In-Kind Non-Food Item Distribution

30 August 2023

Key points

- Do not plan an NFI distribution without coordinating with local authorities and other humanitarian actors, ensuring harmonization and complementary of assistance.

- Ensure that the NFIs selected and procured for the distribution are based on real needs and are culturally appropriate for the target population, based on consultations with groups of different age, gender and diverse characteristics if feasible in the emergency context.

- The target population should receive clear information on the distribution that is tailored to their language, literacy and preferred means of communication. They should also have access to a feedback and response mechanism through which UNHCR can solve immediate concerns.

- The distribution site, inclusive of its access routes, location and layout, must guarantee the safety, security and accessibility of all stakeholders involved, as well as the safeguarding of the NFIs and other equipment on site.

- Prioritize post-distribution monitoring exercises to adapt and modify future NFI programming; determine the usefulness, quality and preferences of NFIs with an AGD lens; ascertain if the NFIs have reached the intended recipients and if they have been used according to the intended purpose.

1. Overview

This entry describes how to plan, implement, and monitor the distribution of in-kind non-food items (NFIs) in an emergency, either through funded partnerships or directly by UNHCR personnel.

Non-Food Items (NFIs) are any items other than food that are distributed to people affected by natural hazard-induced or conflict-induced displacement or other situations of crisis. NFIs are individual and household items that enable forcibly displaced and stateless persons to conduct
their daily lives (eat, drink, sleep, cook, wash and store belongings) and maintain a minimum standard of living.

**Core Relief Items (CRI)** are a **sub-set of non-food items** and are those life-sustaining NFIs that are most widely used by UNHCR operations around the world. The following NFIs are defined as CRIs: reinforced plastic tarpaulins, canvas rolls, mosquito nets, refugee housing units, multi-purpose sleeping mats, cloth for sanitary material, family tents, synthetic sleeping mat, plastic buckets, synthetic blankets, semi-collapsible jerry cans and kitchen sets.

From here on in, this entry will refer to NFIs only, which encompass all CRIs.

For detailed guidance on NFI distributions in a non-emergency context, see the **Operational Guidelines on NFI Management** (accessible to UNHCR staff only).

### 2. Relevance for emergency operations

In an emergency situation, people often flee with little more than the clothes they are wearing and consequently find themselves displaced without any personal belongings. In addition to food and water, they urgently need certain ‘standard’ non-food items (NFIs) to survive, including items for shelter (plastic sheeting), sleeping (blanket, sleeping mat), cooking (kitchen sets, i.e. pots, pans, utensils etc.), energy (fuel, portable light) and health and sanitation (bucket, soap, jerry can, sanitary cloth, diapers, mosquito net). If it is not feasible or appropriate to provide **cash-based assistance** to meet these urgent needs, the distribution of in-kind NFIs is required.

### 3. Main guidance

**a) Principles/Requirements**

**aa) Minimum principles/requirements:**

- The displaced population has access to sufficient, culturally appropriate and gender sensitive individual and general household domestic items to meet their basic needs, contributing to their good health, dignity, safety and well-being.
- The distribution is fast and effective to save lives and prevent distress in the displaced population.
- The target population is aware of when and where the NFI distribution will take place (inclusive of any last-minute changes), as well as the selection criteria (if applicable).
- The distribution is free of any charge and this has been clearly communicated to the target population in advance of the distribution.
- There is zero tolerance for sexual exploitation and abuse, fraud and corruption and this is clearly communicated to the target population.
- The distribution site is in a neutral, accessible, safe and secure location for all stakeholders to conduct the distribution. Age, gender and diversity aspects are considered in the site layout and distribution process. For instance:
  - The site includes an emergency exit and there is a first aid kit available.
  - The distribution site is accessible for the entire target population. Possible alternative
modalities of distribution are in place for persons with mobility restrictions.
  - There is a clear and gender-sensitive (as applicable) crowd control mechanism in place at the distribution site.
  - The target population can share their feedback/complaints on the NFI distribution through a mechanism that is established as soon as feasible.

**bb) Ideal principles/requirements:**

- The distribution is based on a **rapid needs assessment** so that no assumptions are imposed with respect to the household size, structure or needs of the displaced population.
- The displaced population actively participates in the planning, implementation and monitoring of the NFI distribution.
- There is a comprehensive **information campaign** to ensure that the target population receives detailed information about the NFI distribution (when, where, what, why, how).
- There are storage facilities at the **distribution site** to allow for stock to be safely locked away during/after distributions.
- There are gender-segregated WASH facilities (toilets, handwashing stations and drinking water) at the distribution site for the target population and separate gender-segregated WASH facilities for the distribution team.
- The waiting area at the distribution site is protected from the elements (e.g. shaded in summer).
- There is a comprehensive distribution report which outlines the total number of individuals/households reached and the total number of NFIs distributed (per item).

**b) Distribution kits:**

<table>
<thead>
<tr>
<th>Partial NFI kit</th>
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<td><strong>Components</strong></td>
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<td><strong>Appropriate contexts</strong></td>
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<tr>
<td><strong>Applicable populations</strong></td>
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</tbody>
</table>
Complete NFI kit*

Components
NFIs that meet the basic needs and well-being of the target population for shelter, sleeping, cooking, energy, health and sanitation.

Appropriate contexts
Settlements and camps.
Urban.

Applicable populations
All forcibly displaced and stateless persons who are foreseen to remain in the area of the distribution location for the near future (at least 1 month from date of arrival).

* If a partial NFI kit has already been distributed to the target population, only the remaining NFIs (that would make up the complete NFI kit) would be distributed if resources are available, in order to avoid unnecessary duplication.

c) Distribution methods:

Distribution to/via local authorities

Appropriate contexts
Cross-border.
UNHCR and/or funded partners cannot reach the target population (e.g. due to insecurities, access constraints, political sensitivities).

Applicable populations
All forcibly displaced and stateless persons.

