)			
Measles			
Meningitis			
Malaria			
Acute jaundice syndrome			
Acute haemorrhagic fever syndrome			
War injury			
Injury (not war-related)			
Malnutrition			
TB new cases (with/without lab. confirmation)			
Diabetes			
Cardiovascular disease			
Other/unknown			
Total consultations during time period			

13. Review of death register

Health facility or data source: _____

Time period (collect data of a recent period, preferably of the two weeks, or more, preceding the visit)

Beginning date: _____ Ending date: _____

Cause of death	< 5 years	5+ years	Total
Acute lower respiratory infection			
Acute watery diarrhoea (including cholera)			
Bloody diarrhoea (dysentery)			
Measles			
Meningitis			
Malaria			

Cause of death	< 5 years	5+ years	Total
Acute jaundice syndrome			
Acute haemorrhagic fever syndrome			
War injury			
Injury (not war-related)			
Cardiovascular			
Respiratory			
Cancer			
Maternal death			
Other/unknown			
Total deaths			

14. Recommendations for immediate public health action

What must be put in place *immediately* to reduce avoidable mortality and morbidity?

Which activities must be implemented for this to happen?

What are the risks to be monitored?

How can we monitor them?

Which inputs are needed to implement all this?

18

Prevention of and response to Sexual and Gender-Based Violence in emergencies (SGBV)

CONTENTS

Prevention of and response to Sexual and Gender-Based Violence in emergencies (SGBV)[1]

Introduction

1. Everyone who is displaced is likely to find their right to personal liberty and security violated, perhaps in numerous ways. Displaced persons are also unable to find safety and security because community structures and groupings break down during flight and displacement.

Definition:

The term SGBV refers to violence that is directed against a person on the basis of gender or sex. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion, and other deprivations of liberty.

While women, men, boys and girls can be victims of gender-based violence, women and girls are the main victims.[2] Nonetheless, in the context of an emergency it is also important to pay close attention to the situation of men and boys as rape and sexual abuse is also used against men and boys in conflict as a means to humiliate and as a form of torture. For the same reasons, the affected men and boys might be less likely to seek assistance. The term SGBV may sometimes be used interchnagably with violence against women or gender based violence. *(More detailed guidance can be found in UNHCR's Guidelines on prevention and response to SGBV and in those issued by the Inter-Agency Standing Committee.[3])*

Causes and factors contributing to SGBV

2. Gender inequality and discrimination are the root causes of SGBV, but displacement increases the risks due to flight, the exposure to armed groups, tensions with host communities, and the mingling with other unknown displaced persons. While war, conflict and internal strife are the primary causes of flight and displacement; rape and other forms of SGBV may also provoke flight, especially when such violence is used as a weapon of war, including in the context of ethnic cleansing. These forms of SGBV may also occur during flight at the hands of bandits, traffickers, border guards, and/or other individuals in authority. Like men and boys fleeing conflict and persecution, women and girls are increasingly obliged to pay people-smugglers and undertake perilous journeys if they are to reach a country where they can claim asylum. The problems of violence and SGBV may continue during displacement, where prior exposure often leads to continuing problems, including further violence. This is particularly true if women and girls have to travel long distances in search of food, fuel and work and if camps or displacement locations are raided by militia.

3. The dangers and uncertainties of emergencies and displacement place great psychosocial strain on individuals, families and communities which can, in turn, provoke domestic violence in camp, rural and urban settings. High levels of violence that result from the flight from conflict, the disruption of social structures, men's loss of their traditional roles, rapid changes in cultural traditions, poverty, frustration, alcohol and drug abuse, and lack of

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[1] ***This section is adapted from*** *Sexual and Gender-based Violence against Refugees, Returnees, and Internally Displaced Persons: Guidelines for Prevention and Response, UNHCR, May 2003;* ***UNHCR Handbook for the Protection of Women and Girls, provisional release, 2006,*** *and Inter-Agency Standing Committee, Guidelines for Gender-based Violence in Interventions in Humanitarian Settings*, September 2005.

[2] This definition is based on the 1993 Declaration on the Elimination of Violence against Women, Article 2. For further details, see Chapter 5, section 5.3.3.

[3] See UNHCR, *Sexual and Gender-based Violence against Refugees, Returnees, and Internally Displaced Persons: Guidelines for Prevention and Response*, May 2003; and Inter-Agency Standing Committee, *Guidelines for Gender-based Violence in Interventions in Humanitarian Settings*, September 2005.

respect for human rights are all factors that contribute to the violence that is inflicted upon women and children. When communities flee, they bring with them their customs and traditions. Among these are harmful traditional practices, such as female genital mutilation (FGM). While often viewed as cultural traditions that should be respected, these harmful practices are human rights violations.

4. Women and girls who are single heads-of-households and/or without family support are among those particularly at risk of SGBV. Girls at heightened risk include unaccompanied girls, girls in foster families, girls in detention, girl soldiers, female adolescents, mentally and physically disabled girls, working girls, girl mothers, children born to rape victims/survivors.[4]

5. Perpetrators are sometimes the very people upon whom the individual concerned depends upon to assist and protect them, including humanitarian workers and peacekeepers. The sexual exploitation scandals in refugee camps in West Africa and Nepal of the early 2000s, involving humanitarian workers, raised awareness of this problem and resulted in the issuance by the Secretary-General of a Bulletin on special measures for protection from sexual exploitation and sexual abuse.[5] The Bulletin applies to all UN staff including UN forces conducting operations under UN command and control, as well as NGO in contract with UN..

Consequences

6. The consequences of SGBV include unwanted pregnancy, contracting sexually transmitted infections, HIV/AIDS, or acute and chronic physical injury,[6] reproductive health problems, emotional and psychological trauma, stigmatization, rejection, isolation, and increased gender inequality.[7] Women and girls who have been raped may be treated as criminals, as has been the case in Darfur, Sudan, where some have been imprisoned and fined by police for illegal pregnancy.[8] Traditional dispute-resolution systems must be identified and monitored as they often do not generally provide adequate redress to women and girls.

Prevention of and Response to SGBV

7. To prevent and respond to SGBV from the earliest stages of an emergency, a minimum set of activities must be undertaken speedily and in a coordinated manner, with all partners (women's groups and organizations, NGOs, Government, UN agencies and the displaced and host community). Survivors/victims of SGBV need assistance to cope with the harmful consequences. They may need health care, psychological and social support, security and legal redress. At the same time, prevention activities must be put in place in coordination with the community to address causes and contributing factors to SGBV particularly in the design of the emergency response. Effective action to

4 UNHCR, *Sexual and Gender-based Violence against Refugees, Returnees, and Internally Displaced Persons: Guidelines for Prevention and Response*, May 2003, p. 71.

5 Secretary-General, "Bulletin on special measures for protection from sexual exploitation and sexual abuse," ST/SGB/2003/13,9/October 2003, available at http://daccessdds.un.org/doc/UNDOC/GEN/N03/550/40/PDF/N0355040.pdf.

6 One such example is the medical condition of fistula, which occurs when the wall between the vagina and the bladder or bowel is ruptured during obstructed labour. Severe pain and chronic incontinence ensue. Fistula is found where health infrastructure and childbirth care are poor, and is common in girls subject to early marriage. It can also be caused by rape. Surgery can repair the injury, but several operations may be required if the case is particularly severe. When fistula results from rape, survivors are routinely rejected and ostracized by their husbands, parents, and communities.

7 UNHCR, *Sexual and Gender-based Violence against Refugees, Returnees, and Internally Displaced Persons: Guidelines for Prevention and Response*, May 2003, pp. 23–24.

8 Médecins sans Frontières, "The Crushing Burden of Rape: Sexual Violence in Darfur," 8 March 2005, p. 6.

prevent and respond to SGBV forms part of UNHCR's protection mandate. It must be incorporated into the early stages of emergency preparedness and later integrated into the country programme.

For more details refer to UNHCR's 2003 Sexual and Gender-based Violence against Refugees, Returnees, and Internally Displaced Persons: Guidelines for Prevention and Response and the IASC's 2005 Guidelines for Gender-based Violence Interventions in Humanitarian Settings.

Objectives

In an emergency setting, multi-functional emergency teams should work together to establish a coordinated multi-sectoral and interagency response with the community to achieve the following:

- Conduct a participatory assessment to identify potential sources of SGBV and positive community prevention actions and responses.
- Design the emergency actions to respond to and prevent SGBV incidents.
- Establish coordinated confidential referral and reporting mechanisms for victims/survivors of SGBV and provide health, psychosocial, legal and material support as well as strengthening prevention.
- Establish and maintain appropriate measures to ensure the safety and security of the displaced population in coordination with the host government and population.
- Raise awareness with staff and the displaced community on SGBV prevention and response including Code of Conduct and the Secretary General's Bulletin on Sexual Exploitation and Abuse.

The key actions to be undertaken by multi-functional teams to achieve these objectives in an emergency setting have been outlined below. Multi-functional emergency teams should comprise of UNHCR and partner staff members (protection, programme, community services, field, security, other sector specialists – medical doctors etc) who work together to ensure interventions consider the whole picture and strategies are adequate, as well as maximizing resources. Together with the people of concern, they undertake participatory assessment and analyse and discuss solutions to protection risks and assistance problems faced by the displaced communities.

Conduct a participatory assessment to identify potential sources of SGBV and positive community prevention actions and responses.

Key actions

- Through participatory assessments with women, girls, boys and men identify the places in the displacement location and surrounding areas which pose risks and danger and where people perceive security risks relating to SGBV and organize observation/spot checks in the displacement area.
- Ensure all assessments undertaken are participatory and include the subject of security and health needs and collect data by age and sex.
- Undertake participatory assessments with small groups of women, girls, boys and men and triangulate the information to assess security and SGBV risks.
- Target groups with specific needs such as unaccompanied boys and girls, child-headed households, persons with disabilities and older persons during participatory assessments as experience has shown they can be particularly exposed to SGBV.
- As much as possible, ensure that technical experts (water and site planners, engineers, nutritionists, health specialists, etc.) join the multi-functional inter-agency team in participatory assessments.

- Pay careful attention to the following areas/situations which often present security risks:
  - border crossings security check points;
  - registration points and situations where there are exchanges with those in authority (when documentation is required, or with those responsible for distributing assistance or authorizing/signing papers or for assistance);
  - distribution points and challenges some might face in accessing assistance, especially sufficient assistance, particularly plastic sheeting, blankets, soap and food;
  - areas where displaced persons, especially women and children, collect firewood, water and graze animals, including in host community areas;
  - communal latrines and showers (even if separate for women and girls) especially during the nights;
  - communal reception and collective centres where there is a lack of privacy;
  - monitor host population areas where the displaced population accesses services such as schools, community centres to ensure that access routes are safe and secure;
  - market places and local community entertainment centres where there is scope for the exchange of money and goods for specific services that could put individuals at risk; and
  - isolated locations which can create risks especially for young children.
- Discuss and agree on best solutions/mechanisms with the community, in particular with women and girls, to address the risks identified.
- Check if women and girls are able to move around on their own, if not ensure female staff are available to visit them at home and discuss their protection concerns.
- Summarize all the key risk areas and share the information with all staff and partners including the protection working group (if established), technical, security and programme personnel.
- Follow up with staff to ensure that the community perspective on the prevention of and response to SGBV is incorporated into the planning and design of the emergency response as well as the budget requirements.

Design the emergency actions to respond to and prevent SGBV incidences

The design of an emergency operational response with government and non-governmental organizations that is sensitive to SGBV issues should include the five main areas outlined below.

a.Establishment of appropriate community management structures and support to promote a community-based approach to protect women, men, girls and boys from different backgrounds

- Promote the meaningful and equal participation of women and men in all community management committees and other decision-making community-based structures (camp, food/NFI, shelter, health, etc).
- In communities where women do not normally participate in public and community activities, provide them with support and opportunities to ensure that their proposed solutions are considered and put into practice.
- Mobilize the community to identify those individuals and groups most at risk of SGBV and agree on community support and joint monitoring mechanisms including community "watch" teams with female participation.
- Identify members of the community with skills, including women repre-

sentatives, to support SGBV prevention and response mechanisms and train them.
- Work with men and boys specifically on preventing to SGBV in all activities.

b. Protection sensitive shelter and site planning

- Through registration identify groups with specific needs and plan according to their risk analysis and taking into consideration cultural considerations which can expose them to further protection risks.
- Ensure sufficient space and privacy is provided for, especially for female headed households including the potential to be able to lock the door.
- Design communal shelters with sufficient space and adequate material for partitions between families.
- Check that the solution provided is the right one in the cultural context (e.g. in certain contexts it will not be correct to place single or widowed women together on their own) and monitor such groups regularly.
- Make arrangements for alternative sources such as solar energy for lighting in communal areas (especially latrines and showers) and for individual use (e.g. torches for families).
- Plan location and design of shelter areas to promote community spirit and reinforce community-based protection, while preserving privacy, safety and security of individuals and the family unit.
- Ensure that women and minority group community members are provided opportunities to participate in decision-making pertaining to the location of services and shelter design.
- Ensure areas children use are safe and can be monitored by the community including roads to school.
- If firewood is scarce or far away and will lead to protection risks introduce alternative fuel arrangements based on the community's assessment of the best alternatives. This is a priority prevention action in areas where women and children will be exposed to SGBV or where men are physically attacked.
- Where women and children are collecting firewood and selling it for income and this poses a danger to them, introduce alternative and equally remunerative income generating activities.
- In consultation with women and if they consider it appropriate, provide for women's centers to enable safe meeting spaces for different activities including health, psychosocial and legal services in response to SGBV.

c. Effective food and non-food items distribution

Age and sex disaggregated data should be collected to ensure effective planning and distribution based on the specificities of the population.

- All decisions in relation to food and non-food items should be taken with the direct participation of the community and in particular with women of diverse backgrounds and ages.
- All distribution must be monitored regularly, especially during the emergency phase. Follow up focus group discussions should be held with the different members of the community, especially groups with specific needs, to monitor equitable distribution and identify any risks of sexual or other types of exploitation or abuse.
- Set up community based distribution services to support child and grandparent headed households, single older persons and those with disabilities and monitor the system for any

potential abuse.

- Facilitate distribution of individual identity documentation and avoid using ration cards as a substitute for documentation.
- Decide with women who should receive the family ration card.
- Provide sanitary materials, selected and distributed on the basis of discussions with women and girls, to all those of reproductive health age (estimated 25% of total population).

d. Effective protection systems and services

- Establish a system for the early identification of persons who might be at heightened risk of SGBV
- Identify relevant national laws and policies (especially those pertaining to marriage and divorce laws, rape and domestic violence laws, inheritance laws etc) in coordination with local women's associations and analyse them to see if they conform to international human rights laws and promote the rights of the victim/survivor.
- Understand how the displaced community members handled SGBV from a legal perspective prior to displacement by conducting participatory focus group discussions with women and men, including adolescent girls and boys.
- If customary practices and informal justice systems are activated by the community work with leaders ensure they respect international human rights and if necessary provide training on human rights and conduct a comparative analysis with the community on how their system can respect individual human rights.
- Work with the community to institute arrangements for community watch committees with fifty percent female representation and participation and provide appropriate knowledge and skills training.
- Work with partners to promote enrolment of girls in schools and skills training centers for boys and girls and ensure that such institutions are protected from attack and recruitment.
- Promote equal numbers of female teachers in schools and training centers who serve as role models for girls and the community at large.
- Provide specific training/briefings on the implementation of Security Council Resolution 1325 on Women, Peace and Security and SGBV prevention and response for teachers, schools administrators and community representatives and leaders.
- Promote food security and livelihood strategies, particularly for girls with children, single women headed households, young widows, older women and men who are most at risk of abuse, exploitation, and rejection.
- Ensure that programmes for child soldiers address the particular concerns of young mothers and their children.
- Promote other measures, including family reunification, skills training for income earning and recreational activities, both as preventive measures and for girls and boys who have been demobilized.

Finally, establishing schools and education structures early in an emergency will facilitate the prevention of and monitoring of sexual and gender-based violence and it is important to work with teachers on this.

Establish coordinated confidential referral and reporting mechanisms for victims/survivors of SGBV and provide health, psychosocial, legal and material support as well as strengthening prevention.

Key actions

Identification and analysis

- As a multifunctional team with partners, agree on measures to gather information on SGBV including a close review of existing information. In refugee settings, UNHCR will normally take the lead coordination role and in internally displaced persons (IDP) settings United Nations Population Fund (UNFPA) will normally take the lead and UNHCR should actively support the process.
- If a protection working group exists, share all relevant information, and if necessary establish an inter-agency, multi-sectoral SGBV working group.
- Identify key actors/partners, both local and international with access to the fleeing population, in particular women and girls, who may have information about SGBV incidents, in particular health partners and traditional midwives among the displaced population to gather first impressions. Review findings of any health assessments undertaken to check for signs of reported incidents of SGBV.
- Analyse local legal responses to SGBV and cultural perceptions of causes of SGBV among the displaced and the host population.
- Identify key people with relevant skills among the displaced population who can assist, such as doctors, nurses, midwives, and women and men in leadership roles.
- Be on the look out for information relating to community practices that might be harmful to survivors of SGBV or lead them to be dissuaded from seeking assistance and psychosocial support.
- Establish same sex health, psychosocial and legal counselling and services for SGBV victims/survivors and their family members in such a way so as not to draw attention to their situation.
- With the inter-agency protection and/or SGBV working group agree on mechanisms for sharing statistical data and establish a database to provide daily/weekly reporting with a breakdown of cases by age and sex, as well as type (rape, sexual abuse, sexual exploitation, domestic violence, etc).
- Based on an age, gender and diversity analysis of assessments, and in coordination with key persons (if possible at this stage selected by the community) from the displaced mechanisms, develop a plan of action for prevention and response. This should be based on the guiding principles set out in the SGBV guidelines to ensure that the rights and dignity of women and girls are respected, as well as those of men and boys.
- As soon as possible establish Standard Operating Procedures for prevention of and response to SGBV with the action plan coordination with partners.

Referral

- Agree on confidential mechanisms to refer and report on incidents of SGBV and which agencies will provide which kind of assistance (health, psychosocial, legal and security).
- Jointly with partners draw up a SGBV prevention and response information, education and communication plan and disseminate SGBV prevention messages.

- Inform the community in as many ways as possible on these mechanisms and do not rely only on leaders to transmit the information, work with young adolescent girls and boys, single women, etc.
- Ensure the safety of the victim/survivor and his/her family at all times.
- Respect the wishes, rights and dignity of the victim/survivor while also bearing in mind the safety of the wider community as well as the individual concerned.
- In the case of children, ensure expert support to enable age sensitive interviewing and appropriate counselling. In some cases it might be necessary to conduct a Best Interests Determination assessment especially in the case of unaccompanied and separated children.
- Ensure that all allegations of rape and other forms of SGBV are promptly, thoroughly and independently investigated and followed up as per inter-agency agreed response mechanisms.
- Set up a confidential case file management system.
- Provide training to interpreters.
- Prior to counselling survivors to file for legal recourse, conduct a thorough analysis of the security consequences for the individual and his/her family, as well as of the effectiveness of the national legal justice system.
- Ensure clear and timely referral systems for affected persons to receive medical and psychosocial support.
- Accompany any survivor who opts for legal redress to the authorities involved and ensure appropriate standards of treatment, including confidentiality during interviews.
- When necessary make arrangements for persons at heightened risk or who fear for their safety in the community to relocate to a safe area and provide individual follow-up support and monitoring. If the alleged perpetrator is in the community the best option is to discuss this with security services and provide discreet and specialized security services for the survivors and whenever possible make arrangements for the perpetrator to be removed.
- Work with the local police and justice system to ensure a sensitive, appropriate and just response to SGBV cases.
- When necessary and appropriate consider emergency resettlement for SGBV survivors or those persons at heightened risk with no safe alternatives.

Health and psychosocial response

- Ensure all medical staff are trained in the Clinical Management of Rape Survivors[9] and prevention of and response to SGBV.
- Check that medical centres have sufficient supplies of treatment for STI's, emergency contraceptives and post exposure prophylaxis according to national, international and WHO standards.
- Promote female to female health services and translators as required.
- Work with the community to identify and understand how the community normally responds to SGBV and the subsequent emotional trauma.
- Analyse whether these mechanisms respect individual rights and if appropriate strengthen community-based mechanisms for psychosocial support as well as providing for individual counselling.

9 Clinical Management of Rape Survivors – Developing protocols for use with refugees and internally displaced persons (Revised Edition) World Health Organization and United Nations High Commissioner for refugees, 2004.

- Ensure health centers monitor and provide pre-natal maternal health services for pregnant women who may be rape survivors and could require specific support, particularly if they have to be discreet about the pregnancy, due to possible negative repercussions from the family, community or local authorities.
- Early identification of pregnant women in the emergency phase can facilitate safety and security and emotional support when "unwanted" babies are born.
- Be aware of possible negative perceptions towards children born of rape and make arrangements with the community for possible "foster care" of children, if appropriate and feasible.
- Medical centers should follow agreed upon reporting mechanisms and refer survivors who consent for individual psychosocial counselling and refer to legal support centers as required.
- Ensure that former girl and boy child soldiers receive medical assistance, especially related to sexual and reproductive health and sexually transmitted infections (STIs), and psychosocial counselling and follow-up.[10]
- Make sure that forensic evidence is collected according to national protocols to support legal follow up if desired.

Establish and maintain appropriate measures to ensure the safety and security of the displaced population in coordination with the host government and population

Key actions

- Review location of displaced persons and relations with host population.
- Assess existing local security responses to identify and respond to protection gaps including gender imbalance and gender insensitive strategies in protection management and implementation.
- Build partnerships with local authorities and seek their views and understand their attitudes on the safety and security of the displaced persons in particular women and children, and identify interventions to address the safety and security gaps.
- Ensure community policing and security structures take into consideration the specific risks faced by women and men of different age groups and backgrounds and that high risk areas are monitored.
- Arrange for regular patrols by police, security guards or community watch teams of all areas identified by the community and women and children in particular, as being unsafe.
- Identify with all actors, including members of the host community through focus group discussions, the causes of tension, in particular issues in relation to sharing of natural resources such as forests, grazing lands, irrigation and water sources, waste lands etc and opportunities for farm labour and other paid work activities for displaced women and adolescents. Work with all actors to seek solutions.
- Agree on joint mechanisms with host Government and population to ensure safety and security in partnership with civil society and displaced communities.
- Provide support and capacity building to local/host authorities as required, participate in and take an active interest in their and the host community's welfare and promote joint benefits as far as possible.

[10] Save the Children, *Forgotten Casualties of War: Girls in Armed Conflict*, 2005.

- Ensure there are adequate numbers of properly trained police and security personnel and promote gender parity among all security staff.
- If a camp situation, armed security personnel should be situated outside the camp.

Raise awareness with staff and the community on SGBV prevention and response, including Code of Conduct and the Secretary General's *(SG's)* Bulletin on Sexual Exploitation and Abuse as well as coordination mechanisms.

Community

- Identify key, well respected women and men from the community who will be able to gain broad support for the work on SGBV prevention and response and promote the community-based SGBV reporting mechanism.
- Agree with the community the best method to disseminate information on the prevention of and response to SGBV and the key messages to be transmitted.
- Consult with women and girls in particular to verify that the information is culturally appropriate, clear and conveys the intended message.
- Work with the community leaders and members on their role and responsibility to protect and care for survivors and not blame or reject them.
- Emphasize that SGBV reporting, referral and response services, including complaints related to sexual exploitation and **abuse are** confidential and explain how confidentiality will be respected.
- Explain potential consequences of SGBV (unwanted pregnancy, HIV/ infections, etc.) and the treatment and services that will be made available.
- Clarify the psychosocial consequences of SGBV (fear, anxiety, panic attacks, withdrawal, depression, feeling hopeless, isolation, etc.).[11]
- With the community leaders explain the mechanisms jointly proposed for preventing, reporting and responding to SGBV cases, as well as sexual exploitation and abuse cases and other complaints involving humanitarian workers or peacekeeping and security personnel.
- Obtain feedback from different members of the community on the proposed reporting and complaints procedures. Once they are functioning monitor them carefully with the community to check their effectiveness.
- Provide information on UNHCR's Code of Conduct and the Secretary General's Bulletin on Sexual Exploitation and Abuse (SEA) and good practices related to good conduct of humanitarian personnel.
- Use different methods (leaflets, posters, radio talk programmes, classes, and exhibitions, street theatre) to reach out to people through mass campaigns and focus group discussions in market places, distribution and community centres, schools and health centers.

Security personnel

- Coordinate with host/local authorities to assess the level of knowledge and skills available on prevention and response to SGBV, as well as on Code of Conduct and SG's Bulletin on sexual exploitation and abuse.
- Agree on training needs and deliver mini-trainings/briefings as soon as possible and as the situation allows

[11] *See Inter-Agency Guidance on Mental Health and Psychosocial Support in Emergency Settings, to be released in 2006 (IASC).*

in the emergency phase. As far as possible use national legislation to support the messages, as well as regional and international legal instruments, particularly those relating to the rights of women and children.

- Include in the training/briefings information on UNHCR's Code of Conduct and the Secretary's Bulletin on Sexual Exploitation and Abuse.
- Promote gender balance in all security forces (military, police and local).

UNHCR and partner staff

- Assess knowledge and skills on prevention and response to SGBV among UNHCR and partner staff and arrange for mini-training/briefing sessions using Inter-Agency Standing Committee, Guidelines for Gender-based Violence Interventions in Humanitarian Settings, UNHCR's Code of Conduct and the Secretary General's Bulletin on prevention and response to sexual exploitation and abuse (SEA).
- Ensure that all partner agencies whether Governmental or NGOs sign agreements with UNHCR to include an Annex on complying with Codes of Conduct.
- All UNHCR and partner staff should sign the Code of Conduct.
- Establish systems for SEA focal points as required by the SG's Bulletin.
- Monitor and report on SEA cases to the UNHCR Inspectors Generals Office, and report on SGBV prevention and response activities in situation reports.
- Promote 50% female staffing in all functional areas including senior management, both in relation to UNHCR and partners.
- Finally, all staff, UNHCR, partners and security personnel, should wear clear identification tags and names and functions should be provided in writing to the community so that follow-up can be provided in the case of complaints.

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HIV and AIDS

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Overview

Situation

Conflict, displacement, food insecurity and poverty have the potential to make affected populations more vulnerable to HIV transmission. In addition, HIV/AIDS may reduce the coping mechanisms and resilience of such populations. While populations affected by conflict often have lower HIV prevalence than surrounding host populations, they must be included in any successful effort to combat the epidemic. It is incumbent upon UNHCR to incorporate HIV/AIDS interventions into the overall emergency response from the onset. If not addressed, the impacts of HIV/AIDS will expand beyond the current crisis, influencing the outcome of the response and shaping future prospects for rehabilitation and recovery.

Objectives

- Refugees and asylum-seekers live in dignity, free from discrimination, and their human rights are respected.
- Reduced HIV transmission through access to prevention, care and treatment programmes.

Principles of response

- Oppose mandatory testing of asylum-seekers and refugees since this does not prevent the spread of the virus and is at variance with relevant human rights standards.
- To direct HIV and related programmes, ensure that key information is available using the HIV Information System (HIVIS) in order to determine how to implement HIV programmes and provide a baseline to monitor and evaluate programme response.
- Ensure that multi-sectoral coordination systems are established in all sectors of the operation. The inclusion of affected populations, as well as surrounding host populations, in coordination activities together with at risk groups (e.g. women, minority groups, adolescents) is important.
- When implementing minimal essential HIV/AIDS interventions, the programme should be established according to the Inter-Agency Standing Committee (IASC) guidelines for HIV Interventions in Emergency Settings that highlight the following sectors: protection, health, community services, camp management and shelter, water and sanitation, education, and food security and nutrition services.
- Ensure access to prevention and response services for sexual and gender-based violence (SGBV).
- For persons that have started anti-retroviral treatment (ART), continued access to ART must be made available.
- Ensure that people living with HIV and AIDS (PLWHAs) have continued access to support, care and treatment services.
- Under no circumstances must refugees be persecuted on the basis of their HIV infection (e.g. prevent restrictions to freedom of movement imposed on the grounds of HIV status).
- Humanitarian staff must be protected from occupational and non-occupational exposure to HIV.
- During all operations, the code of conduct must be emphasised and adhered to by members of staff.
- Ensure staff have access to HIV prevention measures, including information and condoms and health insurance benefits.

Actions

- Establish multi-sectoral inter-agency coordination systems and meetings to ensure that HIV/AIDS is addressed in all aspects and phases of the response.
- Assess baseline HIVIS data and based on this information establish priority needs and determine required human, material and financial needs and necessary resources.
- Assess whether the HIV status of affected populations is being used in a discriminatory manner and react accordingly. Oppose mandatory HIV testing and any discriminatory measures based on HIV status.
- Protect women, children and other at risk groups and ensure that SGBV programmes establish programmes for appropriate social and medical response to rape and violence, including HIV prevention measures such as post-exposure prophylaxis (PEP).
- Include HIV/AIDS interventions in all sectoral activities such as protection, health, community services, camp management and shelter, water and sanitation, education, food security and nutrition services.
- Follow the IASC guidelines on HIV Interventions in Emergency Settings as well as national and World Health Organization (WHO) protocols and guidelines.
- Establish proper monitoring and surveillance systems using HIVIS.
- Provide staff members with access to HIV information and prevention interventions.

Introduction

1. HIV and AIDS are a policy priority for UNHCR with the ultimate goal of integrating such programmes across all sectors, including protection, community services, health, food and nutrition and education. It is important that HIV and AIDS interventions start at the onset of an emergency and continue throughout the programme cycle.

2. During a humanitarian crisis, the effects of poverty, powerlessness and social instability are intensified. Unfortunately, these are the very conditions that favour the spread of HIV. Such conditions include:

i loss of income, livelihood, homes, health care and education;
ii. increased powerlessness that often leads to sexual exploitation and violence;
iii. severe impoverishment that often leaves women and girls with few alternatives but to exchange sex for survival;
iv. mass displacement that leads to the break-up of families and relocation into crowded camps;
v. breakdown of school, health and communication systems; and
vi. limited access to health and prevention services.

3. Displacement generally brings populations, often with different HIV prevalence, into varying degrees of contact. While populations affected by conflict do not necessarily have high HIV prevalence and in fact, often have lower HIV prevalence than surrounding host populations, they must be included and integrated into host country HIV policies and programmes in any successful effort to combat the epidemic.

Initial response

4. There is an urgent need to include HIV and AIDS into the overall emergency response. If HIV/AIDS is not addressed at the onset of the emergency, its impact will expand beyond the current crisis, influencing the outcome of the response and shaping future prospects for rehabilitation and recovery.

5. Prioritising the response should be based on the implementation of the minimal essential HIV/AIDS interventions in line with the Inter-Agency Standing Committee (IASC) guidelines for HIV Interventions in Emergency Settings (see matrix in table 1, page 403) and adapted to each situation according to its context. The matrix outlines the areas for emergency preparedness, the minimum response and the comprehensive response. The IASC booklet provides detailed guidance in the form of fact sheets on activities required in the minimum response. It is essential that HIV is taken into account in all stages of operation planning and vulnerability assessments, participatory assessments and programme planning should also include HIV and AIDS.

Protection

6. There is a strong and inextricable linkage between protection, human rights and HIV/AIDS.

7. As a result, UNHCR has established the following 10 key points on HIV/AIDS and the protection of refugees, IDPs and other persons of concern.

1. ***Non-discrimination:*** Refugees, IDPs and other persons of concern to UNHCR who are living with HIV should live in dignity, free from discrimination and stigmatization.

2. ***Access to HIV and AIDS health care:*** Refugees, IDPs and other persons of concern to UNHCR benefit as any other individual from the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

3. ***Access to Asylum Procedures and Protection from Expulsion and Refoulement:*** The HIV status of an asylum-seeker does not constitute a bar to accessing asylum procedures. The right to be protected against refoulement is the cornerstone of international refugee law and HIV status is not a ground for any exception to this principle. HIV status would also not fall within the permitted grounds for expulsion to a third country.

4. ***Protection from arbitrary detention and unlawful restrictions on freedom of movement:*** Detention or restrictions on the freedom of movement of persons living with HIV and AIDS is in violation with the fundamental rights to liberty and security of the person, as well as the right to freedom of movement.

5. ***Respect for confidentiality and privacy:*** The HIV status of a person is confidential and should not be shared without the consent of the individual concerned.

6. ***Provision of voluntary counselling and testing (VCT):*** UNHCR supports the use of VCT programmes as long as international standards are met and promotes equal access for persons of its concern to existing VCT programmes.

7. ***Freedom from mandatory testing:*** UNHCR strictly opposes mandatory HIV testing of asylum-seekers, refugees, IDPs and other persons of concern as this is at variance with relevant human rights standards.

8. ***Access to durable solutions:*** The attainment of a durable solution should not be jeopardized by the HIV status of a refugee or a family member. The right to return to one's country may not be denied on the basis of HIV status. With respect to local integration, ensure access to local health and HIV- and AIDS-related services on an equitable basis with nationals in the host country. In the context of resettlement, ensure that where testing is done, human rights are respected and voluntary counselling and testing standards are met. Automatic waivers should be given for HIV-positive resettlement cases.

9. ***HIV-related protection needs of women, girls and boys:*** Women and girls are disproportionately affected by HIV and AIDS. Ensure their protection against sexual or physical violence and exploita-

tion. Special attention must also be paid to children affected by HIV, including those orphaned or otherwise made vulnerable by HIV.

10. ***Access to HIV information and education:*** Ensure widespread provision of information about HIV and AIDS to refugees, IDPs and other persons of concern, particularly with regard to HIV-related prevention and care information as well as information related to sexual and reproductive health.

Coordination

8. The main goal of the coordination effort is to meet the needs of the affected population in an effective, coherent and complimentary manner. The presence of HIV and AIDS adds a further dimension to both the crisis and the aftermath. It is therefore essential that all efforts are made to ensure that a multisectoral coordination mechanism is established.

UNHCR must ensure that the affected communities are involved in planning coordination activities, including host surrounding communities. It is important that women, educators, minority and religious groups, and adolescents are represented.

The following key actions listed below should be considered when establishing a coordinated response from the outset of an emergency response. These include establishing and strengthening coordination mechanisms, providing information and technical support, assessing the HIV situation, and establishing a monitoring and evaluation system.

9. Establish and strengthen coordination mechanisms:

- Identify an HIV/AIDS focal person to take the lead in the coordination of the response to HIV and AIDS. This can be someone from UNHCR (e.g. Programme Officer, Community Services Officer, Protection Officer or Health Coordinator), a government official or someone from UNHCR's implementing or operational partners.
- Promote the incorporation of HIV/AIDS prevention, care and mitigation into situation assessments, participatory assessments and programme planning and response.
- Institute an ongoing review to ensure that HIV/AIDS issues are addressed in all aspects of the operation.
- Work closely with the National AIDS Control Programme and UNAIDS co-sponsors.
- Ensure that both populations of concern and surrounding host populations are involved in the development of programme activities (e.g. community leaders, women's representatives, adolescents).
- Develop a joint plan for implementation; use the HIV/AIDS and Conflict/Displaced Persons Assessment and Planning Tool. (See Frame work at page 406)

10. Provide information and technical support:

- Ensure that appropriate support is provided to all stakeholders for strategic planning, assessment, monitoring and analysis in relation to HIV/AIDS.
- Ensure that national or WHO HIV and AIDS protocols are available and shared with all stakeholders.
- Ensure that HIV/AIDS is taken into account in all stages of planning of the operation; provide support to programme implementation as required.

Assessing the HIV situation

11. In order to coordinate and collaborate with other organizations and authorities, it is essential to set up a standardized database. This database will improve the understanding of the situation, guide pro-

gramme implementation, and provide a baseline for future monitoring and evaluation.

- Review and use existing baseline data from HIV/AIDS programmes.
- Perform HIV/AIDS rapid risk and vulnerability assessment.
- Review existing information and undertake local needs assessments to identify populations most at risk and priority areas for interventions.
- Important information that should be collected is:

i. existing sero-prevalance rates in country of origin and host-country (use nearest sentinel surveillance sites);
ii. HIV/AIDS services to which population had access in the country of origin, including ART, and prevention of mother-to-child transmission programmes;
iii. current level and quality of health services in host country;
iv. background information on demographic and education levels; and
v. type and level of risk factors that make women, children, single-headed households, minority groups, persons with disabilities and drug abusers more vulnerable to HIV transmission.

- Use the Assessment and Planning Tool Framework on page 406 to guide your work.

Establish a monitoring and evaluation system

12. During the acute phase of an emergency, the core programmes described in the IASC matrix should be implemented. Beyond these basic activities, other HIV/AIDS programmes may be continued depending upon the ongoing programmes in the country of origin and host country. Monitoring must be conducted with short-term, mid-term and long-term goals in mind.

13. Using the basic indicators provided in the Assessment and Planning Tool Framework item 10 on page a census needs to be carried out in order to harmonize with existing government indicators.

Only a minimum amount of indicators should be collected to direct programme decision-making and to ensure sufficient baseline data for future monitoring and evaluation.

14. Collect and analyse the data and then provide feedback to the government, partners and the affected communities.

Health response

15. Health coordinators need to consider the special needs of people at risk particularly children and women who are usually the most severely affected by any crisis. All PLWHAs and their families should, of course, be included in any response.

Special attention should be given to high-risk groups such as commercial sex workers, injecting drug users, and men having sex with men.

It is important that programmes are integrated with existing health and reproductive health services; vertical programming should be avoided.

Universal precautions

16. Infection prevention measures are crucial to the safety of health workers, patients and communities. Even with limited staff, equipment and funds, essential measures must be taken to avoid the transmission of infectious diseases such as HIV (as well as syphilis and the various types of hepatitis) through a comprehensive plan for prevention of disease transmission (for more details see chapter 17 on health).

17. The following key actions should be taken into consideration during a health response:

- Ensure running water is available in the health facilities.

- Ensure gloves, needles and syringes are available in sufficient quantities. In health facilities that perform surgical interventions/caesarean sections, ensure availability of goggles and masks.
- Ensure aseptic techniques are used.
- Ensure procedures are put in place for proper sterilization of medical instruments and other medical materials.
- Ensure that health staff are trained on universal precaution procedures.
- Establish guidelines for proper waste management and ensure that all health and support staff (e.g. cleaners) are trained on safe waste disposal (numerous protocols exist from WHO and other organizations).
- Ensure functioning incinerators in a safe and fenced area to safely dispose of medical waste.

Blood transfusions

18. HIV is easily transmitted through blood and thus a safe blood supply is essential and fundamental. Where blood transfusions are provided, they should be safe and follow national and WHO protocols for blood screening and transfusion.

19. Avoid unnecessary use of blood; only give blood transfusions in life-threatening circumstances and when no other alternative is possible (use as a reference the Clinical Use of Blood, WHO 2001).

20. Where blood transfusions are provided in hospitals near the refugees, ensure that basic supplies like reagents, test kits and blood bags are available in sufficient quantity.

Blood donations

21. Ensure that safe donors are selected. Selection of donors can be promoted by giving clear information to potential donors regarding when it is appropriate or inappropriate to give blood. Blood from voluntary, non-remunerated donors is safer than blood from paid donors. Thus, paid donors should be avoided: at the earliest opportunity measures should be instituted to recruit voluntary donors only.

Test all blood donated for transfusion in line with the national or WHO protocols.

22. Screening for HIV, Hepatitis B, syphilis and where possible also for Hepatitis C, should be carried out using the most appropriate assays. In acute emergencies, rapid tests should be used and results of all tests must be treated as strictly confidential.

23. If voluntary counselling and testing (VCT) exists, potential donors should be encouraged to undergo VCT and results provided in a confidential and private manner with appropriate counselling and follow-up. In those cases where VCT in unavailable, results of the HIV tests must not be linked to the potential donor (e.g. one does not inform the client).[1]

Sexually transmitted infections (STIs)

24. Sexually transmitted infections (STIs) are responsible for significant morbidity in adults (and newborns) and may result in complications such as infertility in women and men, cervical cancer, congenital syphilis, low birth weight of newborns, miscarriage and stillbirths. The presence of an STI can increase both the acquisition and transmission of HIV.

25. Immediate actions for the prevention and control of STIs are key strategies in reducing the spread of HIV/AIDS, and can be carried out as follows:

- Provide early and effective STI case management.

[1] *Although this is an unsatisfactory situation, clients who wish to provide blood are not told of their HIV status unless they agree to undergo VCT because blood is only tested with a screening test and not a confirmatory test; thus, there will be some false positives (persons who are negative but the test shows a positive). In the future, as ART becomes available and more routine voluntary testing occurs, this situation may change.*

- Provide standardized syndromic treatment; use national treatment protocols when available and appropriate; if unavailable, use WHO protocols.
- Ensure consistent availability of appropriate drugs (see chapter 17 on Health).
- Ensure that partner tracing is undertaken (i.e. notification and treatment of partners). To facilitate this tracing, each client should be provided with anonymous cards to give to their contacts; management of contacts should be confidential, voluntary and non-coercive.
- Ensure that health education and STI and HIV prevention awareness is provided to STI clients and that clients are provided with condoms and instructions on their use.
- Establish data collection systems for the monitoring of the number of STI cases presenting for treatment by syndrome, sex and age group.
- Plan comprehensive STI prevention, management and surveillance programmes at the earliest opportunity.
- Ensure that the health staff are trained and able to diagnose and treat STIs according to the syndromic approach. Explain the importance of treating the partner as well as promotion and explanation on the use of condoms.

Provision of condoms

26. Condoms offer protection against transmission of STIs and HIV as well as unwanted pregnancy if they are used correctly and consistently. One of the most urgent tasks is to make sure that people have access to **correct** information and that condoms are made **free of charge** and **readily available**.

27. Male and female condoms should be considered as essential items in emergency relief supplies. At the onset of the emergency, Reproductive Health Emergency Kits can be ordered which include both male and female condoms, together with information leaflets.

28. UNHCR has a memorandum of understanding with the United Nations Population Fund (UNFPA) that takes into account the provision of condoms in emergency situations as well as in more established refugee situations. Close collaboration with the UNFPA country offices and the UNFPA humanitarian unit at headquarters is encouraged.

Condom distribution and quality

29. The location of condoms must be carefully considered in order to ensure wide and confidential access. Condoms should be made available to the wider community and not only in health facilities (e.g. places such as food distribution sites, information sites, bars, market places and other relevant sites should be considered). The decision should take into account cultural issues and the communities need to be involved.

30. Condoms of good quality are essential. Condom quality is determined by the quality of the consignment, but also by the handling and storage of condoms at the site. When condoms are ordered locally it is important to ensure that condoms have passed quality tests.

Calculation of condom supplies

31. **Male condoms:** there are many formulas to calculate the number of male condoms required. The easiest formula is to take the total population and use the following formula: No. of condoms / population in 1 month.

In an emergency situation, the indicator to reach is to distribute the equivalent of 0.5 condoms/person/month. In the post-emergency phase, the indicator increases to 1 condom/person/month

Female condoms: For one month, 150 female condoms /10,000 population.

Sexual and gender-based violence (SGBV)

32. The prevention and response to sexual and gender-based violence (SGBV) should be a coordinated approach (see chapter 17 on health, and chapter 11 on CBA and community service). Clinical management of the consequences of rape and the prevention of HIV transmission is essential.