Advantages
Quick and simple handover.
No need for registration data for the target population.
No need for UNHCR/partner personnel for NFI distribution to target population.
May improve UNHCR’s relationship with local authorities.
Opportunity to strengthen capacity of local authorities to respond to an emergency.

Risks
1. Not possible for UNHCR or distribution partners to monitor if NFIs reach intended final recipients. Potential for NFIs to be diverted from their intended purpose.
2. Local authorities may not have sufficient infrastructure and capacity to carry out the distributions.
| Mitigation measures                                                                 | 1. Request for a distribution list from the local authorities and conduct post-distribution monitoring (PDM) with sampled households from target population.  
2. Provide a training for local authorities on the process and principles of NFI distributions. |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Distribution to representatives for the target population</strong></td>
<td></td>
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</tbody>
</table>
| **Appropriate contexts**                                                           | Cross-border.  
Rural and urban.  
Target population is dispersed over a large geographical area.  
Target population comprises small undivided communities.                                                                                     |
| **Applicable populations**                                                         | All forcibly displaced and stateless persons who are unregistered.                                                                                                                         |
| **Advantages**                                                                     | Quick handover.  
Social and cultural values of the target population are respected.  
Representatives are likely to know who are the most vulnerable within the target population and who should therefore be prioritized for the NFI distribution.  
No need for registration data for the target population.  
No need for UNHCR/partner personnel for NFI distribution to target population.  
Participation of target population in the NFI distribution.                                                                                   |
| **Risks**                                                                          | 1. Not possible for UNHCR or distribution partners to monitor if NFIs reach intended final recipients. Potential for NFIs to be diverted from their intended purpose.  
2. UNHCR may select people who are not actually true representatives of the target population’s communities.  
3. Representatives may abuse their power if social structures are inequitable or broken ("gate keepers").  
4. Representatives may not give due consideration to age, gender and diversity when subsequently distributing the NFIs to the target population.  
5. Since the target population is not registered, some households may receive more NFIs than what they are entitled to. |
### Mitigation measures

1. Request for a distribution list from the representatives.
2. Protection personnel gain adequate knowledge of the social structures and power relations within the target population.
3. Ensure there is an effective two-way feedback and complaints mechanism in place for the target population.
4. Undertake spot checks when representatives distribute the NFIs.
5. Conduct a PDM that samples individuals/households with different age, gender and diversity characteristics.

### Distribution to individuals and/or heads of households from the target population

<table>
<thead>
<tr>
<th>Appropriate contexts</th>
<th>Settlements and camps. Urban.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable populations</td>
<td>All forcibly displaced and stateless persons who are registered.</td>
</tr>
<tr>
<td>Advantages</td>
<td>Reduced risk of unequal distribution or duplication of assistance. Can record assistance in case management software.</td>
</tr>
<tr>
<td>Risks</td>
<td>Delay in NFIs reaching intended recipients due to long and resource-intensive distribution process.</td>
</tr>
</tbody>
</table>
Mitigation measures

Ensure adequate human and material resources on site to conduct a smooth distribution. The distribution site needs a clear distribution flow with an entry, waiting area, reception area, distribution area and a separate exit.

Create a system of unique identification for each household (e.g. numbered wristbands or tokens) or use existing ration cards. To avoid real households separating (to obtain more NFIs), seek guidance from community leaders/ other key informants on household compositions. Conduct a PDM that samples individuals/households with different age, gender and diversity characteristics.

d) Distribution locations:

<table>
<thead>
<tr>
<th>Location</th>
<th>Appropriate contexts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ad-hoc temporary site with NFIs distributed from the back of the delivery truck</td>
<td>Cross-border. Transitory situation (populations on the move).</td>
</tr>
<tr>
<td>Ad-hoc temporary site with temporary structures (e.g. rub halls, tents)</td>
<td>Near an international border. Transitory situation. Remote/rural areas.</td>
</tr>
<tr>
<td>Transit / Reception Centre</td>
<td>Near an international border. Settlements and camps.</td>
</tr>
<tr>
<td>Distribution Centre</td>
<td>Settlements and camps.</td>
</tr>
<tr>
<td>Community Centre</td>
<td>Urban. Settlements and camps.</td>
</tr>
</tbody>
</table>

e) Additional Tips:

Emergency Assessment – NARE, MIRA

- Begin by reviewing secondary data sources, such as other assessments and reports, to understand the context and identify gaps in information related to the assessment objectives.
- Consider using a mixed methods approach that combines key informant interviews, direct observation, household interviews and focus group discussions.
- Assessment findings should be able to answer the following questions:
  1. What are the immediate priorities (considering the physical and psychological state of the displaced population, climate and seasonal changes)?
  2. What resources and items do people already possess?
  3. What are people’s preferences? And what cultural norms and practices are they
accustomed to?

4. Which types of assistance, whether in-kind or cash-based, would genuinely provide meaningful help?

5. How do people prefer to receive assistance (in kind/cash)?
   - Perform a rapid assessment of the local market and its potential to support monetized NFI assistance to the target population.
     - Identify potential risks related to the NFIs and associated mitigation measures (e.g., a break in the supply chain could be mitigated by prepositioning contingency stock).
     - Identify whether the targeting of assistance is appropriate, and criteria for the prioritization of assistance if necessary.
     - Capture age, gender and diversity disaggregated data to the extent feasible (e.g., as estimations if the assessment is conducted through key informant interviews or observations).
     - Ensure the assessment team are aware of the correct referral pathways for protection cases, if already in place. Always secure informed consent when making referrals.
     - Include GBV specialized personnel in the assessment team or at least coordinate with GBV actors prior to the assessment. Ensure that non-protection members of the assessment team have a basic knowledge of how to refer GBV cases.
     - Coordinate the assessment with other actors and share findings to promote collaboration and prevent any duplication of efforts.