Responding to SGBV

33. Ensure that health care providers are trained to provide appropriate care. Female health care providers should be trained as a priority, but a lack of female trained health workers should not prevent the service from providing care to survivors of rape.

34. Medical examination should be conducted in privacy and should safeguard the survivor's confidentiality. Perform a medical examination only with the rape survivor's consent.

35. Provide treatment in a confidential manner and in line with the national protocols or the WHO/UNHCR guidelines for clinical management of rape, revised edition, 2003:

- presumptive treatment or treatment for STIs;
- prevention of transmission of HIV through provision of a 28-day course of post exposure prophylaxis within 72 hours post rape;
- provide emergency contraception within five days post rape;
- provide wound and injury care;
- provide tetanus and hepatitis B vaccinations;
- provide follow-up care;
- provide counselling and treatment for psychological trauma; and
- refer to social, legal and protection care services.

36. Together with the Protection Officer identify who is entitled to collect forensic evidence in line with country regulations concerning the type of evidence that needs to be collected. Forensic evidence can only be released to the authorities with the survivor's consent. All types of preventive treatment can start before the evidence is collected.

People living with HIV/AIDS (PLWHAs)

37. With the introduction of the universal Access to anti-retroviral treatment (ART) campaign, more and more people will have access to ART. According to UNHCR's policy on ART for refugees, refugees should have access to ART when surrounding host populations have access to ART. Consequently, over time, an increasing number of conflict-affected and displaced populations will be on ART.

Key actions for UNHCR's anti-retroviral treatment policy for refugees are as follows:

38. In collaboration with the national government and with support from UNAIDS and their co-sponsors, ensure the continuation of ART for people affected by emergencies who were previously on ART, is permitted.

Follow the country's national treatment protocols for the provision of ART and advocate for the inclusion of persons of concern to the national programmes.

39. In line with country and/or WHO protocols, provide cotrimoxazole prophylaxis to PLWHAs. In addition, ensure that PLWHAs have access to insecticide treated nets to prevent malaria.

Additional assistance

40. Facilitating access to safe water and sanitation for families with chronically ill members, including PLWHAs, is essential. PLWHAs may have difficulty

obtaining water due to stigmatization and discrimination, limited energy to wait in long queues, or insufficient strength to transport heavy water containers. Provide hygiene education and promotion and dispel myths and misconceptions about contamination of water with HIV.

41. As a part of the emergency response, ensure that supplementary feeding programmes are established for people with chronic diseases, including PLWHAs. Although targeting food aid to PLWHAs and their families is complex, ensure that targeted food aid does not further stigmatize affected and infected persons.

Establishing comprehensive HIV/AIDS prevention and care services

42. From the onset of the emergency, it is important to plan for the establishment of comprehensive HIV/AIDS programmes. The key actions regarding HIV/AIDS programmes that should be expanded in the stabilized phase are:

- voluntary counselling and testing (VCT) services;
- prevention of mother-to-child transmission services;
- development of more comprehensive and targeted HIV prevention and awareness programmes;
- development of palliative care and home-based care programmes for PLWHAs;
- ensure prophylaxis and treatment of opportunistic infections are established;
- as mentioned above, in line with country or WHO protocols, provide cotrimoxazole prophylaxis to PLWHAs;
- establish links between STI clinics, tuberculosis programmes and VCT services;
- presumptive treatment for malaria for pregnant HIV positive women together with insecticide-treated nets (note, this should be part of an existing programme for all pregnant women); and
- provision of ART.

Food and nutrition

43. Special attention must be given to the nutritional needs (micro and macro) including food rations in emergency operations with a high HIV prevalence. PLWHAs have special dietary and nutritional needs that need to be taken into account. Adequate intake of energy, protein and micronutrients is essential for coping with HIV and fighting opportunistic infections.

44. Specific guidance on food and nutrition as well as breastfeeding for HIV positive mothers is provided in chapter 16 on food and nutrition. More information can also be found in the UNHCR and WFP document entitled "Integration of HIV/AIDS activities with food and nutrition support in refugee settings: specific programme strategies", (2004).

Education

45. Education provides an important protective function for children in emergencies (see chapter 11 on CBA and community services and chapter 20 on education). Schools are places not only for teaching traditional academic subjects but also for the dissemination of HIV/AIDS awareness and life skills training.

46. When education programmes are being implemented, staff must:

- ensure that HIV prevention issues are included in the school curriculum;
- coordinate with other agencies to provide teaching materials that include HIV prevention and life skills trainings; and
- ensure that girls have access to schools and to HIV prevention education through provision of a safe environment free from fears of

harassment or sexual abuse by other students and teachers.

Information on behaviour change and communication (BCC)

47. Communication in emergency situations is essential to assist people in maintaining or adopting behaviour which minimizes the risk of HIV transmission, as well as to ensure that PLWHAs have access to treatment and care services. Do not limit HIV prevention education to schools, but ensure that HIV prevention information is disseminated at distribution sites, markets and other areas where many people gather (i.e. formal and informal education). A key role for BCC lies with the communities themselves together with support from Community Service Officers.

48. It is crucial that communities have ownership of HIV prevention activities through involving them in the identification of priority topics, messaging and development of materials and strategies. Materials on HIV/AIDS prevention and transmission must be culturally and linguistically appropriate and should be part of a comprehensive BCC plan early on during the emergency in order to implement it during the more stable post-emergency phase.

49. Ensure that groups at risk are especially targeted in the HIV prevention activities and that these groups have confidential access to information on HIV/AIDS.

HIV information system (HIVIS)

50. Data is an essential requirement to direct HIV and related programmes as well as to assess their effectiveness. The HIVIS encourages integrated HIV programming by assessing and providing baseline data for conflict affected populations as well as surrounding populations. It examines interactions and HIV prevalence between the populations. It may also be used in a similar fashion for displaced populations and populations of return.

51. The HIVIS consists of 3 components:

1) surveys – behavioural surveillance surveys (BSS) and sentinel surveillance surveys;

2) monthly facility reporting (provided on page 407); and

3) inspections by checklist (provided on page 408).

52. Ensure that all data collected is used as a monitoring and evaluation tool to improve the integrated HIV and AIDS programmes. Also, provide feedback on the information collected to all partners and governments.

Humanitarian staff

53. There should be no discrimination against staff on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV/AIDS (PLWHAs) inhibits efforts aimed at promoting HIV prevention.

Workplace information and educational programmes are essential to combat the spread of the epidemic and foster greater tolerance and understanding.

54. Providing HIV/AIDS information in the workplace, including information about employees' health insurance plans as well as basic HIV/AIDS materials (e.g. information leaflets, condoms, location of VCT sites), are some of the key actions in protecting humanitarian staff. Staff should also have access to post exposure prophylaxis (PEP) for occupational and non-occupational exposure to HIV.

55. Also ensure that staff are aware of staff health insurance benefits regarding HIV and related diseases.

Create an open and supportive work environment; facilitate dialogue around HIV and AIDS among the staff.

56. In addition, provide training on key issues relating to HIV/AIDS including confidentiality, protection and other human rights issues.

In all operations, emphasize the code of conduct and ensure that the code of conduct is adhered to by all staff members.

Key references

1. Guidelines for HIV/AIDS interventions in emergency settings – Inter-Agency Standing Committee, 2003.

2. Directives concernant les interventions relatives au VIH/SIDA dans les situations d'urgence – Inter-Agency Standing Committee, 2003.

3. UNHCR Strategic Plan for Refugees, HIV and AIDS, 2005-2007.

4. IOM/FOM 30/2006 – 30/2006 – Note on HIV/AIDS and the protection of Refugees, IDPs and Other Persons of Concern.

5. Clinical Management of Rape Survivors – Developing protocols for use with refugees and internally displaced persons – revised edition – WHO/UNHCR, 2004.

6. Strategies to support the HIV-related needs of refugees and host populations – UNAIDS Best Practice Collection, UNAIDS/UNHCR, 2005.

7. Integration of HIV/AIDS activities with food and nutrition support in refugee settings: specific programme strategies, UNHCR/WFP, 2004.

7. AIDS and HIV infection: Information for United Nations employees and their families, UNAIDS, 2000.

Glossary

AIDS	Acquired Immune Deficiency Syndrome
ART	AntiretRivoral Treatment
BCC	Behavioural Change Communication
BSS	Behavioural Surveillance Surveys
HIV	Human Immunodeficiency Virus
HIVIS	HIV Information System
PEP	Post-Exposure Prophylaxis
PLWHAs	People Living With HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infections
VCT	Voluntary Counselling and Testing

Sectoral Response	Emergency preparedness	Minimum response (to be conducted even in the midst of emergency)	Comprehensive response (Stabilized phase)
1. Coordination	• Determine coordination structures • Identify and list partners • Establish network of resource persons • Raise funds • Prepare contingency plans • Include HIV/AIDS in humanitarian action plans and train accordingly relief workers	1.1 Establish coordination mechanism	• Continue fundraising • Strengthen networks • Enhance information sharing • Build human capacity • Link emergency to development HIV action • Work with authorities • Assist government and non-state entities to promote and protect human rights4
2. Assessment and monitoring	• Conduct capacity and situation analysis • Develop indicators and tools • Involve local institutions and beneficiaries	2.1 Assess baseline data 2.2 Set up and manage a shared database 2.3 Monitor activities	• Maintain database • Monitor and evaluate all programmes • Assess data on prevalence, knowledge attitudes and practice, and impact of HIV/AIDS • Draw lessons from evaluations
3. Protection	• Review existing protection laws and policies • Promote human rights and best practices • Ensure that humanitarian activities minimize the risk of sexual violence, and exploitation, and HIV-related discrimination • Train uniformed forces and humanitarian workers on HIV/AIDS and sexual violence	3.1 Prevent and respond to sexual violence and exploitation 3.2 Protect orphans and separated children 3.3 Ensure access to condoms for peacekeepers, military and humanitarian staff	• Involve authorities to reduce HIV-related discrimination • Expand prevention and response to sexual violence and exploitation • Strengthen protection for orphans, separated children and young people • Institutionalize training for uniformed forces on HIV/AIDS, sexual violence and exploitation, and non-discrimination • Put in place HIV-related services for demobilized personnel • Strengthen IDP/refugee response
4. Water and sanitation	• Train staff on HIV/AIDS, sexual violence, gender, and non-discrimination	4.1 Include HIV considerations in water/sanitation planning	• Establish water/sanitation management committees • Organize awareness campaigns on hygiene and sanitation, targeting people affected by HIV

5. Food security and nutrition	• Contingency planning/preposition supplies • Train staff on special needs of HIV/AIDS affected populations • Include information about nutritional care and support of PLWHA in community nutrition education programmes • Support food security of HIV/AIDS-affected households	5.1 Target food aid to affected and at-risk households and communities 5.2 Plan nutrition and food needs for population with high HIV prevalence 5.3 Promote appropriate care and feeding practices for PLWHA 5.4 Support and protect food security of HIV/AIDS affected & at risk households and communities 5.5 Distribute food aid to affected households and communities	• Develop strategy to protect long-term food security of HIV affected people • Develop strategies and target vulnerable groups for agricultural extension programmes • Collaborate with community and home based care programmes in providing nutritional support • Assist the government in fulfilling its obligation to respect the human right to food
6. Shelter and site planning	• Ensure safety of potential sites • Train staff on HIV/AIDS, gender and non-discrimination	6.1 Establish safely designed sites	• Plan orderly movement of displaced
7. Health	• Map current services and practices • Plan and stock medical and RH supplies • Adapt/develop protocols • Train health personnel • Plan quality assurance mechanisms • Train staff on the issue of SGBV and the link with HIV/AIDS • Determine prevalence of injecting drug use • Develop instruction leaflets on cleaning injecting materials • Map and support prevention and care initiatives • Train staff and peer educators • Train health staff on RH issues linked with emergencies and the use of RH kits • Assess current practices in the application of universal precautions	7.1 Ensure access to basic health care for the most vulnerable 7.2 Ensure a safe blood supply 7.3 Provide condoms 7.4 Institute syndromic STI treatment 7.5 Ensure IDU appropriate care 7.6 Management of the consequences of SV 7.7 Ensure safe deliveries 7.8 Universal precautions	• Forecast longer-term needs; secure regular supplies; ensure appropriate training of the staff • Palliative care and home based care • Treatment of opportunistic infections and TB control programmes • Provision of ARV treatment • Safe blood transfusion services • Ensure regular supplies, include condoms with other RH activities • Reassess condoms based on demand • Management of STI, including condoms • Comprehensive sexual violence programmes • Control drug trafficking in camp settings • Use peer educators to provide counselling and education on risk reduction strategies • Voluntary counselling and testing • Reproductive health services for young people • Prevention of mother to child transmission • Enable/monitor/reinforce universal precautions in health care

8. Education	• Determine emergency education options for boys and girls • Train teachers on HIV/AIDS and sexual violence and exploitation	8.1 Ensure children's access to education	• Educate girls and boys (formal and non-formal) • Provide lifeskills-based HIV/AIDS education • Monitor and respond to sexual violence and exploitation in educational settings
9. Behaviour communication change and information education communication	• Prepare culturally appropriate messages in local languages • Prepare a basic BCC/IEC strategy • Involve key beneficiaries • Conduct awareness campaigns • Store key documents outside potential emergency areas	9.1 Provide information on HIV/AIDS prevention and care	• Scale up BCC/IEC • Monitor and evaluate activities
10. HIV/AIDS in the workplace	• Review personnel policies regarding the management of PLWHA who work in humanitarian operations • Develop policies when there are none, aimed at minimising the potential for discrimination • Stock materials for post-exposure prophylaxis (PEP)	10.1 Prevent discrimination by HIV status in staff management 10.2 Provide post-exposure prophylaxis (PEP) available for humanitarian staff	• Build capacity of supporting groups for PLWHA and their families • Establish workplace policies to eliminate discrimination against PLWHA • Post-exposure prophylaxis for all humanitarian workers available on regular basis

Annex 2
HIV/AIDS and Conflict/Displaced Persons Assessment and Planning Tool Framework

July 6, 2005

1) Background

a) Refugee situation

b) HIV situation in country or origin and host country (use UNAIDS/WHO country epidemiological fact sheets (http://www.who.int/GlobalAtlas/PDFFactory/HIV/index.asp); use sentinel sites nearest to areas where refugees left in country of origin and live in host country; should add map (see figure below)

c) HIV situation in refugee context

2) Funding

a) Does host country have access to MAP, GFATM, PEPFAR or other sources of funds?

b) Do refugees benefit from them and how can they?

3) Policy

a) Existing National AIDS Control Policy, Guidelines and Manuals.

b) Displaced persons specifically targeted as a vulnerable population under National AIDS Control Programme Policy.

4) Protection

a) No mandatory HIV testing of displaced persons under any circumstances.

b) No denial of access to asylum procedure, refoulement or denial of right to return on basis of HIV status.

c) When required by resettlement countries, HIV testing conducted in accordance with established standards (i.e. accompanied by pre- and post test counselling and appropriate referral for follow up support and services).

d) No laws or regulations prohibiting refugee access to public sector HIV/AIDS programmes in countries of asylum.

e) Specific programmes in place to combat stigma and discrimination against people living with HIV/AIDS.

f) Programmes in place to prevent and respond to sexual violence.*

5) Urban vs. Camp/Site refugees:

a) Describe below activities separately for urban compared to camp/site refugees.

6) Coordination and Supervision

a) Regular meetings among implementing partners in field and in capital.

b) HIV/AIDS programmes specifically included in planning, implementation, monitoring and evaluation stages of programme cycle.

c) Regular attendance at meetings of UN Theme Group on HIV/AIDS and associated Technical Working Groups at capital level.

d) HIV/AIDS Coordinating Committee at camp/site level (including key members/groups of community as well as representatives from host surrounding communities)

7) Prevention

a) Safe blood supply.
b) Universal precautions.
c) Condom promotion and distribution.
d) Behavioural change and communication
i) Development of educational/ awareness materials in appropriate languages
ii) Programmes for in-school and out-of-school youth
iii) Peer education
iv) Youth centres
v) Sports/ drama groups
vi) Programmes aimed at reducing teen pregnancy and combating sexual violence.
e) Integration with local surrounding host communities
f) Uniformed services
g) Voluntary counselling and testing.*
h) Prevention of mother-to-child transmission.
i) Prophylaxis of opportunistic infections.
j) Post-exposure prophylaxis.

8) Care, Support and Treatment

a) Sexually transmitted infections.*
b) Opportunistic infections, including tuberculosis.
c) Tuberculosis
d) Food and Nutrition.*
e) Home-based care.
f) People living with HIV/AIDS.
g) Orphans and child-headed households.
h) Anti-retroviral therapy

9) Surveillance, Monitoring and Evaluation

a) Behavioural surveillance surveys.
b) AIDS clinical case and mortality reporting.
c) Blood donors.
d) Syphilis among antenatal clinic attendees.
e) Sexually transmitted infections (by syndrome).
f) Condom distribution.
g) Opportunistic infections, including incidence of pulmonary tuberculosis.
h) HIV sentinel surveillance among pregnant women and high risk groups such as those attending sexually transmitted infection clinics.
i) Voluntary counselling and testing.
j) Prevention of mother-to-child transmission.
k) Sexual violence.
l) Post-exposure prophylaxis.

10) Data

a) For each camp/site, at a minimum fill in the data requested below (one column is filled in as an example):

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* *Activity has both prevention as well as care and treatment components*

	Country
	Name of Camp/Site
Total population	7,331
Mortality Rates (MR)	
Crude MR (deaths/10,000/day)[1]	0.28
<5 yrs MR (deaths/10,000/day)[2]	0.94
Universal precautions	
sufficient[3] needles / syringes	Yes
sufficient[3] gloves	Yes
blood transfusion screened for HIV	Yes
STI data	
No of condoms distributed[4]	0.3
sufficient[3] condoms	Yes
sufficient[3] STI drugs	Yes
STI syndromic approach	Yes
incidence male urethral discharge (new cases/1000 males/month)	73.00
incidence genital ulcer disease (new cases/1000 persons/month)	1.00
% syphilis pregnant women 1st visit ANC	SNP
VCT	
Access to VCT	No
PMTCT	
Access to PMTCT	No
# persons pre test counseling	NA
% PMTCT uptake # 1[5]	NA
% PMTCT uptake # 2[6]	NA
% HIV prevalence of PMTCT clients	NA
PEP	
Do rape survivors have access to PEP	Yes
Sentinel surveillance among pregnant women	SNP
Latest HIV or RH BSS/KAPB	May 2004

[1] *baseline in sub-Saharan Africa for non-emergency is 0.5 deaths/10,000/day*

[2] *baseline for sub-Saharan Africa is 1.0 deaths/10,000/day*

[3] *sufficient supply defined as no stock out of >1 week at anytime during the past year*

[4] *goal for emergency phase is 0.5 condoms/person/month and for non-emergency phase is 1.0 condoms/person/month*

[5] *# women who counseled on MTCT an offered voluntary test /# women who had 1st ANC visit =%*

[6] *# women who counseled on MTCT, offered voluntary test during 1st ANC visit and accepted test /# women who had 1st ANC visit, were counseled on MTCT and offered voluntary test =%*

SNP=service not provided; NR = not reported; RI = reported incorrectly; NA = not applicable

Annex 3
Key Emergency Indicators

N. Ref. SIR	Indicator Description	Standard	Disaggregation	Ref. Area
34	**Numbers of condoms distributed per person per month**	**≥ 1 per person per month**	**☐ Sex**	**Food, Nutrition and Health and HIV/AIDS**
			☐ Age	**HIV/AIDS**

Rationale

To measure the effectiveness of condom distribution systems

Methods of measurement

Numerator: Number of condoms distributed per month
Denominator: Total population at the end reporting period

Data Sources

Health and community service partners records

Frequency of measurement

Monthly

Notes

- Equivalent to the conventional formula for calculating condom requirements: of the 20% of the population who are sexually active males, 20% use 12 condoms per month, plus 20% wastage and loss. This quantity is provided in the Emergency Reproductive Health Sub-kit No. 1: (condoms)/10,000/ 3 months (UNFPA, The Reproductive Health Kits for Crisis Situations, second edition, 2003).
- List of potential outlets should include health facilities, community centers, youth centers, bars, market places, food distribution sites and outreach workers.

References

- IASC guidelines HIV/AIDS interventions in emergency settings; and Refugees, HIV and AIDS: UNHCR's Strategic Plan 2005 – 2007.
- UNFPA, (2003) The Reproductive Health Kits for Crisis Situations, second edition.

N. Ref. SIR	Indicator Description	Standard	Disaggregation	Ref. Area
17	**Is antiretroviral therapy available in / for hosting community / refugees? (indicate in appropriate cell)**		☐ **Sex**	**Social integration**
			☐ **Age**	**HIV/AIDS**

Rationale

Antiretroviral therapy (ART) is a life saving and essential intervention. refugees should have equivalent access to HIV interventions as those of surrounding host populations.

Methods of measurement

Survey

Data Sources

Implementing or operational partners and Government National AIDS Control Programmes

Frequency of measurement

Annually

Notes

- As with all public health interventions, retugees should receive similar services as those available to surrounding host communities while ensuring that minimum essential services are provided.
- Low cost refers to a co-payment as opposed to non-subsidised ART.

References

- IASC (…) Guidelines HIV/AIDS interventions in emergency settings and Refugees. IASC. Geneva.
- UNHCR, (2005): UNHCR's Strategic Plan on HIV and AIDS for 2005 – 2007.
- UNHCR, (2005) Draft Antiretroviral Therapy (ART) Concept Paper for Refugees.
- United Nations High Commissioner for Refugees (UNHCR). Draft 24 August 2005.