Planning the distribution

   - Develop the distribution plan in consultation with other actors to avoid organizing several different distributions/activities on the same day for the same target population.
   - Visit the distribution site in advance of the distribution (if possible) to ensure it is accessible, safe and secure.
   - Set a realistic distribution target per day, based on the daylight working hours and logistical constraints (i.e., transportation of items, preparation of kits).
   - Do not postpone the start of a distribution if there are delays or shortfalls in procurement. Distribute “partial NFI kits” and use a phased approach where the most vulnerable people at high risk are prioritized first. Once the missing items arrive, plan a second round of distributions to make up the “complete NFI kit”.
   - If applicable and feasible, organize the NFI distributions at different sites to occur on the same day(s) to limit fraud (i.e., people moving from one distribution site to the next to receive several kits).
   - Plan to begin the distribution early in the morning to limit the waiting time.
   - Consider the target population’s habits and potential need to organise separate distributions for persons at heightened risks (e.g., due to diversity) or with mobility impediments.
   - The target population needs to be able to carry the NFIs back to their shelters/accommodation so it may be necessary to break down the NFI kit into manageable/portable smaller kits (e.g., by dividing the kit into 4 packages and utilizing tokens to allow people to return several times to pick up their missing items).
**Information campaign**

- During the rapid needs assessment, identify the preferred means for the target population to receive information (e.g. social media, radio, community leaders, leaflets etc.).
- Clearly explain the eligibility criteria and distribution entitlement scale for the NFI kits, especially if different population groups are qualified for different assistance at the same distribution site. Use simple language and, if necessary, incorporate visuals in the campaign.
- Avoid informing the target population of the date and time of the distribution until the minimum required NFIs have arrived in stock.
- Some NFIs need to be distributed with instructions for use - e.g. mosquito nets, hygiene kits and solar lanterns. UNHCR or partner personnel should be available during the distribution to provide the instructions and answer any questions. Alternatively, instructional posters can be put on display at the distribution site.
- Make use of a range of communication channels, including community leaders (if a stable social structure is in place).
- Explain how the target population can report any concerns about the distribution and their treatment by the distribution team through feedback and complaints mechanisms.
- Keep people at the end of the queue well informed so there is no fear that when their turn comes there won’t be any NFIs left.

**Avoid tensions between different population groups**

- If there are other agencies distributing their own NFIs to the same displaced population, ensure a harmonized approach to the distribution entitlement scale and average household size through an **inter-agency coordination mechanism** (sector or cluster).
- If the quality of NFIs between different agencies differs, agree at an inter-agency level on compensating the recipients of the poorer quality items by providing them with extra supplies (e.g. one household receives 2 poorer quality plastic tarpaulins instead of 1 good quality plastic tarpaulin).
- Ensure the NFI needs of the host/neighbouring communities are included in the distribution plan, subject to available funding.

**When NFI needs exceed UNHCR’s capacity**

- Target the most vulnerable populations (as identified during the rapid assessment and in coordination with protection and with respected community leaders) in the most affected areas.
- If other agencies are present and active in NFI support, coordinate distributions and selection criteria with them.
- If no other agencies are present, lobby donors and international actors for the mobilization of external humanitarian support amongst relevant stakeholders.
- Continuously reassess the situation to ensure that the most vulnerable have not been overlooked.

**Distribution to unregistered populations**
If the displaced population is relatively small, request that they organize themselves into groups of households and compile a distribution list for each group, identifying the most vulnerable households to be served first according to the applicable protection criteria. The NFI distribution would use these household distribution lists, and each group would arrive in turn at the distribution site (i.e. not all at once). The person who prepared the list should be present at the distribution to help the team to check the recipients and prioritize the most vulnerable households.

If the displaced population is large, distributions are not feasible at the household level and representatives should be identified to receive the NFIs.

To avoid the risk of fraud and “recyclers”, consider marking NFI recipients with indelible ink on one of their fingers at the exit from the site.

**Distribution team** (when UNHCR or funded partners distribute to target population)

- As a minimum for each distribution site, the team should comprise the following functions;
  - team leader (holds overall accountability for a successful NFI distribution)
  - offload/onload NFIs and kit assemblage (if applicable)
  - registration / ID verification
  - distribution
  - translator (if applicable)
  - crowd control and fraud prevention
  - security officer (responsible for overall security of the site and crowd control personnel)
  - protection personnel for monitoring, consultation and referrals (including GBV)
  - management of two-way feedback and complaints at help desk
  - management of litigations (in case households/individuals cannot be verified against the distribution list)
  - logistics (driver, storage manager)

**NB:** The number of personnel per function will depend on the distribution site’s capacity for accommodating the target population. For example, if the distribution site can hold 100 people (either waiting for or receiving the NFIs), there should be at least 4 crowd control personnel.

- Ensure gender balance within the distribution team.
- Invite volunteers from the displaced population and host/neighbouring communities to assist with the NFI distribution – e.g. crowd control, carrying kits for recipients who have specific needs (e.g. persons with disabilities, older persons, sick). Ensure to provide compensation for the volunteers’ efforts by either providing them with meals during the day(s) of distribution, cash or other appropriate remuneration.
- For effectiveness and safety, each function within the distribution team could have a checklist of equipment that is required for their role, and this would be verified at the start of each day of distribution. Equipment may include a microphone, security tape etc.

**Distribution site** (when UNHCR or funded partners distribute to target population)

Select the site in consultation with relevant authorities, host/neighbouring community members
and the displaced population.

- Locate the site in the open, away from crowded areas such as markets, schools or healthcare facilities, and not on a busy road or narrow street.
- Avoid sites that are prone to natural hazards and “uncomfortable” – i.e. exposed to the elements, depending on the climate/season (e.g. no shade in summer, exposed to strong winds in winter) or insect-infected.
- A flat and unobstructed area will enable an overall view of the site in order to quickly detect any signs of malfunction during the distribution.
- Ensure the site is physically accessible for people in wheelchairs or other mobility constraints.
- The site should be big enough for the following components:
  1. space for delivery trucks to offload/onload NFIs
  2. one entrance
  3. waiting area for target population (protected from the elements)
  4. reception area (where target population is verified against the distribution list or form of unique ID)
  5. distribution area (where people receive the NFIs)
  6. litigation desk (in a separated, confidential area)
  7. one exit
  8. at least one emergency exit
  9. gender-segregated latrines and water sources for the target population and separate ones for the distribution team (if feasible)
  10. lockable storage for NFIs and equipment (if feasible and if distribution takes more than 1 day).