N. Ref. SIR	Indicator Description	Standard	Disaggregation	Ref. Area
35	Have stocks of condoms ran out for more than a week?	NO	☐ Sex	Food, Nutrition and Health and HIV/AIDS
			☐ Age	HIV/AIDS

Rationale

This indicator measures distribution of condoms at designated points at any one point in time. It reflects the success of attempts to broaden the distribution of condoms so that they are more widely available to people likely to need them and at locations and times when people are likely to need them.

Methods of measurement

Yes or No answer

Data Sources

Health and community service partners records

Frequency of measurement

Monthly

Notes

- List of potential outlets should include health facilities, community centers, youth centers, bars, market places, food distribution sites and outreach workers.
- Outlet types may be analysed by the populations they seek to serve. This provides an idea of the adequacy of efforts to meet the needs of people with potentially high-risk behaviour, such as young people or those in mobile occupations.
- A limitation of the measure is that it provides a “snapshot” of availability at a single point in time. Where distribution is relatively regular, this poses no major problems. However when there are serious disruptions to condom supply at the central level, the repercussions may be felt simultaneously at a large majority of venues. If a survey is carried out at this time, it will appear as though the peripheral distribution system is inadequate whereas in fact the fault lies at the central level. In countries where quarterly retail surveys are undertaken, it may be possible to report an annual average to better reflect consistency of supply.

References

- IASC guidelines HIV/AIDS interventions in emergency settings; and Refugees, HIV and AIDS: UNHCR’s Strategic Plan 2005 – 2007.
- UNFPA, (2003) The Reproductive Health Kits for Crisis Situations, second edition.

19 HIV and AIDS

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Education

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Situation

– Education is a basic human right that can provide an important support to life-saving and life-supporting activities in situations of emergency.

– For UNHCR, safeguarding the right to education is an essential strategy to ensure the protection of children and adolescents and to fulfill its commitments towards the Education for All framework.

– Although UNHCR does not have the lead role in providing education in the new UN humanitarian reform, it should systematically promote the immediate provision of safe learning activities for children and adolescents in-line with its protection mandate.

Objectives

– Protect children and adolescents from exploitation through the immediate provision of safe and child-friendly spaces and the dissemination of life-saving messages.

– Help children addressing their psycho-social needs by restoring a sense of normality and routine through the immediate provision of semi-structured recreational and learning activities.

– Foster durable solutions, by promoting peace, self-reliance, social and economic development

– Assess and plan, together with the community, education gaps, needs, capacities and responses in order to establish within 6 months after the emergency a formal school system for basic education (primary and lower secondary) as well as plan for learning opportunities for adolescents.

Principles of response

– *Access*: Children and adolescents should have an immediate access to child-friendly spaces, where recreational and learning activities as well as psycho-social support can be provided. The provision of such support should be considered as a priority just as other life saving sectors such as health, shelter or food.

– *Safety and Quality*: education activities should be safe enough to provide effective protection to refugee children and adolescents, boys and girls. Prevention and response mechanisms to violence in school should be established. This will in turn have an impact on the quality of the learning environment.

– *Age and gender sensitiveness*: education activities should be age and gender sensitive and address the specific needs of children and adolescents, boys and girls. They should not be limited to children but target adolescents as well, especially as it is when children reach adolescence that they are generally the most exposed to protection risks. In that respect, non-formal education such as vocational training and life skills education should also be included in the programming.

– *Participation*: education activities should be designed, planned and monitored with the full participation of the community, including children and adolescents themselves as well as the education authorities. Action should also be systematically coordinated with other UN agencies with an education coordination.

Action

- Provide immediate, age and gender sensitive, recreational and learning activities in safe and child-friendly spaces .
- Establish education committees/coordination at the local and national levels
- Conduct a community-based assessment of education needs, resources and capacities.
- Develop an education plan that mobilizes the community's capacities to establish basic formal education and targets non -ormal education for adolescents at risk.

Introduction

1. The right to education for people of concern has been endorsed by the 1951 Convention on the Refugee Status, and the 1989 Convention of the Rights of the Child. In an emergency context, measures to promote universal primary education, safe school environment and other non-formal educational activities will help protect children and adolescents from forced labour, physical and sexual abuses, military recruitment and other forms of violence.

2. Establishing an education system is important for the well-being of the whole refugee community, as well as for the social and psychological well-being of children and young people. Setting up recreational activities, school systems and other non formal activities, together with the community, will give a structure and sense of normality to a displaced and traumatized population. Refugees are displaced not only from their homes and families but also from their community. Educational activities can be the community's initial focal point, and can create a sense of routine if the new community is partly structured around familiar institutions such as schools.

Education in emergencies is not only a basic human right but also an essential tool of protection.

3. The displaced community which often includes teachers and skilled persons usually initiates informal schools, even in an emergency situation, as they recognize the importance of a school system. Refugee institutions should support their initiatives and continued management, thus enhancing self-esteem and self-reliance.

4. Other important functions of the education system in an emergency are:

i. To disseminate survival and life skills messages. Simple messages can be spread through educational activities, on important issues such as health, including reproductive health and HIV/AIDS; sanitation, nutrition, SGBV prevention and gender awareness; children rights, landmine safety, peace education and environmental education.

ii. To foster durable solutions by promoting self-reliance, social and economic development. Education provides the "human and social capital" needed for reintegration in the country of origin or local integration in the host country. Appropriate education builds the foundations for social cohesion, peace and justice.

5. Detailed information on planning education programmes and on standards and indicators for refugee schools is set out in the UNHCR's Education Field Guidelines and the Inter-agency Network for Education in Emergencies (INEE) Minimum Standards for Education in Emergencies (MSEE). These guidelines are essential reading for those establishing an education programme in an emergency context.

6. Basic quality education (primary and lower secondary) as well as non formal education for older children who cannot be reinserted in formal schooling must be provided as soon as possible as it can save and protect lives. It should be considered as a priority as much as other sectors.

The emergency education programme should provide immediate and free access to semi-structured, recreational and learning activities in safe environments. It should also plan for the establishment, within six months after the emergency - of a basic education system for all refugee children and of learning opportunities for adolescents.

Early response

7. In the beginning, the aim is to support the community in establishing a simple programme of semi-structured recreational and simple educational activities for children and young people. It is essential for these activities to be delivered in safe and child-friendly spaces where children and adolescents are not exposed to protection risks and can feel safe.

In that respect, it is recommended to create separated spaces and activities for small children and adolescents and to ensure codes of conduct are established for all education staff. For further guidance on safety in learning environments, refer to UNHCR Safe Education Guidelines.

8- Establishing simple educational activities is possible even with limited educational supplies – simply gathering children and adolescents together for a set period each day and keeping them occupied is a valuable first step. This can be achieved through mobilization of teachers, adolescents or youth leaders identified from the refugee population. The activities should support the life-saving measures underway in other sectors by including simple messages on health, sanitation, risks of abuse and other relevant topics appropriate for the children's level. Activities and messages should be designed and planned together with children, adolescents and parents. Annex 3 (p 64) provides examples of recreational and activity materials that could be used to support such a programme.

9. Where possible, it is preferable to procure educational and recreational supplies in the country or immediate region concerned. Supplies obtained through local NGOs may be cheaper, logistics easier and they will benefit the local economy. If this is not feasible, both UNICEF and UNESCO have educational emergency kits that can be accessed. UNHCR's partnership with these two other organizations should be fully operational in an emergency context, as defined by the Memorandum of Understanding.

10. While structured recreational activities are being set up, a comprehensive education programme should be planned according to the results of an initial assessment of needs, gaps, capacities and resources. The assessment should be conducted by education committees representing education authorities, local and international NGOs, refugee children, parents and teachers associations, and other UN agencies identified to support the development of basic education programmes.

11. The initial assessment of education gaps is based on a participatory approach and promotes age, gender and diversity meanstreaming. The educational needs of children should be broken down by age, gender and diverse background and the groups at risks, as well as groups with specific needs, should be immediately identified.

Semi-structured recreational and learning activities should always be delivered in safe environements where children are not at risks of abuse and exploitation.

12. Educational responses should be based on the results of the above assessment and developed together with the refugees, including adolescents and children. Responses should build on existing initiatives and capacities, mobilize all groups within the community, and be prioritized according to protection objectives and risks identified. Resources available and capacities will include skilled persons, with or without teaching experience, family members including adolescents and elders. Textbooks from the country of origin should be used as the basis for preparing curricula and teaching materials, unless the curriculum of the country of asylum is used. Local capacities can also include local NGOs, community structures and government agencies involved in the education sector. The community,

through the creation of education committees, should be fully mobilized and involved in the identification of gaps and responses.

Basic education (primary and lower secondary)

13. Within 6 months after the first major displacement, the initial non-formal educational and recreational activities should be developed into a single, unified primary school system, based preferably on the curriculum of the country of origin. Where the school system in the country of asylum is similar to that of the country or area of origin and refugee numbers are limited, resources may be provided to local schools to enable them to accommodate refugee students, provided this is cost-effective. Decisions should be taken with the participation of both the refugees and the authorities representing the Ministry of Education.

The provision of education to the refugee community may be perceived by the host community as a privilege that their children do not enjoy. If the government is in agreement and there is a common language of instruction, it is usually appropriate to open the schools to the local population or reinforce existing schools. Some assistance may therefore be provided to national schools located very close to refugee sites.

School structures and locations

14. In order to open schools as early as possible, temporary shelters may be constructed in safe locations using plastic sheeting or semi-durable materials. The location of schools, latrines and recreational spaces should be defined with the participation of all refugees, including children and adolescents, with due consideration for security issues.

School locations should be within walking distance for children. Latrines for girls and boys should be separate. The community should be mobilized to help build and maintain safe school buildings, and be organized in comittees representing the interests of teachers, parents and students.

If camps are very large, smaller, decentralized schools are generally preferable to large schools to avoid children being at risks on their way to school. The likelihood that additional classrooms may be needed at a later stage should likewise be borne in mind at the time of site selection and demarcation.

Curriculum and learning materials

15. The curriculum should preferably be based on that of the country or area of origin, to facilitate reintegration upon repatriation providing that both the refugees and the authorities agree on this principle. The curriculum should be enriched with life skills and values on HIV/AIDS, children and women rights and land mine sensitization, reproductive health and/or SGBV prevention modules. School hours should be defined in consultation with teachers, parents and children and adapted to family and work constraints, especially where the girls have to fetch water and firewood for their family or do home chores.

16. Educational materials described in Annex 4 can be used to establish a basic education programme. The materials in this list would meet the initial needs of 1,000 refugees, and include sufficient writing materials for two classrooms of students in the earliest stages of primary school, plus one classroom for students who have completed 2 or 3 years or more of primary schooling. If each classroom is used initially for separate morning and afternoon shifts, then a total of 240 students can be catered for. Typically there would be two or more writing materials kits (of

the type specified in Annex 4) per school, according to the number of classrooms on each site.

Recruitment of teachers and classroom assistants

17. It should be made clear to the initial volunteer teachers that selection tests will be held as soon as is practicable. The recruitment of female teachers and female classroom assistants should be encouraged to enhance protection of girls from sexual harrassment by male pupils and teachers. Once selected, all teachers should sign a code of conduct that explicitly prohibits them from abusing children. The code of conduct should be defined by teachers, parents and students themselves in close collaboration with the relevant authorities, and they should be publicized in each classroom through child-friendly messages.

18- Teachers should receive adequate support and compensation as well as trainings on children and women's rights, psycho-social support and codes of conduct. Training needs and opportunities should be defined at an early stage together with teachers, community structures and government agencies.

19- Community-based prevention and response mechanism to violence in schools, including SGBV, peer to peer violence and corporal punishment, should be established together with teachers, students and parents in order to ensure learning environments are safe. For further guidance, refer to UNHCR

Secondary and Non-formal education

20. Non-formal educational activities, such as literacy and numeracy classes, life skills education or vocational training, should be structured for groups who cannot be integrated into formal education. This includes secondary students where higher secondary is not available, out of school adolescents, young adults or groups with specific needs (disabled, ex-child soldiers, etc). The activities should be defined on a participatory basis and built on the existing capacities and resources in the education sector, both within the refugee camp and the hosting area. Vocational training offered should be relevant to the job market to ensure that the adolescents and young people can secure employment and where appropriate the necessary tools should be provided.

21- However, all efforts should be made to reinsert the adolescent girls and boys into formal schooling. Access to secondary education should be facilitated and supported with the participation of international NGOs, the refugees and the relevant authorities of both the hosting area and the country of origin.

Allocation of resources

22-. Budget allocations should prioritize activities that will reinforce the safety and the quality of learning environments as compared to school infrastructures as such. It is preferable to have schools in semi-durable materials so as to have enough resources left for the reproduction of school didactic materials, school materials, teacher's trainings, and school-based sensitization on children and women's rights, forced recruitement, or SGBV.

23- Initial budgets should provide for the printing or photocopying of codes of conduct as well as classroom materials for pupils and teachers, based on core elements of the country of origin curriculum, where applicable, as well as for the initial purchase of school and recreational supplies. Budgetary provision may also be necessary for the translation and reproduction of materials supporting health, SGBV prevention, environment, peace education, children rights and other messages.

24- Resources should also be mobilized to offer non-formal educational opportunites to adolescents, young adults or groups with specific needs. When funds are lim-

ited UNICEF should be fully involved in the provision of materials, school kits, and teacher training and a joint plan of action with key stakeholders should be defined as soon as possible and presented to donors.

Education coordination

25. Education committees are in charge of assessing education gaps and identifying responses or are empowered to do so. Education authorities should take the lead in establishing education committees with equal representation of men, women, girls and boys and coordinating the education emergency response. However, when the authorities are not operational, an inter-agency cooordination committeee will provide guidance and coordinate education activities while efforts are made to build the capacities of the authorities.

26. The Inter-Agency Network for Education in Emergencies (INEE), consisting of UN Agencies and NGOs, provides updated technical knowledge and ensures cooperation at a global level to improve the quality of education in emergencies.

27. Although UNHCR may not take the lead role in providing education in an emergency, it should always retain a monitoring and advocacy role. This is important to ensure that all refugee children and adolescent girls and boys have access to safe learning environments in emergencies, as education is part of UNHCR's protection mandate.

In the education sector, UNHCR has agreements in place for emergency staff deployments. These secondments can be deployed within the first emergency response team or within the first weeks of the initial response.

28. The staff deployed will be responsible for promoting and supporting the establishment of education committees and organized early-stage recreational activities on a participatory basis. He or she will liaise with local and national education authorities, UN agencies and partners in order to coordinate education programmes early in the response, as well as to conduct joint assessments and share information.

29. UNHCR and other agencies should actively collaborate with the Education Ministry of the country of origin and that of asylum. Initially, efforts should be made to obtain school textbooks and teachers' guides. Thereafter education committees should be convened and meetings on education participated in, in order to discuss curriculum, teachers'training, recognition of diplomas, accreditation of the grades obtained including access to local schools and vocational training centers.

Education in returnee and IDP context

30. In returnee and internally displaced persons (IDP) situations, a community-based approach should be systematically adopted. Assistance should not target individuals (ie. registered returnees or IDPs alone) but benefit the community as a whole in order to avoid conflicts and stigmatization. Education programmes should target schools or vocational training centers located in areas of return or displacement, and include targetted actions to improve the quality of the education environment. Punctual and financial support to returnees or IDPs alone should be limited to the neediest families.

Action

- **Arrange separate recreational and learning activities in safe environments** for children and adolescents in order to restore a sense of normality as soon as possible.
- Consult UNHCR Headquarters and the local UNICEF office regarding availability of educational and recreational materials and provide adequate materials to support community initiatives (see Annexes 3 and 4).

- Make sure children and adolescents are consulted when defining the activities and arrange the timing around other household and family duties to ensure maximum participation.

□ **Establish education committees** to include refugee teachers, parents and children girls and boys, local education authorities, relevant UN agencies, and the implementing partner at appropriate levels (district and/or national).

□ Send a request to UNHCR headquarters for the **deployment of an Education Officer** when necessary.

□ The education committee must **conduct a comprehensive assessment of education gaps**, resources and capacities based on the results of the participatory evaluation. Make sure that the specific needs of children at risk, including teenage mothers, former child soldiers, disabled children and other groups at risk are taken into account and that they participate in the definition of activities.

□ Based on the findings of the assessment, the education committee **develops an Education action plan** that meets the requirements of the different identified age groups and backgrounds of the boys and girls. Ensure the education plan involves mobilizing the community's capacities to establish both formal and non-formal education activities and to secure safe access to quality education for girls and boys.

□ The education plan should **focus on the safety of learning environements and the quality of education**, gender parity and should also include:

- accurate statistics on children who were and were not in schools before flight, disaggregated by age, gender and grades;
- identification of safe school sites together with refugee children and adolescents and the UNHCR multifunctional team;
- definition of school hours adapted to household and work constraints;
- a defined curriculum enriched with specific modules on health, SGBV, children rights, violence prevention, landmines and/or HIV/Aids;
- the number of didactic materials and text books needed;
- teachers recruitment procedures, codes of conduct and supervision mechanism;
- an identification of needs, resources and partners for the provision of teachers training on codes of conduct, children and women's rights and pyscho-social support, including for female teachers who should be trained in priority;
- the establishment of community-based mechanisms to prevent and respond to violence in school settings including SGBV reporting mechanisms
- identifying relevant, non-formal, educational activities to address the needs of adolescents at risks and/or with specific needs.

- Identify an implementing partner who will work together with the education committee to establish a **monitoring and reporting mechanism on the safety and quality of learning environements.** Indicators should be identified to monitor the impact of the educational response on boys and girls, adolescents and groups at risk and/or with specific needs. A list of indicators is provided in the INEE Minimum Standards for Education in Emergencies p 25 (see reference below) as well as in UNHCR Standards and Indicators.

- Education programmes should be **monitored and evaluated regularly** through a participatory approach to identify potential gaps and protection risks. **Adjustments** should immediately be sought to address the root cause(s) of the identified protection risks rather than the symptoms.

Key references:

– UNHCR Education Field Guidelines , Geneva, 2003

– Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction, Inter-Agency Network on Education in Emergencies, Paris, 2004.

– Emergency Field Handbook, UNICEF, New York, 2005.

– Action for the Rights of Children – Module on Education.

– UNHCR Safe Education Guidelines, 2007

– UNHCR Education Strategy 2007-2009

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Supplies management and transport

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Situation

Refugee emergencies are often in locations far from the main sources of supply and communications. Exceptional efforts (without which an operation may fail) may be needed to ensure the provision of supplies and services. However without these, the whole operation will fail.

Objective

The timely delivery of the materials needed for the refugee operation.

Principles of response

- There should be a single, unified "supply chain" with standardized procedures and coordinated with external agencies such as WFP. The term "supply chain" includes the sourcing, procurement, transport, import, management, storage and distribution of goods and services required to meet operational needs.
- Duplication of supply chain support within the UNHCR operation must be avoided.
- A single coordinating body of all the relevant UN agencies may be required to implement certain aspects of the supply chain such as transportation and storage (e.g. a "UN Joint Logistics Cell");.
- Request urgently needed supplies from the UNHCR Central Emergency Stockpile if they are not available locally for immediate delivery.
- Ensure there is good communication between offices involved in the supply chain and timely information exchange regarding logistical capacities and constraints.
- Transport and storage arrangements must have spare capacity: things often do not go according to plan, needs, and the demand for supplies, may increase.
- Seek technical assistance when necessary.

Action

- Make a comprehensive plan for all supply chain functions. Integrate supply chain arrangements in the overall planning from the start, coordinate with all sectors, and take into account any special requirements.
- Identify weak elements in the supply chain and inform operational managers of actions rendered critical due to lead time (the delay between the request for material and its arrival).
- Seek out knowledge on local conditions and assess implementing possibilities with local suppliers, or other agencies.

Introduction

1. The vital role of the supply chain must not be overlooked in the initial planning, and the input of a logistics specialist is required on any assessment mission. The more remote the location of the displaced, the more difficult will be the logistical problems, yet these are the situations where logistic support or the lack of it becomes the key to success or failure.

The ability to deliver the right supplies to the right place at the right time and in the right quantities is a prerequisite for an effective emergency operation.

2. The supply chain must provide for international purchase, transport, swift unloading and duty-free clearance on arrival, local purchase, transit storage, onward transportation, and final distribution, with proper stock control at every stage. Figure 1 shows the likely major components of the system in diagrammatic form.

3. Logistical support can be disrupted by unpredictable events and many factors outside UNHCR's control including customs delays, breakdowns, looting, and the vagaries of nature. Furthermore, the numbers requiring assistance often increase during the emergency phase of an operation.

The supply chain must provide for spare capacity because available capacity may become quickly overwhelmed.

Organization of the supply chain

- A single coordinated operation is essential and duplication of supply chain services must be avoided.
- This requires a clear understanding of overall needs and the responsibilities for meeting them.
- Three key qualities of a good supply chain are: rapidity, flexibility and security.

Assessment

4. A clear understanding of the overall needs by all concerned is essential. Needs assessment and planning should be carried out together with government, WFP and NGO partners.

5. An easily understood and comprehensive list of requirements is essential as the starting point for meeting the basic material needs. Without it, great confusion can result. With such a starting point, the balance of needs, requirements and distribution can be continuously monitored, and the effect of these relief goods or services will be immediately apparent.

Planning

6. Three key qualities of a good supply chain are: rapidity, flexibility and security. These three qualities depend on good coordination and communications as well as good planning. When planning for and developing the supply chain, ensure:

i. *Rapidity:* Response time is critically important in emergencies, and advance planning is essential to optimize resources, and not waste time correcting avoidable mistakes or inefficiencies. Planning must take into account lead times.

ii. *Flexibility:* Logistics are dictated by the circumstances of the operation and terrain, and must be able to quickly adapt to rapid changes in circumstances. Plan for the worst case scenario, and build in the required flexibility and adaptability.

iii. Security: The security of personnel and relief goods must be a priority in the logistics plan. Security risks vary from theft and looting to war.

iv. *Coordination:* Coordinate planning and implementation with other agencies, in particular WFP who often have good local transport and logistical capacity. WFP is normally responsible for food supplies up to the agreed Extended Delivery Point – see chapter on food and nutrition.

v. Avoid duplication of logistical services by different organizations and ensure a single, coordinated operation.

vi. A single coordinating body of all the relevant agencies may be required to implement certain aspects of the supply chain such as transportation and storage (a "UN Joint Logistics Cell") – guidance on setting this up is given in **UN Joint Logistics Cell: Standard Operating Procedures**. Ensure effective coordination by: advising team members and staff from other organizations of minimal lead times, respecting deadlines and delivering the expected supplies at the time and place agreed and keeping to agreed loading and transport schedules.

vii. *Comprehensive planning:* Have an overview of the whole operation when planning for and managing services, materials, staff and time.

viii. Spare capacity: The logistics plan must provide spare capacity, taking into account factors which would cause delays (such as vehicle breakdowns).

ix. *Cost-effectiveness:* Ensure proper maintenance of warehouses, efficient stock control, and well negotiated contracts (e.g. for transport, warehouses, customs clearance, and

maintenance). Ensure purchases are made from competitive sources in accordance with UNHCR regulations – although initial purchases may be made with speed as a foremost concern, plan follow-on supplies in good time to be able to purchase from competitive sources.

x. *Good communication:* A regular exchange of information between the offices involved in the supply chain is essential. Headquarters should give the Field as much notice as possible of procurement and shipment of goods or services, estimated times of arrival (ETA), changes in delivery schedules, and of contributions in-kind. The field should advise Headquarters of any changes to importation laws, acknowledge receipt and distribution of consignments, and advise Headquarters of contributions in-kind. It is equally important for the field to make all necessary preparations to receive relief supplies and deliver to the beneficiaries at the earliest possible time.

There must be good communications facilities at dispatch and arrival points as well as mobile communications sets on surface transport.

xi. *Clear responsibility:*

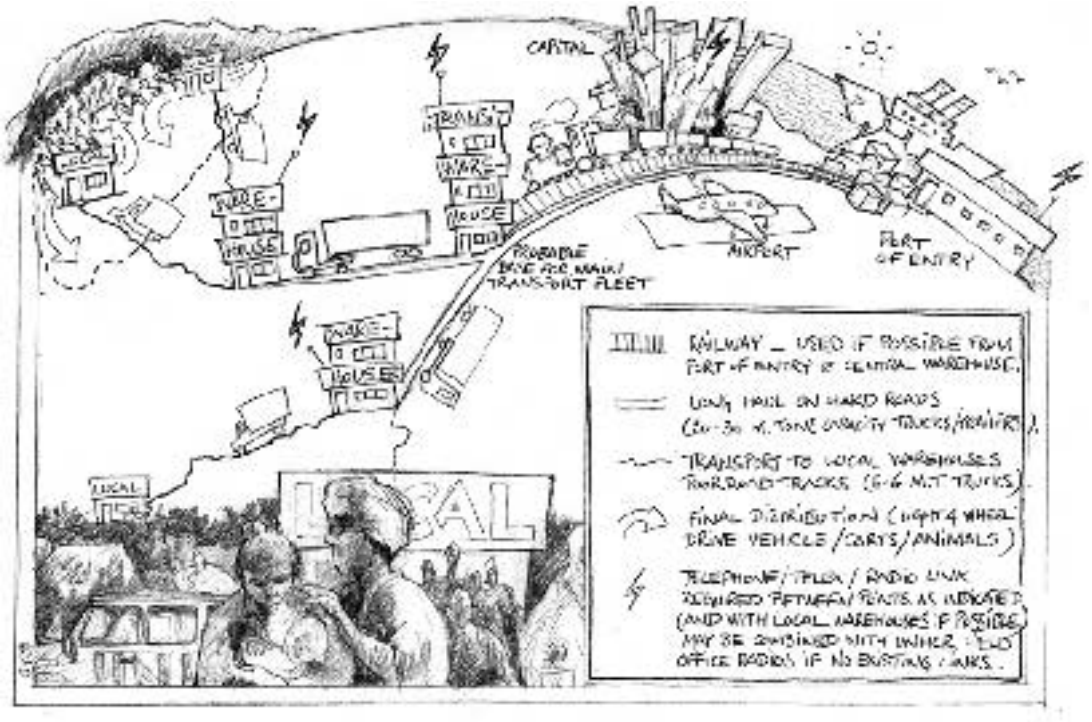
Whatever the arrangements in the field, the line of responsibility and reporting to UNHCR by the operational partners must be clear.

The major decisions about supply chain issues should be taken by the same person with the appropriate responsibility and authority.

Local and other resources

7. The supply chain should use local resources and knowledge as far as possible. Where there is a good existing warehousing and distribution system, outside assistance may not be necessary. Where outside assistance is required, sources include:

i. Supply Management Service (SMS) at Headquarters (which handles procurement of goods and services, logistics, fleet management, and asset management;



ii. government disaster agencies or emergency corps, and Government Service Packages from donor governments (see chapter on implementing arrangements); and
iii. an NGO or commercial firm with appropriate experience.

Setting up the supply chain

8. The circumstances of each emergency will determine what type of supply chain support is required – whether it is directly implemented by UNHCR, through an operational partner or as a commercial contract.

9. Steps to establish the supply chain include the following:

i. Make arrangements for the duty-free import/export of relief goods, and duty-free and tax free purchase of relief goods with the appropriate governmental authorities. To avoid delays, this must be done before the goods are due to arrive.
ii. Investigate the possibility of using local suppliers, establish vendor roster.
iii. Select warehouses appropriate for their purpose (for storing food or non-food items; for trans-shipment, storage or distribution). Ensure that access roads and doors allow easy loading and offloading.
iv. Select appropriate transport for goods and/or passengers: determine the type and the number of light and heavy vehicles, vessels, aircraft and trains needed. Calculate fuel and maintenance requirements (tyres, lubricants, parts and mechanics).
v. Use temporary assistance during peak demand for staff.
vi. Provide the necessary staff support equipment such as office equipment and supplies, light and water, vehicles, freight handling items, power, communications, and accommodation.
vii. Put in place a documentation and filing system, and use standard forms to report on the status of relief goods. Advise and train personnel on procedures.

Supplies

- Assess what is readily available on the local market: if locally available items are appropriate, make at least initial purchases locally;
- The basis for UNHCR procurement is competitive tendering;
- Standard specifications have been developed for common items;
- Certain emergency relief items are stockpiled centrally by UNHCR and can be accessed quickly in an emergency.

Introduction

10. The basis for all UNHCR procurement is competitive tendering. This process is made easier and more efficient by standard specifications.

11. Headquarters' Supply Management Service gives advice and provides support on all procurement and logistics matters and is responsible for international procurement. Guidance on local purchase can also be sought from other UN organizations. Tendering procedures are described in Annex 2 to chapter 8 on implementing arrangements.

12. When drawing up tender documents and purchase orders it is essential that all specifications, quantity, required delivery, packaging and payment terms be clearly stated. Care must be taken to ensure that contract terms protect the rights and immunities of UNHCR. Requests for tenders should in any event include UNHCR's standard terms and conditions. Advance payments and cash transfers to suppliers must be authorized by Headquarters.

13. If procurement is to be undertaken by implementing partners on behalf of UNHCR, the principles of competitive bidding must be followed (detailed in-

formation is also available in **Supply Management Handbook, Chapter 8 of UNHCR Manual**). UNHCR staff should monitor local and international procurement made by implementing partners for the UNHCR-funded programmes.

14. Care should be taken to avoid purchasing different qualities of the same items.

Local and international procurement

15. If emergency relief items are available locally, compare prices where possible with the international market. Use catalogues or send local prices to the Supply Management Service in Headquarters who will advise on the most appropriate course of action. Assess what is readily available on the local market: if locally available items are appropriate, make at least initial purchases locally. At the same time however, consider the cost-effectiveness of continuing such local purchases beyond the initial phase of the emergency, compared with making those purchases internationally.

16. Local procurement can offer a number of advantages over international purchases. These could include:

i. lower prices;
ii. speed and flexibility of delivery;
iii. local acceptance; and
iv. benefits and incentives to the local economy (particularly in areas affected by a large refugee influx).

17. However, the disadvantages of local purchase could include:

i. higher prices;
ii. inappropriate quality;
iii. sudden price increases (due to sudden heavy demand) on the local market, adversely affecting the local consumer population and causing resentment; and
iv. higher maintenance costs.

18. As a rule, no more than 15% would be an acceptable premium for prices of locally procured goods over the total delivered cost of internationally procured goods.

Local procurement

19. When the capacity of the local market is limited, care must be taken to avoid price increases caused by organizations bidding against each other for the same supplies. Provided there is clear agreement on the needs, coordination of purchases and even combined orders among the organizations concerned should be possible.

International procurement

20. UNHCR has entered into a number of Frame Agreements for a range of products. The purpose of these agreements is to ensure the availability of goods of an agreed quality at competitive prices, and reduce total lead time. These items include blankets, plastic sheeting, essential drugs, kitchen sets, semi-collapsible jerry cans, and buckets. Support and office items supplied under frame agreements include light vehicles, vehicle tires and tubes, generators, ballistic armour, computer and telecommunications equipment, and some office equipment and supplies. Lightweight emergency tents were added to the Frame Agreements as well as to the Central Emergency Stockpile.

21. The UNHCR Catalogue of Most Frequently Purchased Items gives summary specifications, reference number, price (US$), country of origin, and, where relevant, production capacity, production lead times and estimated shipping times. It also includes a list of current Frame Agreements.

22. When requesting Headquarters to make a purchase, be sure to use both the reference number for a product, and the name and date of publication of the catalogue. If specifications are not available for the product wanted, inform the Supply Management Service of the purpose of the

product and the context in which it will be used.

23. Bear in mind lead times for international purchase can be lengthy.

Emergency stockpiles

24. Certain common relief items are stockpiled centrally by UNHCR, or by suppliers on behalf of UNHCR, and can be accessed quickly in an emergency.

The UNHCR stockpile includes the operations support items listed in the Catalogue of Emergency Response Resources. These items can be ordered through Headquarters.

25. Other UNHCR operations in the region may hold stocks that could be made available – these offices should be approached directly about the most urgent requirements.

26. UNICEF, WHO, WFP, the IFRCS and NGOs also maintain emergency stockpiles with supplies which may be available to UNHCR.

Specifications and catalogues

27. There are a number of catalogues of products with detailed specifications. Using standard specifications (and Frame Agreements) is not intended to limit choice, but simplifies supply, and ensures better integration of equipment, spare parts and services. Generic specifications also make the procurement and tendering process fairer (e.g. comparing prices). Annex 1 gives detailed specifications of certain common relief items.

28. Catalogues of specifications include:

i. **UNHCR Catalogue of Most Frequently Purchased Items**. This is published annually by UNHCR's Supply Management Service, and available on Intranet. It gives brief specifications, price, and lead times.

ii. **IAPSO Emergency Relief Items.** This is a two volume electronic catalogue published by the Inter-Agency Procurement Services Office (IAPSO) of the United Nations (www.iapso.org). A large number of standard specifications adopted by UN are available in this catalogue, and there are additional IAPSO catalogues on other items (see key references).

iii. **UNICEF Supply Catalogue.** UNICEF also produces a large illustrated catalogue (www.unicef.org/supply/index_26071.html).

Considerations in product choice

Environment

29. UNHCR has a policy, also applicable in emergency situations, to ensure awareness and supply of environmentally friendlier products. Impact on the environment is considered an integral part of product quality. Where two or more suppliers are offering items which are substantially the same in terms of specifications, price, quality, and delivery time, the policy is to give preference to the product whose manufacture, use and disposal is less harmful to the environment. For further details see Environmentally Friendlier Procurement Guidelines, UNHCR, 1997.

Shelter

30. For shelter, local materials and methods of construction should be used where possible, combined with tarpaulins or polythene sheeting if necessary. Except for nomadic tribes, tents are not a satisfactory type of long-term shelter. They are, however, a valuable last resort in emergencies. Remember that tents may deteriorate rapidly if stored for any length of time, particularly if humidity is high. For the above reason, UNHCR has developed a lightweight emergency tent which can be stored for a longer period than the cotton-canvas tents. The specifications of the lightweight tent is available with SMS and on the intranet.

In-kind donations

31. In-kind donations should always be evaluated against actual needs and cultural appropriateness. All offers for in-kind donations should be discussed with Donor Relations Services and the Supply Management Service in Headquarters before being accepted (see Supply Management Handbook, chapter 8 of UNHCR Manual). Particular attention should be given to packaging (which must meet transport requirements) and expiry dates of products offered.

Clothing

32. Used clothing is often offered in emergencies but is generally an unsatisfactory way of meeting a need for clothing and should be discouraged. It often arrives in poor shape, dirty or badly sorted and will frequently be inappropriate for the customs of the refugees. Consider the alternative of purchasing particularly locally made clothes, and ensure that what is provided is culturally acceptable.

Transport

- Vehicle fleets should be standardized (same makes and models).
- Ensure there are sufficiently trained drivers, fuel, lubricants, spare parts, tyres, maintenance personnel and facilities.
- It may be necessary to improve access roads, bridges, airport, or other infrastructure.
- A substantial margin of spare transport capacity (10-20%) must be provided.
- With health and community services, assess particular requirements for transporting refugees in a repatriation operation, and/or distribution for vulnerable groups.

International transport

33. Arrangements must be made in advance with the relevant authorities for priority clearance and duties exemptions.

Air

34. In the emergency phase, supplies from abroad may arrive by air. Provide Supply Management Service at Headquarters with an update on the handling capacity of the airport (state of equipment, working hours, etc.) and the list of documents required for import and export of relief supplies.

Sea

35. As soon as details of the arrival of relief supplies by sea are known, arrangements should be made for clearance and priority allocation of an alongside berth and/or handling of cargo. In principle, relief supplies should be loaded only on vessels with the capacity for self-discharge. Whenever discharging alongside, they should do so directly onto trucks if possible. Arrangements for onward movement of the supplies and any interim storage necessary must also be made well in advance of the estimated time of arrival of the ship.

National transport

Transport networks

36. In many countries, existing transport services do not have a large spare capacity or may not serve the area where the refugees are located.

37. Where a suitable rail network exists, this can be an effective way of moving supplies. However, many railway systems are either congested or short of rolling stock (the locomotives and carriages used by railways) and long delays may be encountered. In most cases, onward movement by road to the final destination will be necessary.

38. Assess rail, road and inland waterway capacity, journey times, reputable trans-

port contractors, freight rates, capacities and facilities at trans-shipment points (for example transferring goods from ferry or rail to road), and availability of fuel supplies and maintenance facilities. Explore if other humanitarian agencies have spare transport capacities.

Evaluate various transport corridors (including reception capacity) for cost and speed of delivery – even airlifts may not always significantly reduce delivery time.

Road transport

39. Light vehicles will be needed for staff and for specific purposes such as ambulances, and heavy vehicles for transporting cargo, and for transporting refugees in repatriation operations.

40. There must be appropriate servicing facilities, including fuel, spare parts, and administrative support. Special arrangements, e.g. establishing workshops, may be necessary.

Managing a transport fleet requires strong administrative skills, good communications and close coordination with the procurement and other functions to ensure efficient timing for collection and delivery.

Assessing and planning vehicle needs and servicing facilities is described in Annex 2.

41. Drivers must be given training in UNHCR procedures. A sufficient number of drivers must be hired to ensure that recommended working hours are not exceeded.

Accident rates increase markedly with tired drivers.

A system must be established to monitor and control vehicle use, (see Annex 4 for an example of a vehicle log sheet). For light vehicles, drivers should be assigned to a specific vehicle for which they should be responsible.

42. In some situations, urgent action may be necessary in order to improve access roads. Technical advice will be of paramount importance in deciding how improvements should be made (seek advice through Technical Support Section at Headquarters). These improvements could be undertaken by the ministry of transport (or appropriate authority), perhaps supported by refugee labour. In some situations, careful briefing will be required about alternative routes in case usual roads are impassable.

43. Vehicles, bicycles, or animal or hand carts could be used for final distribution. Observe how local movement of supplies normally takes place.

Transport capacities

44. If a commodity is to be transported by truck, the number of trucks needed should be calculated from the following information:

i. The quantity of goods to be transported in weight and volume.
ii. The type of commodity to be transported, such as fragile goods (special handling) and temperature sensitive (special cooling system).
iii. Type of truck available and its capacity in payload and volume.
iv. How long a round trip takes (including loading and offloading).
v. Time allowed for routine maintenance capacity or time allowed for other known factors (driver breaks).
vi. A margin for unpredictable events (such as breakdowns, accidents, bad weather, road and bridge repairs). The size of this margin will depend on many factors including the likelihood of new arrivals and the need to build up buffer stocks near the refugees. In difficult conditions, the theoretical capacity might need to be increased by 25% or more.

45. To give an example for food:

i. The number of refugees served is 30,000 who need 500 g/person/day, which is total 15,000 kg /day, or 15 MT /day.
ii. Truck capacity is 20 MT per truck.
iii. The rainy season journey time from the port of entry to a regional warehouse serving the 30,000 refugees is 3 days out and 2 days back.
iv. One day per round trip is added for routine maintenance.
v. The road surface can take a truck and trailer with a combined payload of 20 MT.

46. Therefore it will take 6 days for one truck to transport one 20 MT load, and 30,000 refugees will require 90 MT of food every six days. Therefore the theoretically required capacity is for 4.5 such trucks. In such circumstances, it is clear that six trucks would be the prudent minimum.

47. Appendix 1 (Toolbox) sets out the capacities of different means of transport.

Transporting people by road

48. Logistical support will be necessary when transporting people for e.g. repatriation operations or relocating refugees to another site . Ensure there is close coordination with health and community services. Take particular care to look after vulnerable individuals, and minimize any risk of family separation. Passengers must be registered on a passenger manifest, wristbands should be used whenever possible, and water and food provided if it is a long journey. Ensure trucks have safe access (for example ladders).

49. When transporting medically vulnerable individuals such as pregnant women, it is preferable to use buses or ambulances. If trucks must be used, weigh the trucks down with sand bags to minimize the roughness of the transport. If there is a risk that some passengers might have a contagious disease, disinfect the vehicles after the journey.

50. Determine the number of light and heavy vehicles needed. These could include minibuses for 8-12 passengers to transport staff and vulnerable individuals, ambulances or mobile clinics (ask health staff about specifications), vehicles for transporting possessions, and mobile workshops.

51. If a convoy is necessary, plan for escort vehicles at the front and back of the convoy. If the operation involves many journeys over a short distance, consider having roving patrols with telecommunications, in case there are problems or breakdowns. For further details, see Supply Management Handbook, section on moving people.

Reception of goods

- Have a single consignee and address and inform Headquarters of any changes.
- Use the internationally accepted marking and packaging standards.
- Inspect goods on arrival and register insurance claims: supplies can get lost or arrive damaged.
- Advance arrangements with appropriate government authorities and freight forwarders will be necessary for rapid handling of supplies from abroad.
- Develop and promulgate a clear policy for customs clearance procedures for NGOs.

Consignment

52. Ensure offices sending supplies know who the consignee is. The consignee would normally be the Representative, with an indication in brackets of any special instructions, for example “For (name of project/NGO)”.

Have the same consignee and address for all items required from abroad for the UNHCR emergency operation.

However, where UNHCR was not previously present it may be better to consign c/o a UN organization already well known in the country, for example United Nations Development Programme (UNDP), provided no delays will result. Similarly, there should be a single consignee and address at the camp level.

53. Whether purchases are made locally or abroad, proper packing, labelling, marking are essential. All organizations and donors need to use a uniform system for marking or labelling relief consignments – use the following guidelines:

i. Colour code: The colours used for the relief supplies are: red for foodstuffs, blue for clothing and household equipment, and green for medical supplies and equipment;

ii. Labelling: If necessary the consignment should bear one of the international hazard warning signs (fragile, no hooks, keep dry, etc.). Consignments of medicines should state on the outside of the package the content and the medicines' expiration date and whatever temperature controls are necessary. English or French should be used on all labels and stencilled markings, though another language may be added. It is essential that the final destination (or port of entry) appears at the bottom of the label in very large letters;

iii. Markings: All internationally or regionally procured goods will normally be marked with the UNHCR project code, purchase order numbers, commodity, packing specifications, port of entry and the consignee. Relief supplies should always be packed by commodity type. Mixed consignments create problems in warehousing and in the ultimate distribution at the receiving end. The colour code recommended loses its value if, for example, medical supplies are packed in the same container as food;

iv. Size and weight: Packing units should be of a size and weight that one person can handle (ideally, 25 kg; up to a maximum of 50 kg) since mechanical loading and unloading equipment may not be available at the receiving end.

Advance notice should be sent to the consignee. The following information (preferably in one document) is essential, for safe transport and ease of handling at the receiving end:

i. name of sender (or "shipper") – normally the Supply Management Service in Headquarters;
ii. name of consignee;
iii. method of transport, the name of the vessel or the number of the flight or truck, estimated time of arrival, port or airport of departure, and name of transporter (e.g. aircraft of shipping company);
iv. a detailed list of contents, including weight, dimensions, and number and type of packing units;
v. a pro-forma invoice or gift certificate showing the value of the consignment;
vi. if the consignment is insured then the type of insurance, name of company, etc.;
vii. the clearing agent, including the name of the person to be contacted in the receiving country; and.
viii. instructions or special requirements for handling and storing the supplies

An acknowledgement should be sent to the sender as quickly as possible after consignments are received, and indicate whether the goods were received in good order and/or there was any loss or damage.