- Enclose the site by a fence and use partitions to separate the different areas (i.e. waiting area, reception area, distribution area).

Renewable items

- Some NFIs are renewable (e.g. soap, sanitary cloth, fuel) and need to be replaced regularly, requiring a routine distribution.
- Ensure that the first emergency NFI kit contains a supply of renewable items for at least 1 month.
- If the market conditions are favourable and a cash feasibility study has been conducted, consider transitioning the renewable items to cash-based support.

Onsite monitoring during distribution

- Make a check on people leaving the site as to whether they were included in the distribution list and what they received in terms of NFIs. The frequency of these spot checks will depend on the total number of people moving through the site in one day and the distribution team’s capacity.

Post-distribution monitoring

- Decide on either household level surveys, key informant interviews, focus group discussions or a combination of all 3 modalities.
The gender of the PDM enumerator should be the same as that of the respondent.
Consider adding some key PDM questions to regular protection monitoring if there is limited capacity to undertake a full PDM exercise.
Interview more people from sub-groups of concern and aim for a proportional number of respondents from these sub-groups.
PDMs can be used to evaluate the NFI recipients’ current situation and level of vulnerability, verifying if they are still eligible for future assistance.
When conducting household level surveys, observe what items are available in the house and their condition, compared to what was distributed.
Check the local markets to ascertain if any of the NFIs distributed are being sold.

Post emergency phase

- Plan and prepare for the post emergency phase from the beginning of the emergency.
- Consider how to avoid creating dependency for forcibly displaced and stateless persons on NFI assistance from UNHCR and/or other humanitarian actors.
- See “Renewable items” above.

Checklist: Distribution preparations

1. Know the context and stakeholders:
   - What other actors (including local authorities) can temporarily store, provide and/or distribute NFIs?
   - Where can they distribute NFIs?
   - What NFIs can they provide?
   - Where can they safely store NFIs and what is their storage capacity?
   - Can NFIs of adequate quality be sourced on the local market?
   - Is there an inter-agency coordination mechanism in place for NFIs?

2. Know the target population:
   - Who is actually in need of NFIs within the displaced population?
   - Are there members of the host/neighbouring communities also in need of NFIs?
   - How many individuals/households in total (even approximate) are in need of NFIs?
   - Is the target population registered?
   - What are the age, gender and diversity profiles of the target population?
   - Are there people with specific needs that will require ‘non-standard’ NFIs?

3. Know what NFIs to distribute:
• Is the target population on the move/in transit?
• Does the target population possess and/or have access to any standard NFIs prior to distribution?
• What are the cultural preferences for NFIs?
• What NFIs are in stock in country?
• What NFIs are already in the pipeline?

• 4. Know how many NFIs to **source/procure**:

  • How many NFIs of adequate quality are available in the local market?
  • How many NFIs need to be procured internally from global stockpiles or externally from local and/or international suppliers (on top of current and pipeline stocks)?
  • Could there be any disruptions to the supply chain that need to be factored into the calculation?
  • How many NFIs should be procured and set aside for contingency stock?
  • What is the warehouse/storage capacity for new and existing NFI stock?

• 5. Know how many NFIs to **distribute**:

  • What is the distribution entitlement scale for the target population?
  • What items are required at the household and individual levels?

• 6. **Know to whom to distribute the NFIs**:

  • Will the NFIs be distributed to individuals, households or community representatives? Alternatively, will the NFIs be handed over to local authorities for their subsequent distribution to the target population?
  • How will NFIs be distributed for persons with reduced mobility?

• 7. **Know where to carry out the distribution**:

  • Can a safe, secure and accessible location be identified?
  • Is there adequate access for the delivery transport?
  • Is there sufficient space for the safe offloading and distribution of NFIs?

• 8. **Know when to carry out the distribution**:

  • Has a date(s) and time(s) been set for the distribution which suits the NFI recipients and aligns with site access and security parameters?
  • Is there an information campaign for the target population?

• 9. **Know the impact of the distribution**
4. Standards

Distribution site

One distribution site should handle no more than 20,000 individuals (e.g. if the average household size is 5 people, approximately 4,000 - 5,000 people would attend the distribution site).

The site should be no greater than 5km from where the target population are accommodated.

Post-distribution monitoring

A PDM is conducted between 2 weeks and 2 months after the distribution.

Sample sizes:

- 15% of the population for distributions to 200 households or fewer.
- 10% of the population for distributions to between 200 and 750 households.
- 5% of the population for distributions to more than 750 households.

Core output indicator

Number of people who received non-food items.

Annexes

Camp Management Toolkit

Tip sheet on applying the UNHCR AGD Policy to persons with disabilities.pdf

5. Links

UNHCR/OG/2021/04/Rev.1 Operational Guidelines on Non-Food Item Management (accessible to UNHCR staff)
UNHCR Risk Management Tool: Management of Non-Food Items (accessible to UNHCR staff)
MSF Non-Food Items Distribution: Emergencies IDPs/Refugees and Natural Disasters
WFP Emergency Field Operations Pocketbook
6. Main contacts

Head of Operational and Partnership Management Unit

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Cash based interventions (CBIs)

19 February 2018

Key points

- Analyse the feasibility of cash, and justify the reasons for not using cash.
- Establish SOPs for CBI.
- Agree with partners on a collaborative approach to CBI.
- Establish a multi-functional team to oversee a CBI.
- Involve PoC in all the steps of cash delivery.
- Reach out to CBI experts in house.

1. Overview

This Entry provides guidance to field operations when they consider the introduction of cash based interventions (CBIs), including multi-purpose cash grants (MPGs).

A ‘cash-based intervention’ is any intervention in which cash or vouchers for goods or services are provided to refugees and other persons of concern (PoC) either as individuals or as representatives of a community.
Note. Cash or vouchers that are provided to governments or other state actors, or to humanitarian workers or service providers, are not CBIs. The terms CBI, ‘cash-based transfer’ and ‘cash transfer programming’ are interchangeable.

Multipurpose cash grants (MPGs) are regular or one-off cash transfers to a household that fully or partially cover a set of basic or recovery needs in different sectors (for instance, for shelter, food, education, and livelihood) and support protection and solutions outcomes. By definition, MPGs are unrestricted cash transfers that put beneficiary choice (the prioritisation by beneficiaries of their own needs) at the centre of programming. They are designed to offer refugees and other PoC as much dignity, flexibility and efficiency as possible commensurate with their needs and capacities.

Assuming the context is appropriate, the steps and tools for implementing CBIs are outlined below.

2. Main guidance

Protection objectives

- To give PoC the right to choose how they meet their basic needs, taking their changing needs into consideration.
- To boost the host economy and so create a better environment for asylum and co-existence.
- To facilitate PoC access to national services.
- To promote a rights-based, community-based and participatory approach.
- To increase refugees' self-reliance, by combining cash and livelihood interventions.
- To help people to be economically active, and thereby achieve financial inclusion.
- To link humanitarian cash programmes to national social safety net programmes, whenever possible. If this cannot be done at the outset, programmes should mirror existing systems in order to facilitate a smooth transition later on.

CBI policy outlines the following lines of action:

- Embed CBI as a corporate priority.
- Proactively consider cash when you evaluate different forms of transfer.
- Exercise leadership; promote coherence and complementarity.
- Maximize partnership by ensuring that all aspects of CBI programmes are joined up.
- Use direct transfer wherever possible to deliver cash assistance to refugees and other PoC.
- Ensure that CBI programmes are subject to appropriate financial controls.

Do a cash feasibility and response analysis
UNHCR multi-functional teams should employ the Cash feasibility and response analysis toolkit to decide whether CBI is feasible in a given operation. Use the toolkit after undertaking a needs assessment and if there is evidence that CBI is an appropriate way to address PoC needs.
To establish the feasibility of CBI, analyse the seven key areas outlined below.

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<th>Area of analysis</th>
<th>Key questions and main tools</th>
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<tbody>
<tr>
<td><strong>1. Market access and capacity</strong></td>
<td>Are local, regional, and national markets accessible? Can they provide the goods or services that are required? Can they do so at an appropriate price? If demand increases following the introduction of a CBI programme, can markets respond? <a href="https://example.com">UNHCR, Market Assessment Companion Guide and Toolkit</a>.</td>
</tr>
<tr>
<td><strong>2. Protection risks and benefits</strong></td>
<td>What are the protection risks and benefits of using CBIs compared with alternatives? What are the protection implications for individuals, households and communities? How can these risks be mitigated and managed? <a href="https://example.com">UNHCR, Guide for Protection in Cash-Based Interventions</a>; and <a href="https://example.com">UNHCR, Protection Risk and Benefit Analysis Tool</a>.</td>
</tr>
<tr>
<td><strong>3. Financial risks and benefits</strong></td>
<td>What are the potential financial risks and benefits of using CBIs? How can risks be mitigated and managed? <a href="https://example.com">UNHCR, Template for country-level standard operating procedures (SOPs) for UNHCR cash-based interventions (CBIintranet)</a>.</td>
</tr>
<tr>
<td><strong>4. Political context</strong></td>
<td>What is the host government's position on providing CBIs to PoC, nationally or locally? What are other CBI actors, including the Government, doing? What is the regulatory environment? Best practice is summarised in UNHCR, <a href="https://example.com">Cash feasibility and response analysis toolkit</a>.</td>
</tr>
<tr>
<td><strong>5. Transfer mechanisms and delivery options</strong></td>
<td>Which organizations provide financial services? What is their coverage and how reliable is the service they provide? How long might it take to contract and establish the required services? What is the regulatory environment? <a href="https://example.com">UNHCR, Cash Delivery Mechanism Assessment Tool (CDMAT)</a>.</td>
</tr>
<tr>
<td><strong>6. Costs and cost-efficiency</strong></td>
<td>What is the cost of delivering CBIs, relative to alternative options? What are the costs of different transfer mechanisms? <a href="https://example.com">Maintool. Best practice is summarised in UNHCR, Cash feasibility and response analysis toolkit</a>.</td>
</tr>
</tbody>
</table>
7. Skills and capacity

What skills are available in the operation that will assist delivery of CBI? What level of commitment is there? Consider a range of functions, including information technology (IT) and budgeting and accounting. What additional internal capacity is needed? An overview of the steps required to establish a CBI is attached to this Entry.

Protection Risks

Always prepare a protection risk mitigation matrix when you design an assistance programme. It will help you to identify the potential harmful effects and risks of CBIs, who is at risk, how serious the harms might be, how likely they are to occur, and whether the programme’s design can mitigate risks (by selecting particular payment, delivery or feedback mechanisms, for example). An example of a protection risk mitigation matrix can be found on the intranet.

Weigh risks against potential benefits; consider alternative forms of transfer if risks cannot be mitigated. Monitor programmes regularly; establish accountability frameworks with effective feedback and response mechanisms.

In summary, when you assess whether a CBI programme is feasible, ask the following key questions to assess protection risks and benefits:

- Are affected communities included as participants in all phases of the programme cycle?
- Will MPGs create or exacerbate protection risks or improve benefits for individuals, households and communities?
- Have individuals with different or specific needs and protection risks been consulted?
- Have two-way feedback mechanisms and focal points been established to ensure regular communication?
- Are we working closely with colleagues in protection and other relevant sectors?
- Have we done a gender, age and diversity analysis?
- Does the MPG design take account of complementary activities and services?