Clearance procedures

54. The supplies coming in for the operation may far exceed the scope of the routine arrangements between the authorities and the local UN community. Problems and delays may be avoided by discussing in advance the procedures to be followed by UNHCR with senior officials in the foreign ministry, ministry of finance, customs authorities, and airport and port authorities. The aim is immediate release of incoming supplies.

Arrangements for clearance procedures and duties exemptions must be made in advance.

55. Arrangements will need to be made with:

i. The Civil Aviation Authorities (CAA) and airport authorities for priority clearances for relief flights (whether international or national) and waiver of fees. These arrangements include: over-flight clearance; free landing rights, air traffic control and parking; priority handling of aircraft and charges at cost for handling services.
ii. The ministry of finance and customs authorities for exemption from duties and taxes of goods and services (such as the tax element of landing fees and fuel tax). Ensure the Ministry of Finance (as well as the CAA) have been advised in advance of planned airlifts for the operation.

56. UNHCR's cooperation and/or implementing agreement with the government should allow for the duty-free import of all items, provided that they are required for the operation (see chapter on implementing arrangements, and the UNHCR Checklist for the Emergency Administrator). Special duties exemption and customs clearance procedures may have to be developed for the emergency.

Implementing partners' clearance

57. UNHCR can undertake the customs clearance for implementing partners' relief supplies, provided these meet the purposes of the emergency operation. This will allow some control over the arrival of clearly unsuitable goods, and help in the coordination of material assistance.

58. Guidelines should make it clear to all potential consignors that UNHCR will undertake to clear only supplies for which notification is received prior to dispatch and which are considered appropriate. The guidelines should be made available to implementing partners active in the operation and to new implementing partners on arrival.

Guidelines on customs clearance for implementing partners should be drawn up as early as possible in the operation.

A copy of these guidelines should be shared with Headquarters and reference to this general procedure made in any NGO briefings at Headquarters, as well as in the first few general sitreps.

Handling costs and other fees

59. The expenses incurred in customs clearance, handling, storage, and onward movement of supplies belonging to UNHCR should be budgeted for. UNHCR might receive supplies procured by an implementing partner on their behalf, in which case all expenses involved should normally be borne by the implementing partner, and UNHCR will be the "consignee of convenience" (not the "owner" or "donee"). However, in certain circumstances and provided the supplies are items directly foreseen in the UNHCR operation (for example blankets, tents), UNHCR may also meet onward transportation costs.

Inspection and damage

60. All consignments must undergo a visual and quantitative inspection on arrival

(by staff) and some deliveries will be required (under government regulations) to undergo a qualitative inspection by a government designated inspection company.

61. If during the inspection, visible damage is noted, the damage must be clearly indicated on the shipping documents and a claim lodged against the last transporter within three days of receipt of the goods. The claim should indicate the dollar value at which UNHCR holds the transporter fully responsible for the loss or damage. A copy of the claim should be sent to the Supply Management Service in Headquarters who will follow up. The value of the loss or damage must include any associated transport costs. If damage is not visible and the packaging is undamaged, transporters will only accept a claim if it is lodged within seven days of receipt of the goods. Take photos of the damaged goods before signing for receipt of the shipment.

Do not accept supplies that do not meet contract specifications.

Headquarters should always be informed immediately of any damage or shortfalls or if the products do not meet specifications.

Insurance

62. Some damage, whether during transport or storage, is inevitable and considerable sums may be involved in the loss. Internationally procured supplies are insured against loss or damage in transit. Insurance claims must be reported to SMS for processing.

Storage

- There must be appropriate storage capacity, correctly sited.
- The requirement for buffer stocks must be properly calculated and forecasted – do not hoard "just to be prepared".

Basic requirements

63. Goods must be protected from damage due to bad handling or improper stacking; the adverse climatic effects of the sun, rain, cold or humidity; attacks by pests; and bacteriological decomposition of both food and non-food items over time.

64. Storage facilities may be required for:

i. initial storage near the port of entry;
ii. transit storage at certain key transshipment locations;
iii. local storage no farther than one day's transport from the refugees; and
iv. storage at camps.

See Figure 1 for information about location of storage facilities.

65. Warehouses must be accessible in all seasons and weather – plan well in advance of the winter or rainy seasons. Existing government warehousing should be used if it meets operational requirements.

66. Security of supplies must be ensured. Warehouses must be secure against theft, and should be lit if possible. Storage for local purchases should be the responsibility of the supplier whenever possible. Particular attention must be paid to those items requiring special storage.

67. A single large building is better than several small ones, as long as there are sufficient loading doors and access ramps. The doors must be large enough to allow for quick loading and offloading and small enough to keep control of the entry and alleyways.

68. Organize the distribution and storage system so that supplies are handled a minimum number of times. This will not only incur less costs, but also less damage and loss. Remember the rule "first in first out" for stock management and avoid offloading in the rain.

Considerations in warehouse selection

69. Warehouses should be well-constructed, dry, well-ventilated, and provide protection from rodents, insects and birds. The floor should be flat and firm and the building should be easy to access, with suitable arrangements for loading and unloading (e.g. a ramp or platform).

70. When selecting a warehouse check the following:

- state of the roof and ventilation;
- state of the walls and whether they are water tight;
- state of the floor, its insulation and general water drainage;
- number of traffic lanes and doors;
- availability of handling equipment and labour;
- utilities (water, electricity, toilets, fire protection);
- office space and lodging for drivers and guards;
- special configuration as necessary for example for fuel, construction material, water reserves; and
- fences, guards, and secure doors and windows.

71. Warehouse capacity required will depend on the nature, variety and quantity of goods supplied, the numbers of refugees they serve, and what outside support they need. Buffer stocks of essential items, particularly food and fuel, should be built up close to the refugees.

Sufficient stocks should be on hand to cover likely interruptions in the delivery schedule. As a rule of thumb, this should cover one to three months distribution.

Conversely, care should be taken not to hold unnecessarily large stocks of items that are not immediately required by the refugees, e.g. seasonal items such as heaters or blankets.

72. The volume of a warehouse necessary to store a given commodity may be roughly estimated as follows. First calculate the volume of the goods. As an indication:

1 Metric Tonne of	Occupies approximately
Grain	2 m^3
Medicaments	3 m^3
Blankets (approx. 700 heavy blankets per bale)	4-5 m^3
Blankets (loose)	9 m^3
Tents (approx. 25 family tents)	4-5 m^3

If the goods can be stored to a height of 2 metres, the minimum surface area occupied by the goods will be half their volume. Increase this surface area by at least 20% to allow for access and ventilation.

73. For example, the approximate size of a store to hold 2 months' supply of the cereal staple for 30,000 refugees receiving an individual cereal ration of 350 g/day would be:

350 g x 30,000 x 60 days = 630 MT

1 MT of grain occupies 2 m^3

Therefore 630 MT occupies 1,260 m^3

1,260 m^3 stored to a height of 2 m gives a surface area of 630 m^2, add 20% for access = 756 m^2 of floor space. A building some 50 m long by 15 m wide would therefore be indicated.

Warehouse construction

74. If suitable storage facilities do not exist, they may have to be built. Local techniques, materials and practices are likely to be the most appropriate in the longer-term. However, for rapid construction, it may be necessary to use prefabricated (tent) warehouses as a temporary measure. These should be carefully sited, protected from surface water by digging ditches if necessary, and with raised platforms inside (for example using pallets, or groundsheets on sand). The contents must not touch the tent walls. Prefabri-

cated warehouses are held as part of the UNHCR central emergency stockpile. They are 24 m long x 10 m wide with a capacity of between 750 to 1,100 m^3.

Stock management

- Effective stock management and security are imperative and must cover the whole supply chain through to the final distribution to families or individuals.
- Report on stock levels, movements, losses, damage and distribution using the UNHCR Commodity Tracking System (CTS).

75. The stock management system should ensure that initial low quantities of goods can be put to best use and quickly into distribution.

A sound stock management and distribution system is essential in order to identify potentially critical shortages in time and assure final delivery to the beneficiaries.

Levels of relief may not meet total requirements of the beneficiaries – the agencies involved must identify what goods should be immediately distributed and to whom.

76. The stock management and distribution system should identify what has been ordered, where the goods are, when they will be delivered, and where they have been distributed. This information must be available to those responsible for the operation.

77. Control mechanisms include verifying the bulk consignments on arrival, physical stock checks in the warehouses, individual ration cards or distribution checks at the sites and carefully calibrated measures (scales) for final distribution. The nature of these mechanisms will depend on the circumstances, but they must be in place from the start and they must provide real and not just theoretical control. The supplies actually distributed to the refugees must be reconcilable with those known to have been delivered, those remaining in storage, and those which are lost or damaged.

78. In the emergency phase certain basic controls should be established at once, in addition to the controls over actual distribution. These are described in Annex 3.

79. The UNHCR Commodity Tracking System (CTS) is a computerized tool for stock management, which uses information from purchase orders and shipping and warehouse documentation (described in Annex 3), to track goods from their arrival at the port of entry of the country of operation, to the final distribution point. An additional module ("pipeline management module"), which can be attached to the CTS, tracks goods from the point of source (globally) to the port of entry.

80. The stock control and distribution system (including CTS) provides information to fulfil reporting obligations – ensure the system takes account of reporting needs as specified by Community Services, Field and Programme Officers. See UNHCR Commodity Distribution, A Practical Guide for Field Staff for further guidance, in particular on setting up a reporting system for distribution.

81. Supply Management Service in collaboration with MSRP is in process of developing a Fleet Management System (FMS) which is a computerized tool for fleet management, which keeps track of the maintenance and repair of vehicles, generators, etc., of fuel consumption, vehicle insurance, and the registration of vehicles, their re-deployment and disposal.

82. Assistance with setting up the CTS or FMS (when it is ready) can be obtained from Supply Management Service, Geneva. Both CTS and FMS will be part of the MSRP when it is implemented in the field.

Key references

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1 IOM116/94 FOM120/94, UNHCR 14.12.94.

Annex 1: Standard specifications for certain common relief items

These specifications can be useful in drawing up tender requests where local purchase is possible, to assist in negotiations with suppliers, and to give a clear indication of what could otherwise be supplied at short notice through Headquarters (some items are available in the emergency stockpile – see Appendix 1, Catalogue of Emergency Response Resources).

1. High Thermal Fleece Blankets – Item no 2028

Composition: Polyester – 100 % - TOG (Thermal Resistance of Garment): min: 1.5

Bursting Strength: 350 kpa, min: 25 kg both ways – Thickness: min 3.5 mm under load of 20g/cm^2 – Weight: 250g/m^2 – Colour: Assorted colours (Dark Blue, Grey, Brown, Dark Red)

Dimension: 150 cm x 200 cm – Edges: Folded and Stitched

Marking: UNHCR Logo printed. Size of logo 40cmX40cm to be placed in the centre of blanket.

Packing: a) in bales of 30 blankets secured with polyester band; b) the size of bag shall be as the size of the folded blanket, namely: 45 x 35 x 65 cm in order to improve stability and stackability of the bales; c) the bales should be compressed. – Gross weight per bale: Approx. 23 kg – Number of blankets per 20' Container – 5,250 (without pallets);

2. Woven dry raised blankets (Type B) (for cool climates)

Composition: Woven, minimum 50% wool. Balance of new synthetic fibre

Size: 150 x 200 cm, thickness 5 mm

Weight: 1.5 kg

T.O.G.: 2.0 - 2.4 (thermal resistance of garment)

Finish: 10 stitches/decimetre or ribbon bordered 4 sides

Packing: Compressed watertight wrapping in pressed bales of 30 pcs. Each bale of 30 pcs would be about 0.35 m^3 volume and weigh 50 kg.

3. Heavy duty plastic bucket, 10 litre

Type: Heavy duty plastic bucket, multi purpose, with lid

Material: High density polyethylene (HDPE), food grade material, conical seamless design

Handle: Steel-wire bale handle, fitted with plastic roller grip, rust proof

Thickness: Minimum 1.0 mm

Dimensions: Approx. top diameter: 30 cm; approx. height: 30 cm; volume 0.01 m^3

Weight: 450 g

4. Jerry cans, 10 litre Semi-collapsible jerry cans

(Semi-collapsible jerry cans are the preferred option because of the much lower shipping volume, but they are sometimes difficult to obtain locally).

Type: Semi-collapsible plastic jerry cans for drinking water

Material: Manufactured of food grade HDPE (i.e. containing no toxic elements)

Construction: Semi-collapsible; built-in carrying handle, wide enough for adult hand; screw cap linked to container by polymide string; jerry can opening 35 mm (inner diameter); 0.6 mm thick walls.

Impact resistance: Must withstand drop from minimum 2.5 m containing maximum volume

Operating temperature: -20 to 50°C

Weight: 200 g/pce

Packaging: 150 pcs/wooden crate. Each crate weighs 49 kg, volume 0.38 m^3

Non-collapsible jerry cans

As above, except non-collapsible, weight 400 g/pce; 1 mm thick walls; jerry can opening 40 mm (inner diameter)

5. Kitchen sets

Kitchen sets – Type A

a) 1 aluminium cooking pot, 7 litre, minimum thickness 1.75 mm, with lid minimum thickness 1 mm, two cast aluminium handles, sandpaper finish.
b) 1 aluminium cooking pot, 5 litre, as above, minimum thickness 1.6 mm.
c) 5 aluminium bowls, minimum thickness 1 mm, 1 litre capacity, rolled edge border, sandpaper finish.
d) 5 deep aluminium plates, minimum thickness 1 mm, 1 litre capacity, sandpaper finish.
e) 5 aluminium cups, minimum thickness 1 mm, 0.3 litre capacity, with handle, rolled edge border, sandpaper finish.
f) 5 stainless steel table spoons, polished finish.
g) 5 stainless steel table forks, polished finish.
h) 5 stainless steel table knives, polished finish.
i) 1 kitchen knife with stainless steel blade, cutting edge 14/15 cm long, 2.5 cm wide with moulded plastic handle.
j) 1 galvanized steel bucket, 15 litre, 0.5 mm thick, tapered with raised bottom, curled brim and metal arch handle.

Packing: Individual carton: 30 x 30 x 33 cm = 0.02 m^2

Weight: Approx. 5.5 kg

Kitchen sets – Type B

Consists of the following items: a, b, c, (or d) e, f and optionally i).

Packing: 4 sets per carton: 56 x 56 x 19.5 cm = 0.06 m^2

Kitchen Sets – Type C

Consists of the following items: a, c, (or d) e and f.

Packing: 4 sets per carton: 54 x 54 x 19.5 cm = 0.05 m^2

6. Reinforced plastic tarpaulins in sheets

Sheets are 4 m x 5 m each.

Material: Made of woven high density polyethylene fibre; warp x weft (12/14 x 12/14 per inch); laminated on both sides with low density polyethylene with reinforced rims by heat sealing on all sides and nylon ropes in hem; 1000 dernier min. Stabilized against ultraviolet rays and excess heat for long outdoor exposure (1.5% loss of strength in yarn and in lamination); provided with strong aluminium eyelets or equivalent on four sides of the sheet at 100 cm centre to centre.

Dimensions: Thickness: 200–230 microns; weight 190 g/m^2; density 0.9–.95 kg/cubic decimetre.

Tensile strength: Min. 600 N both directions of warp and weft (BS 2576, 50 mm grab test or equivalent).

Tear resistance: 100 N Min. both directions (BS 4303 wing tear or equivalent).

Heat/cold resistance: Flammability: flash point above 200°C.

Colour: Blue one side white on reverse; UNHCR logo.

Weight: 4.8 kg per piece, packed in bales of five, weight per bale 22.5 kg; volume per bale 0.045 m^3.

7. Soap bars:

Composition: Min. 70% fatty acid: max. 20% moisture, max. NAOH 0.2% max. NACL 1.25%; no mercury content. Local standards of lower content of fatty acid might be acceptable.

Weight: Soap bars should be approx. 125 g/piece.

8. Double Fly double fold centre pole tent

Family sized tent.

External dimensions: 4.4 m x 4.4 m (outer fly), surface area 19.36 m^2, centre height 3 m.

Internal dimensions: 4m x 4m, floor area 16 m^2, centre height 2.75 m, side wall height 1.8 m (25 cm distance between outer and inner fly).

Material: Cotton canvas; 100% cotton yarn (10/2 x 10/2 twisted in warp 42/44, weft 24/26 threads per inch, plain weave); 15–16 oz/m^2. Canvas to be free of weaving defects and finishing faults adversely affecting strength, waterproofness and durability. Water proofing/resistance to water penetration by paraffin wax emulsion and aluminium acetate to withstand 20–30 cm hydrostatic head. Stabilization against decomposition of the fabric (rot-proofing) with copper napthanate.

Poles/ropes/pegs: 4 aluminium or bamboo poles for roof corners (2 m x 22 mm diameter); heavy duty sectional steel tube (or aluminium or bamboo) centre pole, plastic clad or galvanized (3 m x 50 mm diameter). Complete with ropes made of 9mm 3 strand polypropylene; 24 T-Type bars 40 mm x 40 mm, 50 cm long; 12 iron pegs (25 cm x 9 mm diameter), one iron hammer of 1 kg; one repair kit with one straight and one curved needle with 20 m of suitable thread for tent repair, illustrated assembly instructions with list of contents.

Groundsheet: Reinforced PVC groundsheet 250g/m^2.

Packing: All rolled into a canvas bag. Weight 100–130 kg, dimensions: 2 m x 50 cm diametre (0.4 m^3).

Annex 2: Planning vehicle needs

1. Assessing needs

Assessing vehicle needs involves not only calculating the vehicles which are needed, but also assessing what vehicles it will be possible to operate and maintain in the area of operation. Make sure that the existing infrastructure (roads, workshops and fuel) is fully evaluated before obtaining vehicles.

What will the vehicles be used for and how many are needed?

Heavy vehicles

i. Will the vehicles be used for transporting people or relief supplies?
ii. What will be the frequency of use (one-off transport, or scheduled deliveries for distribution)?
iii. What is the total quantity (of goods or people) to be transported?
iv. Are any special configurations necessary: if a truck is to carry dangerous goods e.g. fuel, ensure that dangerous goods regulations are followed.

Light vehicles

i. How many vehicles are needed for staff? In an emergency, it is advisable to have a ratio between light vehicles and international staff of 1:1. In more stable situations, slightly fewer vehicles per staff member may be acceptable.
ii. What special vehicles might be needed (e.g. ambulances for transporting vulnerable refugees)? The main categories of light vehicles which might be useful are: sedan and minibus (4x2 only), and station wagon, van, pick-up, and ambulance (both 4x2 or 4x4).

What configurations of vehicles are needed?

i. What is the condition of the routes that will be used? Tarmac roads, good unpaved roads (with stone or macadam surface), sand or dirt trails, or no roads (in which case consider animals for transport).
ii. How long are the journeys expected to be?

Light vehicles

i. What configuration light vehicles should be used according to road conditions: 4x2 or 4x4?

Heavy vehicles

i. What configuration for heavy vehicles should be used according to the road conditions: 4x2, 4x4, 6x2 or 6x4?
ii. Should trailers be used? Trailers can be more economical, i.e. with a relatively small investment one is able to transport twice the amount of cargo. The following configurations for heavy vehicles (trucks/trailers) could be appropriate:

i. Truck with trailer (6x2 or 6x4) with a combined capacity of 20-40 MT for transport up to 3,000 km, 2-7 day trip, normally for use on tarmac roads.
ii. Truck (6x4, 4x4, 4x2) for intermediary distribution with a capacity of 10-15 MT (normally 1 day trip) on unpaved roads with stone or macadam surface.
iii. 5-10 MT capacity trucks on tracks and trails (generally for trips of half a day or less up to distribution points).

Trailers

Prior to purchasing trailers, the following additional questions should be considered:

i. Are the roads and bridges suitable to drive on with trailers?
ii. Are the drivers capable of driving with trailers?
iii. What are the regulations in the country regarding the weight and length of truck-trailer combinations?
iv. What type of trailer is needed? Can the trucks be operated with trailers or would tractor trailers be better? Can the trailer be transported on the truck on empty runs? Ensure there are air-brakes, a towing hook, extra fuel tanks and spare wheels. Particular attention must be paid to the tow-bar strength and number of axles.

What makes and models of vehicles would be appropriate?

i. What makes of vehicles are maintained (to supplier specifications) by local service dealers? The heavy vehicle fleet must be standardized to suitable makes and models already operating in the country. If a mixture of models of truck is unavoidable, it may still be possible to standardize to a single make.
ii. What is the availability of vehicles: the spare capacity of local transport companies, and possibility of purchasing new or second hand vehicles?

Infrastructure (fuel, workshops)

i. Is there a service network available with the know how to maintain the fleet, or will it be necessary to set up dedicated workshops and fuel stations?
ii. Are there sufficient spare parts and tyres in the local market, or must they be imported?
iii. Is fuel (diesel and gasoline) and are lubricants readily available in the area of operation? (note the number of fuel stations, capacity and likely availability of fuel at each).

2. Sourcing vehicles

Vehicles (whether light or heavy) can be: rented locally, provided by the government, loaned from another UN Office in the region, re-deployed from another

UNHCR operation, or purchased. Heavy duty vehicles can also be provided under a standby arrangement (see Catalogue of Emergency Response Resources, Appendix 1). If trucks are to be purchased internationally, send a request to the Supply Management Service in Headquarters by completing the appropriate form (Operations Analysis Form for Trucks – request this from Headquarters if necessary).