For further information on protection risk and benefits analysis, see UNHCR, Operational Guidance and Toolkit for Multipurpose Cash Grants, pp. 33-35.

Other risks

During feasibility planning, it is important to assess the financial and operational risks associated with particular methods of transfer and delivery mechanism, including the harms they might
because, and the probability that harm will occur. Use UNHCR's Risk Mitigation Matrix to assess risks, identify who is at risk and the possible harms, and set out mitigating measures. Based on this analysis, assess whether the risks are such that a CBI programme cannot be justified or cannot be implemented. Additional risks that need to be analysed include legal, political and socio-economic risks. An example of a financial risk mitigation matrix can be found on the intranet.

**Key decision points**

The multi-sectoral nature of UNHCR's refugee mandate makes it sensible to use CBIs because they can address a range of needs cost-effectively, during displacement and on return. Before designing and implementing a CBI response, it is essential to:

- Determine whether to use cash, based on a feasibility assessment and analysis.
- Agree collaboration arrangements with partners if cash is feasible. In refugee settings, UNHCR should coordinate a cash approach with sectors and agencies, as well as with the Government and safety net programmes.

UNHCR's Guidance on Cash-Based Interventions in Displacement Settings will help teams to analyse whether CBIs are an appropriate way to achieve protection and assistance goals, and to design suitable programmes.

**Key steps**

To implement a CBI in an emergency, take the following steps:

- Establish a multi-functional team (MFT). Include staff who have expertise in cash management and distribution.
- Establish a CBI focal point who can coordinate with counterparts in HQ, with the MFT, and with partners.
- Link with existing coordination systems and partners who are already implementing CBIs (on advocacy, data collection, targeting, delivery of assistance, etc.).
- Do a rapid needs assessment (or similar programme) to guide your programme design.
- Assess the market (for access, availability of goods, prices, etc.).
- Consider political factors, including support for cash and CBI.
- Consider the relative merits of multipurpose cash grants and sectoral cash grants and decide the value of the grants that will be distributed.
- Identify an appropriate financial service provider or partner who is competent to deliver the services you require swiftly and in an appropriate manner.
- Because it is a priority to facilitate the financial inclusion of refugees, seek arrangements that will enable them to open individual bank accounts.
○ Develop standard operating procedures (SOPs) that set out in precise terms how the CBI is to be implemented. Make use of technology wherever it will improve efficiency or access.

The table below indicates how a CBI should be designed and implemented in an emergency. **Note.** The sub-steps are not always chronological. These activities can and should happen in parallel.

**Analyse options and choose the best combination**  
**Plan, design and implement the response**

<table>
<thead>
<tr>
<th>Engage with stakeholders</th>
<th>Identify a CBI focal point.</th>
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<tbody>
<tr>
<td></td>
<td>Establish or activate a multi-functional team (MFT) or cash task team (CTT).</td>
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<tr>
<td></td>
<td>Contact external stakeholders and find out whether a cash working group (CWG) is active.</td>
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<tr>
<td></td>
<td>Assess the skills and capacity of the MFT and partners.</td>
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<tr>
<td></td>
<td>Design and conduct a training for (i) UNHCR staff and (ii) partners (if needed).</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Assess needs and determine objectives</th>
<th>Identify and analyse existing CBI assessments and reports.</th>
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<tbody>
<tr>
<td></td>
<td>Analyse needs.</td>
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<tr>
<td></td>
<td>Determine programme objectives.</td>
</tr>
<tr>
<td>Analyse options and choose the best combination</td>
<td></td>
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<tr>
<td>------------------------------------------------</td>
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<tr>
<td>Assess political feasibility.</td>
<td></td>
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<tr>
<td>Conduct a market analysis.</td>
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<tr>
<td>Assess protection risks and benefits, and safety considerations (macro).</td>
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<tr>
<td>Assess delivery options. (Include a macrorisk assessment of the financial sector.)</td>
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<tr>
<td>Assess cost efficiency.</td>
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<tr>
<td>Assess the skills and capacity of potential implementing partners and financial service providers.</td>
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<tr>
<td>Determine whether it is appropriate to apply conditionalities.</td>
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<tr>
<td>Select a form of transfer or a combination of forms; and a delivery mechanism.</td>
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<tr>
<td>Refine objectives.</td>
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<tr>
<td><strong>Plan, design and implement the response</strong></td>
<td>Develop the programme strategy. Decide how you will target beneficiaries, and the value of the cash transfer.</td>
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<tr>
<td></td>
<td>Design and test IT solutions.</td>
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<tr>
<td></td>
<td>Assess operational and financial risks and develop a strategy to mitigate them.</td>
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<tr>
<td></td>
<td>Assess protection risks and develop a strategy to mitigate them.</td>
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<tr>
<td></td>
<td>Develop a communications and information strategy for internal and external stakeholders.</td>
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<tr>
<td></td>
<td>Plan the allocation of resources.</td>
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<tr>
<td></td>
<td>Draft and publicise terms of reference and a request-for-proposals. Select partners (financial service providers or implementing partners) and finalize contracts.</td>
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<tr>
<td></td>
<td>Determine criteria for selecting retailers who will participate (if appropriate).</td>
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<tr>
<td></td>
<td>Select a vendor to create or manage vouchers (if required).</td>
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<tr>
<td></td>
<td>Develop country-specific SOPs that set out administrative and financial procedures.</td>
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<tr>
<td></td>
<td>Secure approval for the SOPs.</td>
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<td></td>
<td>Train partners.</td>
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<tr>
<td></td>
<td>Establish financial arrangements and transfer funds.</td>
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</tbody>
</table>
Key management considerations

- In line with UNHCR's policy on CBI, operations will systematically and proactively consider the feasibility of using CBIs as the preferred form of transfer in emergencies.
- Decisions to use only in-kind assistance must be based on solid evidence that this option is preferred by beneficiaries, or is a necessary response to the weakness of markets or financial service providers.
- In inter-agency fora, UNHCR should seek proactively to integrate CBIs in emergency responses and accept a coordination role where CBIs are adopted.
- UNHCR should not allow a position to arise in which it loses cash funding because of the food/non-food division of responsibilities with WFP. Where donors push for a single agency model, UNHCR should seek to be the lead agency for multi-purpose cash, including for food and non-food.
- Where it does not use CBIs in an emergency, notably after the first six months, UNHCR must be able to explain why.

Resources and partnerships

- UNHCR will cooperate on CBI with host governments, agency partners, PoC, donors, and private sector actors (particularly if they have expertise or comparative advantages in areas critical to the delivery and effectiveness of cash assistance). Use shared mechanisms accessible to all the humanitarian actors in a response. Do not establish parallel delivery systems for CBI unless there is no other option.
- Wherever possible, transfer cash assistance through a financial service provider.
- If they are to function effectively, CBIs must be supported by an active multi-functional team that includes (at minimum) colleagues from supply, finance, programming, and protection, as well as sectoral colleagues. Each has a role to play in the different phases of
a CBI: assessment of needs, markets, and financial service providers; analysis of risks; choice of the transfer and delivery mechanism; procurement and contracting; implementation and monitoring.

- Seek support. The CBI Section at HQ stands ready to offer technical advice, deploy CBI experts, provide training, support the procurement process, communicate CBI achievements, and more.

**Annexes**

UNHCR, Policy on Cash-Based Interventions

UNHCR, Strategy for the Institutionalization of Cash-Based Interventions 2016-2020

UNHCR, Basic needs approach

UNHCR-WFP Addendum on Cash Assistance to Refugees to the January 2011 MoU

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3. **Learning and field practices**

4. **Links**

   Cash for Health: Key learnings from a cash for health intervention in Jordan
   CaLP/UNHCR, Review of the Common Cash Facility in Jordan
   The Greece Cash Alliance, Meeting Basic Needs through a harmonized Partnership ...
   Cash for education – A global review of UNHCR programs in refugee situations
   Cash Based Interventions for WASH Programmes in Refugee Settings

5. **Main contacts**

   Contact the CBI Section in UNHCR Headquarters. At: hqcash@unhcr.org.

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**Health needs assessment**

08 January 2024

**Key points**

- An initial rapid health and nutrition needs assessment is essential to inform the design of an
Effective public health intervention

- Initial rapid assessments should be multi-sectoral in character and the teams should include expertise in public health, nutrition, WASH, shelter/site planning and protection.
- A more detailed sector-specific health and nutrition assessment will also be required after the initial rapid assessment to guide the response.
- Ensure that the local health authorities and partners are engaged throughout the entire process of the initial rapid assessment and subsequent assessments.
- Process the information gathered in the assessments and share with partners to inform public health programming.

1. Overview

Emergency public health interventions must be evidence-based, needs-based and context-specific. Following the Needs Assessment in Refugee Emergencies (NARE) a more detailed health and nutrition assessment should be conducted. This examines refugees' most immediate health problems and needs; reviews public health risks (disease outbreaks, malnutrition, access gaps); and maps the resources that are available and the resources that are needed to deliver effective assistance. The health needs assessments should be carried out by public health technical experts with relevant experience.

2. Relevance for emergency operations

In order to plan and implement effective health programs in an emergency, it is essential to know the health and nutrition status of the affected population, the status of the existing health system and potential health risks as soon as possible.

3. Main guidance

Emergency Phase

Health needs assessments should take place in the first days of an emergency and be coordinated and supervised by an experienced Public Health Officer.

The aim of an initial health assessment is to:

- Obtain an overview of the situation.
- Identify immediate needs and gaps.
- Identify major causes of mortality & morbidity and the nutrition situation (for nutrition assessment see chapter on nutrition needs assessment).
Assess the level of risk of outbreaks of possible disease.
- Map availability of, and access to, primary and emergency health care
- Map the available health resources and the additional health resources needs.
- Map the available partner and services availed by partners.
- Establish priority actions.

**Methodology**
Data is derived from different sources, requires specific tools and methodologies and is expanded over time.

Health needs assessments (1) use both primary and secondary data, (2) analyze both qualitative and quantitative data. (3) and should ideally be carried out jointly with partners and led by a public health expert.

There are different types of needs assessments and tools. Initial rapid assessments provide the initial information needed and are then followed with more detailed assessments over time.

- Needs Assessment in Refugee Emergencies (NARE)

The NARE is principally designed to assist UNHCR operations with initial multi-sectoral assessments. NARE highlights information that is derived from pre-crisis and post-crisis secondary data analysis, before the primary data collection begins. For primary data collection, the NARE suggests data elements that can be derived from facility visits, observations, key informants and focus group discussions. It promotes the cross-analysis of information derived from multiple methodologies across multiple sectors to ensure a rapid, relatively complete picture.

The NARE checklist has dedicated sections on public health, nutrition and food security. In the initial phase of an emergency, health assessments should be done as part of the NARE. Where the NARE or similar multisectoral needs assessments are not done, it is required to conduct a health assessment jointly with partners and ensure that the information is shared with other partners and sectors. The NARE public health and nutrition checklist provides an overview of standard questions.

- The Multi Sector Initial Rapid Assessment (MIRA) is a joint multi cluster/sector assessment that offers an early rapid overview of the situation and determines immediate needs and gaps. It is ideally conducted within the first days (72 hours) of the post-emergency onset to inform the initial emergency response. This can be conducted as part of the NARE or as a standalone assessment.
- Detailed Health Sector-Specific Assessments provide a more in-depth analysis of specific health areas. This is usually done following the initial rapid needs assessment, including exploring identified gaps further. A UNHCR Public Health assessment tool has been developed and is available in the UNHCR Public Health Emergency Toolkit.