In order to analyze the procurement options, take into account the following:

i. Expected length of operation. If the expected length of the operation is short, (3 - 6 months), or the situation is very unstable, it may be better to rent, loan or re-deploy rather than purchase vehicles, because of high initial costs.

ii. Comparative costs. Compare the cost of renting vehicles with the cost of purchasing them (including delivery costs). Consider purchasing second-hand vehicles if they are in good enough condition.

iii. Servicing and other benefits. Take into account that renting vehicles will include servicing and other benefits (such as drivers, insurance) which would need to be separately arranged if the vehicles are re-deployed, purchased, or loaned.

iv. Time. Light vehicles can be quickly deployed from the UNHCR emergency stockpile (see Appendix 3). Purchasing new vehicles can be very time consuming, because of long delivery times (up to 8 months if they are manufactured to order, which is usually necessary for the configuration of heavy duty vehicles for UNHCR operations). If there is an urgent need for heavy vehicles, inform Supply Management service at Headquarters of the vehicle requirements and infrastructure, who will look into possible options (re-deployment, purchase etc.) in the international market and regionally. If it becomes necessary to purchase vehicles, early notification and action will be a priority.

v. Other options. Consideration could also be given to the possibility of "grafting" the heavy vehicle fleet onto a large national or regional transport organization. That organization's infrastructure, including workshops, offices, etc. would then be immediately available as would its accumulated experience of operating in the country.

The vehicles exclusively involved in the operation should be individually numbered and distinctively marked – for example, white with blue markings.

3. Fuel and maintenance facilities

There must be adequate servicing facilities, including sufficient supplies of fuel and spare parts. Maintenance and repair must be carried out regularly and as per manufacturers' standards, either through local service dealers or through a UNHCR workshop. Regular maintenance will prevent minor problems turning into major ones. Proper driving and care by the drivers can be an important factor in keeping vehicles on the road and prolonging their life. Adequate training, incentives and supervision will be the key to this.

Fuel and lubricants

- Assured supplies of fuel and lubricants must be available where they are needed (make sure oil and lubricants are in accordance with manufacturer's specifications – and new). This may require separate, secure storage arrangements and an additional fleet of fuel tanker vehicles. It may be necessary to establish fuel stations to ensure fuel supplies.

Spare parts and workshops

Consumable items (filters, shock absorbers, brake linings etc.) and spare parts must be available, especially tyres: tyre life may be no more than 10,000 km in rough desert or mountain conditions. Arrangements for maintenance and repair include:

i. Making use of or strengthening existing facilities:
   Existing commercial, government or UN facilities (e.g. WFP or DPKO) may be able to service additional UNHCR vehicles or could be strengthened in order to do so.

ii Establishing dedicated workshops:
   Workshops may have to be established by UNHCR solely for the operation – for example a central, fully equipped workshop, including personnel, tools, soldering capacity, spare parts store, and transport administration office. In addition, depending on the size and area of the operation, consider also having smaller workshops and transport administration offices closer to isolated destinations.

iii. Mobile workshops and heavy recovery vehicles may also be necessary:
   Always ensure there is recovery capacity for trucks, such as mobile workshops, recovery trucks, winches, etc.

Annex 3 – Stock management systems

This annex gives an indication of the basic components of a stock management system. The minimum level of controls necessary will vary with each operation. Simple controls and accounting established from the start will be much more effective than a sophisticated system later. No system will be effective unless it is understood by those required to operate it. Training will be required for all staff involved. All these documents are UNHCR forms apart from waybills. The computerized UNHCR Commodity Tracking System (CTS) relies on the information contained in this paper system.

1. Stock control

i. Pipeline report: Each order or consignment (including contributions in-kind), should be tracked using a pipeline report. This records all stages of stock movement from the initial request for goods through, as applicable, requests for tenders, placing of order, notification of shipment, planned delivery time and place, actual time of arrival, and distribution details.

ii. A simple board where progress can be monitored visually is likely to be very useful and can be set up at once.

2. Source documents

Source documents identify the quantity of the commodity, specifications, packaging, value and origin.

i. Purchase order. This defines the order: specifications, number of units ordered, price/unit, total price, packaging, date of purchase, supplier, destination etc. It should make reference to the legally enforceable standard conditions of contract.

ii. Contribution Advice Form (CAF)/ Donation Advice Form (DAF). When contributions in-kind are pledged, Fund-raising and Donor Relations Services in Headquarters issues a CAF or DAF. This gives similar information to a purchase order and the information should be used to track the goods until final distribution in order to account to the donor as stipulated in the CAF/DAF.

3. Authorization documents

i. Release request. This is a formal request for goods which authorizes warehouse staff to release goods from stock.

ii. Transporting/warehouse request. This gives formal approval for NGOs to use UNHCR transport or warehouse facilities for their goods.

4. Certification documents

There are a number of documents which are used to certify that goods have been received, delivered, and/or sent in good order.

i. Waybill/air waybill/bill of lading. This is the shipping document and contract with the transporter showing the destination and accompanies the goods from the port of loading to the contracted destination in duplicate. This document is the basis for customs clearance and enables staff to check goods actually received against those loaded. Duplicate copies are also used by procurement staff to verify goods dispatched against those ordered (i.e. against the purchase order form). Where the movement is between UNHCR warehouses, use the delivery note (attached as Annex 4).

ii. Release note. This is used when goods are collected at the warehouse and the goods leave UNHCR's stock control system – the person (driver or consignor, for example an NGO) who collects the goods certifies that goods have been received in good order.

iii. Delivery note (see Annex 4). The delivery note is sent with the goods when they are transported (under UNHCR's control) to another location (for example another UNHCR warehouse). The receiver of goods signs the delivery note to certify that the goods have been received in good order, and a signed copy is returned to the sender. It is used when the goods have been sent by rail, road or barge (an "Aircargo Manifest" is used where the goods have been transported by air).

iv. Receipt note: Where goods have been received without a delivery note or waybill/bill of lading, a receipt note is signed by the receiver of the goods and sent to the sender for certification.

5. Warehouse documents

Whatever the size of the warehouse or store and wherever it may be located, the minimum recommended book-keeping controls are those outlined below. They must be complemented by routine inspection to ensure goods are properly stored and protected, and by a periodic audit.

i. Daily incoming shipment log sheet. This is used to record basic details of all inward consignments – description of goods, quantity, supplier, name of person receiving and date of receipt, with cross reference to waybills (above).

ii. Daily outgoing shipment log sheet. This is used to record basic details of all outward consignments – description of goods, quantity, destination, and date of dispatch, (with cross reference to waybill, delivery or receipt note).

iii. Stock card (sometimes called a bin card). One stock card for each different commodity in the warehouse is used to record every in and out movement of that particular commodity, with cross reference to the appropriate entries in the incoming/outgoing log sheets. It gives a running balance. Where possible those actually receiving and issuing the goods should not also be responsible for maintaining the stock card.

iv. Daily stock report (see Annex 4). This gives basic details of goods in stock and the quantity, value, weight of these commodities for each warehouse location.

v. Loss/damage report: to report loss or damage to stock (whether incurred during transport or storage).

Movement of goods

The easiest control to ensure that goods reach their destination may be to make (final) payment (for the goods, of the driver or transporter, as applicable) conditional on return of the certified duplicate of the delivery note or waybill. More comprehensive controls and measures (e.g. monitors) may be required later, and are anyway needed to ensure that goods reach their destination (in the worst case, this control only indicates that they did not). But provided the signatories for both authorization and receipt are carefully chosen, and signatures controlled (combining them with a UNHCR seal is recommended), this should be an effective initial safeguard.

Annex 4 – Stock management forms

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

Vehicle Daily Log Sheet

Date:	**Starting Mileage:**

Vehicle Check:

☐ Oil	☐ Water (Radiator & Windscreen Washer)	☐ Brakes (Foot & Hand)	☐ Front Lights	☐ Rear Lights
☐ Tool Kit & Jack	☐ Spare Tyre	☐ Vehicle Clean	☐ Full Tank	☐ Radio Check

Driver (Print Name):	**Driver's Signature:**

Destination	Passengers	Time Out	Time In	Official / Private	Starting km Reading	Ending km Reading

Fuel (liters):	Mileage when fueled:
Fuel (liters):	Mileage when fueled:
Engine Oil (liters):	Engine Oil (type):

Remarks:

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

Delivery Note

Distribution:	
2 copies for Destination *	(Yellow and Blue)
1 copy for UNHCR	(White)
1 copy for Driver	(Pink)
1 copy for Dispatch Warehouse	(Green)

Delivery Note No.

Page _____ of _____ Pages

Issuing Warehouse / Location (Consignor)	**Release Authority**
Receiving Warehouse / Location (Consignee)	**Convoy Number (if applicable)**
Final Destination	**Container Number (if applicable)**
Route	**Transporter (Print Contractor Name)**
Rail Wagon Vessel or Vehicle Plate No.	**Driver (Print Name)** **Signature**

Control No. PO or Donor	Item Description	Packing Unit (PU)	Pieces per PU	PU Weight Gross Kg	No. of PU Loaded	No. of PU Unloaded	Loss / Damage Remarks

Total No. of PUs Loaded _____ **Total Kg Loaded** _____

Delivery Note prepared by (Print Name):	Date	Signature
		OFFICIAL SEAL

** All items have been LOADED

Loading Supervisor (Print Name):	Date	Signature	Loading Time: Start Finish

** All items have been RECEIVED except as circled and as per remarks above, or on the reverse;

Unloading Supervisor (Print Name):	Date	Signature	Unloading Time: Start Finish

OFFICIAL SEAL

1. The Consignee at the receiving warehouse must check the quantity delivered and note any loss or damage.
2. ** Any losses or damages must be noted on this form by the Unloading Supervisor.
3. * The consignee at the receiving warehouse must sign all three copies of this Delivery Note and hand over two copies signed and stamped to the driver who will return the Blue copy to the Issuing Warehouse / Consignor.

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

Daily Stock Report

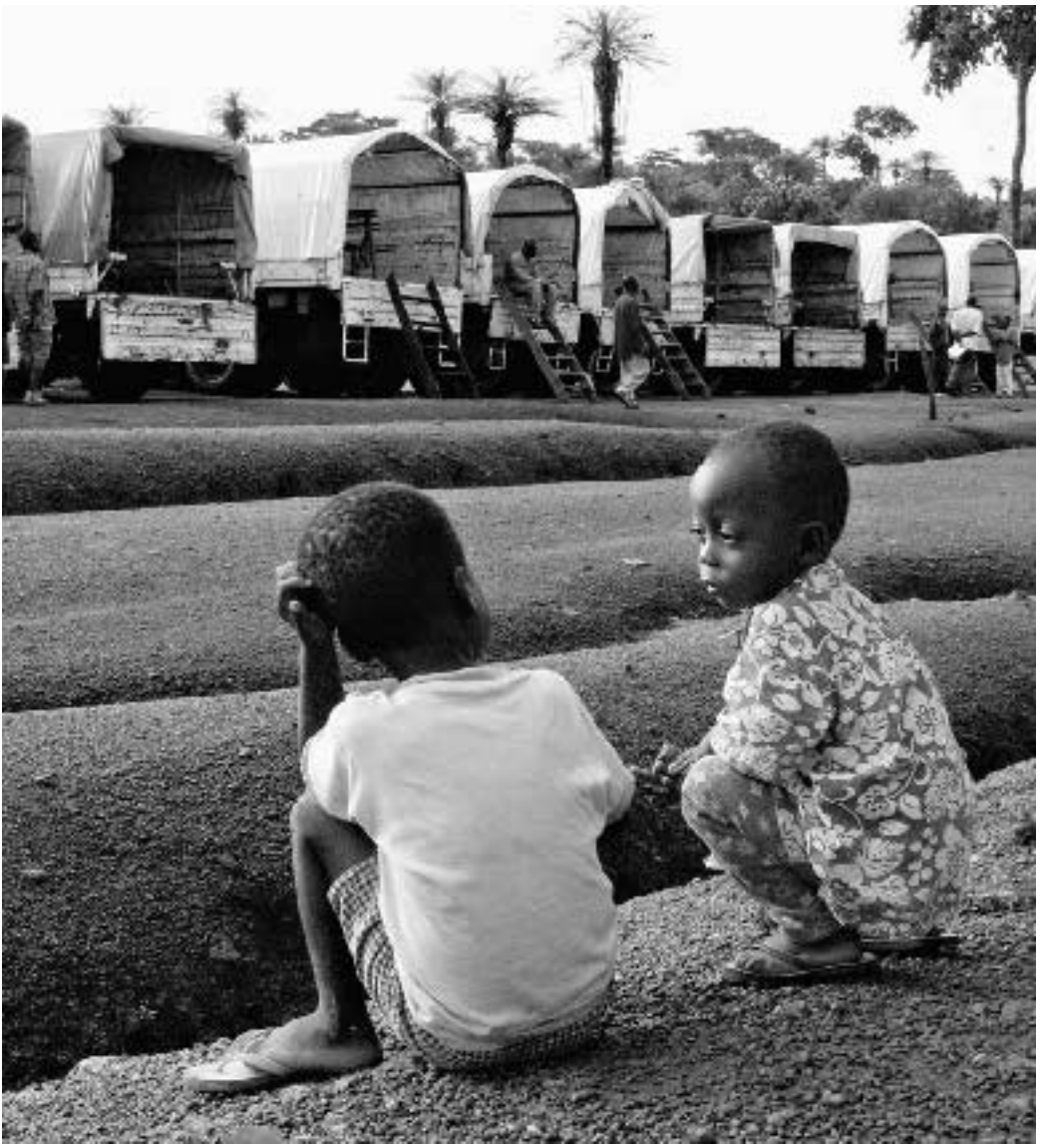
Prepared by:
Checked by:
Distributed:

Organization / Office:	Location:	Date:

Commodity					Stocks Quantity in Pieces or Net Kgs				Remarks:
Control No. PO or Donor	Description (Specific)	Packing Unit (PU)	Pieces per PU	Net Kg per PU	Opening Balance	Issued	Received	Closing Balance	

22

Voluntary Repatriation



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Voluntary repatriation, resettlement and local integration are the commonly accepted three 'durable solutions' to refugee crises. Nowadays regarded as the principle solution for the majority of situations, voluntary repatriation where and when feasible brings alive everyone's human right to return home.

Situation

As political, security and other changes in a number of refugee-producing countries may unfold at an unexpectedly fast pace, it is not always possible to carefully design and plan return and reintegration operations. Voluntary repatriation operations may have to be organized at short notice, and therefore require at times "an extraordinary response and exceptional measures".

When conditions in the country of asylum are perceived as being more dangerous and life-threatening, and all other solutions have been exhausted, repatriation may amount to emergency evacuation. Under such circumstances, life-saving return makes up for the lesser of evils.

Principles of response

The decision whether or not to return home belongs to the refugees. They should neither be forced to return, nor prevented from doing so. Repatriation should be based on a free and informed decision and take place in safety and dignity. The voluntary nature of the repatriation must be verified and safeguarded by UNHCR.

Voluntary return should only be undertaken where there has been a fundamental change in the circumstances causing displacement. Its success largely depends upon the achievement of a reintegration process relentlessly supported by all stakeholders.

Action

Collect and analyse information in the country of origin concerning the conditions for return, share this information with the refugees.

Define the nature of UNHCR's involvement in the repatriation, communicate this to all staff, and to governments and other agencies as appropriate.

Deploy sufficient staff to collect information on the intentions of the returnees and to assess whether the repatriation is voluntary or not.

Provide assistance to returnees in every stage of the return operation, including monitoring of their treatment upon arrival in the area of final destination

Introduction

1. Voluntary repatriation is usually characterized either as:

i. "spontaneous", i.e. where refugees return by their own means; or
ii. "organized", i.e. where refugees return in an organized manner assisted by UNHCR.

2. Spontaneous return tends to take place amidst or in the wake of conflict situations. As and when growing numbers of people spontaneously opt to go back UNHCR usually adjusts its planning assumptions and repositions its presence to provide timely and effective protection and assistance along routes of return and in the country of origin. UNHCR needs to established first and foremost whether it will assist at all in conflict situations, which will depend entirely on the particular circumstances of the situation.

3. Early presence in the prospective areas of return should be sought to establish monitoring systems to gather information on the conditions prevailing in the country of origin and which will be provided to the refugees (e.g. concerning landmines, routes of return and overall conditions).

UNHCR's role in voluntary repatriation

4. UNHCR's role in voluntary repatriation includes the following:

i. Verify the voluntary character of refugee repatriation.
ii. Promote the creation of conditions that are conducive to voluntary return in safety and dignity.
iii. Promote the voluntary repatriation of refugees once conditions are conducive to return.
iv. Facilitate the voluntary return of refugees when it is taking place spontaneously.
v. Organize, in cooperation with NGOs and other agencies, the transportation and reception of returnees, provided that such arrangements are necessary to protect their interests and well-being.
vi. Monitor the conditions of returnees in their country of origin and if guarantees given by the country of origin are adhered to. Intervene on behalf of the returnees if necessary.

5. UNHCR should maintain objective and up-to-date information about the situation in the country of origin. Personnel on the ground should stay in close touch with refugees' thinking on the possibility of voluntary repatriation, and keep the refugees and concerned governments informed accordingly.

6. A distinction is to be made between "promotion" and "facilitation" of voluntary repatriation. Repatriation should only be promoted when it appears, objectively, that the refugees can return in safety and with dignity and the return has good prospects of being durable. UNHCR can promote voluntary repatriation without being in charge of organizing all aspects of the return movement. Frequently, members of a group will make their own arrangements for return, with or without assistance from UNHCR.

7. When UNHCR does not consider that, objectively, it is safe for most refugees to return, but even so refugees indicate a strong desire to return voluntarily and/or have begun to do so on their own initiative, UNHCR must be careful NOT to promote the repatriation, but may take some steps to facilitate it. UNHCR must make clear to the authorities and the refugees that support for such repatriation is based on respect for the refugees' free decision to repatriate and cannot be interpreted as an indication of adequate security.

8. Facilitating repatriation can, depending on the circumstances, include providing information to the refugees, advising on the limits of UNHCR protection and material assistance during and after their return, negotiating amnesties, establishing a presence in the country of origin and monitoring their treatment. The issue of material assistance requires careful handling, so that assistance is not interpreted as a pull factor nor as promotion of repatriation by UNHCR.

9. Where there is a mass spontaneous repatriation in conditions where UNHCR does not consider that, objectively, it is safe for most refugees to return, and in emergency conditions, Headquarter's advice should be sought to define UNHCR's role in such circumstances.

Conditions for a voluntary repatriation

10. In an organized voluntary repatriation, there must be:

i. safeguards as to the voluntary nature of the return;
ii. safeguards as to treatment upon return; and
iii. continued asylum for those who do not repatriate and remain refugees.

Voluntary nature of the return

11. Ensuring the voluntary nature of the return includes ensuring

i. the decision to repatriate is made freely;
ii. the refugees are making an informed decision based on an accurate country profile; and
iii. the decision is made expressly and individually (women on equal footing with men).

12. Voluntariness must be viewed in relation both to conditions in the country of origin (calling for an informed decision) and the situation in the country of asylum (permitting a free choice). Voluntariness means there should be no duress, compulsion or undue pressure on the refugee to repatriate. The decision is based on accurate, objective information.

13. A field office should analyse both factors, relying for the first, to a large extent, on direct interviews with all segments of the refugee community, including women. Consider refugee attitudes both towards changed circumstances in their home country and towards the situation in the country of asylum.

14. Voluntariness also means that the refugees should not be prevented from returning. In certain situations, economic and political interests in the country of asylum may lead to interest groups trying to prevent repatriation.

15. Whatever the nature of the repatriation, the refugees should be kept fully in formed of the situation in the country of origin in order to guarantee the voluntary nature of the return. Though refugees are often already well informed, it may be necessary to provide additional information on the situation in their home country.

16. Information should be available about their planned reception and prospects for reintegration into their community. They will want to know if they have the right to repossess their houses and land, what the type and amount of material support they will initially receive, what they can take with them, etc.

17. Many of their questions may be best answered by:

i. arranging for refugee representatives (including women) to make a visit to the home area to see the situation at first hand, if this is possible (go and see visits);
ii. assisting with the exchange of letters;
iii. enabling communication by radio with relatives in the country of origin;
iv. displays of information about home conditions; and
v. formal or informal discussions with recent visitors to the area of return, or through visits to the refugee camps of returnees or country of origin local authorities.

18. Whatever the method, care must be taken to ensure that the refugees are given as fair (and objective) a picture as possible of conditions in their home area.

19. The refugees must freely express their intent to repatriate. They may be unused to taking individual or family decisions of this nature, but programmes must be structured so that their rights in this regard are safeguarded.

20. In instances of organized return, the use of a voluntary repatriation form (VRF) is recommended (see Annex 1). Where there is any risk of coercion, either from outside or by factions among the refugees, the form should be signed in private in front of a UNHCR officer or other neutral witness. He or she may need to interview the refugees to ensure that their decision is truly voluntary. Where circumstances allow, more informal confirmation of voluntariness than these may be used and simple lists of names may suffice. In cases of massive spontaneous return, completion of a voluntary repatriation form will not be realistic and UNHCR must position officers along the routes of return to monitor, interview and intervene where necessary to determine if instances of coercion are taking place.

Treatment on return

21. The durability of voluntary repatriation depends, to a large extent, on the protection given to returnees during their reintegration into their home country.

22. The state of origin bears responsibility for the protection of returnees, its nationals. However, UNHCR involvement with returnees is justified by virtue of its protection role on behalf of refugees and the Office's statutory responsibility to seek voluntary repatriation as a durable solution for refugees.

23. UNHCR cannot guarantee safe treatment of the returnees, although they will often request such assurances. UNHCR's involvement with returnees is set out in more detail in the UNHCR handbook, the Voluntary Repatriation Handbook, which includes information on amnesties and monitoring.

Amnesties, assurances, guarantees

24. In any voluntary repatriation, appropriate legal safeguards are essential. UNHCR recommends that, in addition to conditions set out in a repatriation agreement, governments independently promulgate amnesties or legal guarantees for returnees. Such declarations should include the right to return, freedom of residence, and the provision of an amnesty. As a minimum, they should stipulate that returnees not be subjected to any punitive or discriminatory action on account of their having fled their country.

25. If the government consults UNHCR when drawing up an amnesty, it is particularly important to propose that the amnesty should be both:

i. A group amnesty: The amnesty should be extended on a group basis, rather than requiring individual determination.
ii. A blanket amnesty: The amnesty should whenever possible be a blanket one, not distinguishing between different types of prior 'crimes'. Such distinctions can create major problems, for example in a situation where a clear differentiation between political and criminal offenses may not be possible. Unless the amnesty is a blanket one, repatriates may not know if they are covered until they return, which may be too late. If a complete blanket amnesty is not possible, then a time limitation on the amnesty (offenses committed before or after or between given dates) should be the aim.

Monitoring

26. UNHCR must have direct and unhindered access to returnees to monitor their safety and reintegration conditions. This should include access to prisons or detention centres (liaison with ICRC and UN High Commissioner for Human Rights will be important in this regard as well as information-sharing with other NGOs working with returnees).

27. If returnees are at risk due to inadequate state protection, UNHCR should intervene on their behalf as appropriate, for example by remedial action, or formal protest at local, national or even regional level, and ensure there is good reporting. In case national or regional authorities systematically refuse to enact remedial action, UNHCR may be forced to review its role in the repatriation process.

28. UNHCR's returnee monitoring role alone will never provide a mechanism for ensuring the safety of returnees and respect for international human rights standards in the country of return. It can be a helpful influence to enhance respect for amnesties, guarantees, the rule of law and human rights but should never be seen as a substitute for state responsibility.

Continued asylum for those who remain refugees

29. Any voluntary repatriation operation and/or agreement must insist that inter-

national protection for those who choose to stay longer in the country of asylum is ensured. Some refugees may continue to harbour a well-founded fear of persecution and therefore would not wish to repatriate. Others may delay their decision, or decide against repatriation, prefering to wait and see until more persons have returned succesfully.

30. This may mean the continuation of any existing operation, but for a reduced number of beneficiaries. Any voluntary repatriation operation will have to be planned and conducted in the context of a broader comprehensive strategy for durable solutions. If refugees remaining in the country of asylum are unlikely to be willing to return home, based on their particular profile and their specific needs, local integration and resettlement may need to be considered as durable solutions

31. If there is a serious problem of coercion, or intimidation, it may be necessary to move those who decide not to repatriate to another location immediately after they have reached this decision. This, too, should be foreseen and covered in any voluntary repatriation agreement.

Other protection concerns

Groups with specific needs

32. Throughout all phases of the operation particular attention has to be paid to groups with specific needs such as unaccompanied and separated children, unaccompanied older persons, the disabled and chronically ill as well as the specific needs of unaccompanied women and single heads of households. In large-scale spontaneous repatriation movements, family members may become separated during the operation and it will be necessary to establish tracing services to reunite families. During registration the identity of groups with specific needs and follow-up mechanisms in the country of asylum or country of origin, should have been recorded.

33. Unaccompanied and separated children require specific arrangements for return (please refer to Action for the right of the Children -ARC). In addition, special travel arrangements might be required for pregnant women, chronically sick persons, etc.

Being prepared for spontaneous repatriation

34. Proactive steps to ensure preparedness for spontaneous repatriation include:

i. Being well informed about the refugee caseload, in particular its origin, history, composition, reasons for flight, and its view of developments in the country of origin.
ii. Liaising closely with the UNHCR office in the country of origin to determine whether internally displaced people are returning home or other developments which could lead to a return movement. Such return movements are often sparked by refugee fears that they could lose their land, property or jobs if they do not return.
iii. Being in close touch with the prevailing concerns of the refugees.

Preparing for repatriation

35. The steps below should be considered in any kind of repatriation, including in emergency circumstances. The management principles described in chapters 1 to 9 should be referred to (e.g. planning, needs assessment and implementation) and reference should also be made to chapter 21 on supplies and transport.

36. If indicators for a spontaneous repatriation are present, contingency planning should take place, including identifying protection and material assistance needs in the country of origin and en route, and establishing a capacity for monitoring in areas of return including a direct UNHCR or operational partner presence.

Agreement between the parties

37. Whenever possible, a formal voluntary repatriation agreement should be concluded between the governments of the countries of asylum and origin and UNHCR in the form of a Tripartite Agreement. A tripartite commission should in any event be established as soon as possible when organized voluntary repatriation is foreseen. However, it is important that UNHCR does not enter into tripartite repatriation arrangements without due consultation with the refugees, and that their reoccupations are always kept foremost.

38. UNHCR's role in developing repatriation agreements is to:

i. Work with the two governments to ensure that any such agreement respects the basic protection considerations already outlined.
ii. Help provide material assistance, where necessary, to enable the agreement to be implemented.
iii. Monitor the return programme, with particular attention to protection, and to ensure free and unhindered access will be given to returnees. UNHCR should also be present in the country of origin to monitor returnee reintegration.

39. The actual content and scope of the formal agreement will depend on the circumstances. An example can be found in Annex 5 in the Voluntary Repatriation: International Protection Handbook.

40. The question of whether those wishing to repatriate are in fact nationals of their claimed country of origin may arise. Responsibility for determining this rests with the government of the country of origin. However, if particular issues arise over nationality claims or problems related to statelessness that cannot be resolved at field level, contact HQ for advice on how to proceed.

Coordination

41. UNHCR is likely to be responsible for the practical coordination of an operation which by definition will involve more than one country.

42. Cross border communication and coordination between UNHCR offices on both sides of the border can make or break an operation. The underlying principle of cross border coordination should be that voluntary repatriation operations have to be determined by the conditions, absorption capacity and preparedness in the country of origin.

43. One UNHCR officer should be designated with overall responsibility for the repatriation operation in countries of asylum and origin, and for the actual movement, for example the Representative in the country of origin. The need for a coordinator is even greater when substantial repatriation will take place from more than one country

of asylum. The designation of a focal point officer at Headquarters is equally important.

Staff

44. Because of UNHCR's protection responsibilities, such operations are often staff-intensive in the field. UNHCR staff may be needed to:

- witness the refugees' voluntary declaration of a wish to repatriate;
- maintain a presence, sometimes a continuous one, in the settlements, along routes of return, at border crossing points and in the transit and arrival centres;
- accompany the returnees during the journey;
- monitor treatment of the returnees on return; and
- mount those parts of the logistical operation not contracted out to operational partners and monitor those that are.

Estimation of numbers

45. An important element for planning is the number of refugees likely to repatriate, which will rarely be known accurately for a variety of reasons. Nevertheless, a best estimate will be required, and assumptions will need to be made. Plans must be flexible, taking into account the fact that a common pattern is a slow start as refugees wait to see how the initial movements go and how the first repatriates are received.

46. Information should be obtained on:

i. The numbers of refugees intending to repatriate. Estimates should be obtained by random sampling of intentions, discussions with refugee elders, leaders, women, teachers and others in touch with the community and who are aware of likely intentions. Assumptions can also be drawn from observing current spontaneous return and identifying obstacles being faced by the returnees. A survey related to spontaneous return must be prepared with refugees as questions often arise concerning issues of forced return or false expectations.
ii. The number of refugees for whom repatriation is unlikely to be an option at this stage.
iii. Current location and numbers of refugees in the country of asylum.
iv. Province and district of origin (intended destination) in the country of origin. Determination of priority provinces and districts of return will be based on the number of potential returnees.
v. Lists of those with special needs.

47. Information for a repatriation operation, including iii – v above, should be processed using *proGres* (UNHCR standard registration software). *ProGres* is a holistic registration and case management tool which can be used during an emergency phase to record personal bio-data, to capture individual photos, and to create beneficiary lists (see chapter 11 on registration and population estimation).

Likely routes of return

48. Identify principal routes of return from the refugee camp to the destination in the country of origin based on the likely methods of return (roads, trains, airports, etc.). Identify border crossing points (primary, secondary, tertiary and minor foot paths). Consider which routes are safer, and where there may be danger of mines.

49. A range of maps with varying degrees of detail should be compiled with the support of the Field Information and Coordination Support Section in HQ as regards FICSS. Data should be imported into maps, charts and graphs. Use standard names and spelling for all locations since in many cases these may have changed.

Mass information campaign

50. In addition to ensuring the refugees have access to accurate information on conditions in the country of origin, they should also have direct access to information about the voluntary repatriation operation itself. Posters, leaflets, verbal presentations, radio and TV programmes, etc. in the refugees' language(s) should be used to explain as thoroughly as possible the envisaged voluntary repatriation operation. A simple leaflet, setting out the formalities to expect on arrival and arrangements made, can do much to help the repatriates and facilitate the reception process. It is important that at each stage of this information campaign care is taken to ensure it is as objective as possible and that no false expectations are raised. Do not hesitate to tell a refugee that the answer to some questions about specific conditions in the country of origin are not known. It should also be made clear to the refugees that on return he or she is outside the scope of UNHCR's protection responsibilities and once more subject to national laws.

Departure

51. Registration: Annex 1 contains a sample registration form – the Voluntary Repa-

triation Form (VRF), including a declaration of intent to repatriate. Where *ProGres* for the computerization of the registration data has been used, pre-completed VRF forms can be produced. These computer printed forms contain the required data on those individuals and families wishing to repatriate and the print-outs can be signed by those concerned.

52. Deregistration: Upon departure to their country of origin, repatriates have to be de-registered from any camp or assistance related records to ensure a proper scaling down and adjustment of assistance in the country of asylum.

53. Assembly prior to departure: Unless repatriation can take place directly from the settlements, special arrangements will be required for transit centres prior to the actual move, including transport, accommodation, food and basic health care as well as the orderly completion of the necessary administrative formalities. In some circumstances, registration may conveniently take place at the transit centres.

54. If repatriation takes place by means of organized transport, computerized passenger manifests, allocating passengers to convoys, could be prepared using the *ProGres* repatriation module. This will also allow the system to deregister refugees who are repatriating and exclude them from assistance in the camps.

On route

Organized repatriations

55. Identify sources of emergency assistance already available along the routes of return (medical facilities and potable water sources). Where sufficient assistance is not already available there will be a need to establish temporary "way stations" for rest and overnight accommodation, food distribution (prepared food or cooking facilities), first aid stations, water points, etc. The form and degree of assistance required will, in part, depend on the means of transportation used by the returnees.

Other issues for consideration include availability of fuel and facilities for vehicle repair.

56. A considerable UNHCR presence will be required to monitor and verify the voluntary nature of return, to assess needs and to coordinate with offices in the country of origin and asylum. They should provide up to date information on numbers, needs and likely routes to be used.

Mass spontaneous repatriations

57. Where UNHCR is providing assistance in mass spontaneous repatriation, the same issues need to be considered as above. However, providing the assistance to a large unorganized mobile population will present challenges, and there will be additional protection concerns. The following steps should be taken:

General arrangements

- Establish or strengthen positions on the routes (way stations) for the provision of protection and assistance for the mobile population. Factors determining location of way stations include, availability of water and mode of transportation of the refugees. If the refugees are traveling mainly on foot, the distance between the way stations en route should be closer to one another than if the refugees are traveling mainly in vehicles.
- Establish a visible UNHCR presence at way-stations using flags, UNHCR stickers and other visibility material. Ensure that UNHCR staff can be clearly identified, particularly those in mobile teams.
- Designate which UNHCR office will have responsibility for which sections of the route.
- Make arrangements to support UNHCR staff living temporarily at way stations by providing tents or

other accommodation, drinking water, cooked meals, etc.
- Establish mobile assistance along the routes, between way stations.
- Install voice and data telecommunication at UNHCR temporary offices along the route.
- Equip all UNHCR vehicles with communication equipment.
- Arrange for a common radio channel through which all organizations involved can communicate.
- Put one experienced radio operator and/or technician in charge of coordinating the telecommunications along the whole route.
- Have debriefing meetings in the evening and allocate tasks for the following day;
- Introduce a single common numbering system for all vehicles.
- Communicate the daily movement plan through staff meetings, bulletin boards and daily sitreps.
- Provide information to the refugees on the location of way stations, etc. through the placement of signs along the route in languages that the refugees understand, through announcements on local radio stations and announcements using megaphones.
- Make preparations for reception in the country of origin – at the border transit centres, and in likely districts of return, e.g. prepare the local population, as well as local government, and negotiate reception and treatment at the border.
- Establish or strengthen a presence in the country of origin to facilitate integration and monitor treatment of returnees.

Protection and material assistance

- Set up temporary water tanks with tapstands at way stations (e.g. using bladder tanks).
- Fill water tanks by pumping from local sources or tankering, ensuring adequate treatment of the water.
- Preposition sufficient quantities of water treatment chemicals at way stations and/or water collection points.
- Establish mobile water maintenance teams.
- Arrange for water tankering and refilling of water tanks at night if necessary.
- Fit water tankers with distribution taps for mobile water distribution.
- Provide refugees with small jerrycans (2-5 liters) which can be carried easily.
- Demarcate defecation areas (or trench or other latrines) at way stations, designate people to encourage and control their use.
- Identify teams for clean-up of defecation (or latrine) areas, during their use and to restore the area following the end of the population movement.
- Preposition lime for clean-up of defecation areas.
- Reinforce existing hospitals and health centres which are on the routes with staff and supplies. Establish health facilities at way stations and mobile health teams in between the way stations. Ensure that there are adequate supplies of Oral Rehydration Salts with health centres and mobile health teams.
- Try to prevent refugees concentrating in one area to avoid transmission of epidemics.
- Preposition high energy biscuits or other convenient food (preferably types requiring little or no cooking) and distribute them at way stations.
- Position staff with responsibility for unaccompanied minors at all way stations.
- Establish mobile teams to identify and collect unaccompanied minors.

- Ensure that staff responsible for the care of unaccompanied minors are highly visible.
- Clearly define which types of people are to be considered "vulnerable" for the purposes of the population movement and ensure that all the organizations involved are using the same criteria for identification and care.
- Arrange separate transport to collect vulnerable persons, and their families.

Travel formalities

58. Immigration formalities: Every effort must be made to avoid the need for individual or family clearance to repatriate by the country of origin before movement. Not only would this create major practical problems and delays, it would also be contrary to the spirit of any properly comprehensive general amnesty. If individual travel documentation is required at all, the registration form should suffice.

59. Customs formalities: Customs formalities are generally waived or simplified in repatriation operations but this should be checked well in advance. Special arrangements may be needed where the refugees wish to repatriate with personal possessions such as vehicles or livestock.

60. Health formalities: Health requirements (vaccination certificates, etc.) should not exceed those required for normal travelers. Extra vaccinations, e.g. cholera, typhoid, are sometimes requested on the grounds that the refugees would pose special health hazards. Where vaccinations are required, WHO's advice should be sought and if necessary they can be conveniently recorded on the registration form if the refugees are not already in possession of individual vaccination cards.

On arrival in country of origin

61. The principle of return in safety and dignity does not cease to apply once the return movement is completed, but applies and should be monitored until such time as the situation in the country of origin can be considered stable, national protection is again available and the returnees are reintegrated into their community.

Registration on arrival in Country of Origin

62. In certain situations, in particular in an emergency EVACUATION, it may be the case that no repatriation registration was undertaken in the country of asylum. In this case a system should be set up to register the returnee population to facilitate UNHCR access to all returnees in the different areas of return. In some circumstances, a returnee card may be appropriate.

Monitoring and UNHCR presence

63. A UNHCR presence is vital for returnee monitoring. The presence of other appropriate organizations, and liaison with them, is also important. The purpose of monitoring is to assess whether national protection has been effectively restored and extended to all returnees. The basic principle is non-discrimination – that returnees are treated the same as the resident population and are not targeted or discriminated against in any way. Monitoring should cover general conditions (human rights violations, and security, food security, access to basic facilities and property, freedom of movement, honouring of any guarantees), as well as random individual monitoring.

Reception by resident population

64. Where the return is spontaneous there may be less time to make preparations in the country of origin. Steps should be taken as soon as possible to prepare the resident local population for the arrival of the returnees to promote acceptance and integration if necessary.

Material assistance

65. Material assistance and protection are interlinked and should usually be reinforcing. The provision of material assistance to returnees enhances the possibilities to monitor this population and is important in making return a lasting solution. Where assistance is given without discrimination on a community basis it can also help with acceptance of the returnees and integration. The question of the nature and degree of assistance programmes in the country of origin, as well as the length of time UNHCR should remain involved in the country of origin, are covered in more detail in the references listed below.

Access to land and property

66. Property is a key resource for returning refugees – either in terms of access to accommodation and return to one's home, or as a means of livelihood. Resolving this can be very complex, particularly in relation to women's rights, but must be addressed if the repatriation is to be successful and durable. UNHCR can play a role through negotiating with the authorities to protect the legitimate rights of returnees.

Landmines (Please refer to chapter 26 on staff safety for safety advice on mines and ExCom Conclusion 74 (XLV) 1994 .)

67. The presence of landmines on main routes of return and in returnee settlement areas poses tremendous danger for repatriating refugees and is therefore a major protection concern to UNHCR. The need for return "in safety and dignity" means that UNHCR cannot promote or facilitate the voluntary repatriation of refugees in patently dangerous situations with the risk of injury or death.

68. Within the UN system, issues relating to mine clearance are primarily the responsibility of the Department of Peace Keeping Operations (DPKO). Where necessary UNHCR may help fund minefield surveys and demarcation, but involvement in actual mine clearance is exceptional and requires approval from Headquarters. The focus is therefore on less costly measures that lead to immediate risk reduction for the refugees like mine awareness campaigns. The danger of mines should be considered from the earliest stages of planning a repatriation.

69. The following activities should be considered:

Identification of return routes and potentially dangerous areas of return and landmine survey: UNHCR should obtain reliable information on areas seriously affected by the presence of landmines and discourage refugees from traveling to or through such areas. While a landmine survey is a national responsibility, UNHCR may also be able to contribute information obtained through its presence in the country of origin as well as through interviews with refugees in the country of asylum. DPKO have a database on mines which includes country specific information on estimated numbers and types, and progress in clearance.

Repatriation method: The presence of mines may have an impact on the proposed repatriation method – for example it may be necessary to encourage refugees to repatriate by means of UNHCR organized transport rather than returning spontaneously.

Mine awareness campaign: If landmines are a factor, then a mine awareness campaign should be part of the mass information campaign prior to departure in the country of asylum, and continue in the country of origin. Ensure that the campaign reaches all sectors of the population – both men and women should be involved with the planning and training activities of the awareness campaign. The campaign must be sensitive to levels of literacy, roles in society, and culture. It should cover: existence, appearance and

danger of landmines, how to avoid injury, safe rescue procedures, and recognizing warning signs.

Demarcation (marking mined areas) and mine clearance: UNHCR should ensure that returnee areas and routes of return are included as priorities in national demining and demarcation plans. Returnees and local population must be taught about the demarcation signs used.

Key references

Registration – A Practical Guide for Field Staff, UNHCR Geneva, Geneva 2006.

Voluntary Repatriation: International Protection, UNHCR, 1996. (updated edition expected beginning of 2007).

Handbook for Repatriation and Reintegration Activities, UNHCR, May 2004.

Framework for Durable Solutions for Refugees and Persons of Concern, UNHCR May 2003 - Repatriation, Reintegration, Rehabilitation & Reintegration 4 Rs Framework.

Protection Learning Programs, module on Durable Solutions and Voluntary Repatriation (revised in 2006).

UNHCR Supply Manual, Section 6: Moving People.

Annex 1: Sample voluntary repatriation form

An example of the type of form that might be used for a large-scale repatriation is given below. Where *ProGres* is used, it produces a pre-completed form with information taken during registration, which will then only need the signature. This form can be modified to suit the requirements of the operation.

Notes for those drawing up the form

1. Agree the information required with the authorities. All of the items in the example below may not be necessary.

2. Agree who needs to complete a separate form. The example is designed to be completed by each person over 18 years old and unaccompanied children, but it may be sufficient to have the head of the family group complete one form for all accompanying dependents.

3. Agree on the number of copies and language(s): normally original plus three copies with the following distribution: original – authorities; UNHCR in country of asylum; copy 1 – applicant; copies 2 and 3 – for travel and arrival formalities.

4. If at all possible, print the forms in sets on 'pre-carboned' paper.

5. Draw up simple completion instructions.

UNHCR Voluntary Repatriation Form

Linked Cases:

Family/Group No:

Family Name	First Name	Sex	Y O B	Place of Birth	Relationship PRA

Intended Departure Date: _____ Reception Center: _____

Intended Destination: _____ _____ _____

Admin Post Location

I, the undersigned principle applicant, declare that I (and my dependents) after due consideration wish to be repatriated to _____

Applicant: Date: Witness:

Annex 2: Types of transport

General considerations

Below are some advantages and disadvantages of the common means of transport. Whichever form of transport is used, the plan should also take into consideration:

1. Food, accommodation and minimum emergency health care during the journey. Where distances are short, it is recommended that only material assistance needed for the duration of the journey, plus, if essential, for the first few days after arrival, be distributed prior to departure. This will help reduce any incentive to "repatriate" several times.

2. Capacity to move all reasonable private possessions of the refugees, if at all possible at the same time as their owners. Remember that what refugees carry with them on return will be used to ensure more successful reinstallation and move more quickly towards self-sufficiency (i.e. roofing material, livestock, etc.).

3. Appropriate security and the maintenance of public order during all stages of the journey.

4. Arrangements for the safe transfer of the required documentation, passenger lists, registration forms, etc., and for keeping statistical records of the progress of the operation.

5. Escort or monitoring of the actual repatriation by or on behalf of UNHCR. At least for the first movements, a UNHCR staff member should accompany the returnees. Ensure voluntariness even during the movement stage.