The table below, extracted from UNHCR NARE health needs assessments, summarizes the health data to be collected, sources and tools available.
<table>
<thead>
<tr>
<th>Information needed</th>
<th>Health status and risks</th>
<th>Health resources and service availability</th>
<th>Health system performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The current health status of the affected populations: mortality, morbidity trends. health risks (potential outbreaks), nutrition status</td>
<td></td>
<td>Existing facilities and services of national health authorities, other national and non-state actors, and international partners</td>
<td>Access, coverage, utilization, quality and effectiveness of the services currently available</td>
</tr>
</tbody>
</table>

| Tools | NARE; Multisector initial rapid assessment \[**MIRA**\], UNHCR Public Health assessment; Early warning alert and response \[**EWARS**\], UNHCR integrated refugee health information system \(i\)RHS) Basic Indicator Report \(BIR\) | UNHCR Public Health assessment; Health Resources and Services Availability Monitoring System \(HeRAMS\); Who, what, where (and when) \(3W/4W\); WHO Surveillance System for Attacks on Health Care \(SSA\) | Health Information System \(HIS\), or \DHIS2 or partner reports |

| Data sources | Direct observation; Secondary data from pre-emergency sources; Primary data collected at provider level; Surveys | Direct observation; Secondary data from national authorities; Coordination mechanism/information management | Direct observation; Data collection assessments; Surveys |

Not all the information needed can be obtained by an initial rapid assessment. Adopt a phased approach that starts by collecting key indicators and advances to a more comprehensive assessment.
Deliverables:

Identify health priorities

Analysis of the data collected will help to define health priorities and to identify particularly vulnerable groups.

Capacity of health system

The assessment should determine the capacity of the existing health system to meet the needs of refugees and potential gaps.

Presentation of results

The findings of the initial assessment should be synthesized in a report. This should be shared with the authorities, partners and other stakeholders and be used to inform the response plan to address the identified needs.

Monitoring and surveillance

A health information system (HIS) should be put in place from the start of an emergency. The UNHCR integrated refugee health information system (iRHIS) is designed especially for this purpose. It is widely accepted by partners and governments. The objectives of any health information system are to:

- Rapidly detect and respond to public health problems and epidemics.
- Monitor trends in health status and continually address public health priorities.
- Evaluate the effectiveness of interventions and service coverage.
- Ensure that resources are correctly targeted to the areas and groups in greatest need.
- Evaluate the quality of public health interventions.

Post emergency phase

Health needs assessment is an ongoing process that continues in the post emergency phase. Needs may evolve and change over time and should be monitored through routine HIS data and specific repeated assessments as indicated.

Health needs assessment checklist

- Initiate a rapid health needs assessment at the onset of an emergency, usually as part of a multi sectoral assessment.

- Coordinate the assessment with national authorities and partners and include the affected community.
• Collect the data.

• Identify public health priorities, vulnerable groups and health system capacity.

• Synthesize findings in a report to be shared with partners.

• Use findings to inform and plan the response and priority public health actions.

• More detailed public health assessments can be conducted over time.

4. Standards

UNHCR Global Strategy for Public Health 2021-2025 (Strategic Objective 1, result 1)

Health and nutrition assessment

Conduct a joint public health and nutrition needs assessment at the onset of an emergency to guide key and timely actions by relevant stakeholders.

Annexes

UNHCR, Needs Assessment for Refugee Emergencies (NARE) Public Health and Nutrition Checklist

WHO and UNHCR, Assessing mental health and psychosocial needs and resources, 2012

UNHCR Public Health Emergency Toolkit: Assessment chapter and checklist, 2021

5. Links

6. Main contacts

Public Health Section, DRS: hqphn@unhcr.org

WASH in rural areas

01 January 2020

Key points

- Ensure that all WASH actors, and the local and national authorities, are coordinated and collaborate well.
- Ensure that every refugee living in a rural dispersed settlement has safe access to water, sanitation and hygiene.
- Monitor key WASH indicators and access to the WASH services regularly.

1. Overview

WASH (water sanitation and hygiene) interventions in rural dispersed settings aim to improve refugees' safe access to water of sufficient quality and quantity, and good quality sanitation; to improve hygiene practices; and to improve WASH in hospitals, health and nutrition centres, schools and other institutions, with the aim of providing the same quality of services to host villagers and ultimately reach national WASH service standards.

This entry discusses WASH responses in rural dispersed settings. WASH interventions help to improve hygiene and health and reduce morbidity and mortality among both refugees and host populations. In the first phases of an emergency, a WASH response in rural dispersed settings focuses on identifying WASH infrastructural gaps and needs, and software components required, as well as monitoring the WASH situation. The best outcome is to provide dispersed refugees with full access to national services. To achieve this, it is crucial to collaborate closely from the beginning with the ministries responsible for water, environment, and infrastructure, as well as with municipalities and development actors such as UNICEF, UN-Habitat, and bilateral donors.

The WASH sector works closely with health and nutrition to address potential causes of waterborne diseases and malnutrition, and to reduce public health risks associated with poor water, sanitation and hygiene services and practices. At the start of an emergency, in addition,
WASH works closely with physical/site planning and local authorities on the selection and allocation of sites and villages.

2. Main guidance

Protection objectives

- To ensure that refugees and host populations in rural dispersed settings have safe access to sufficient water of good quality.
- To ensure that refugees and host populations in rural dispersed settings have safe access to sanitation and hygiene of good quality.
- To respect the right to safe water and sanitation.

Underlying principles and standards

**UNHCR’s Public Health Strategic Objectives 2014-2018:**
1. Refugees have safe access to water of sufficient quality and quantity.
2. Refugees have access to quality sanitation.
3. Refugees have improved hygiene.
4. Improved WASH in institutions.

**Note that UNHCR has developed a comprehensive public health strategy that applies to emergency and non-emergency operations in camp and out-of-camp settings.** In rural dispersed settings, UNHCR aims to integrate refugees into national services, and therefore, UNHCR and its partners should apply water & sanitation national standards.

The following SPHERE standards may apply for WASH in rural dispersed settings, among others:

Hygiene Promotion

- **SPHERE, Hygiene promotion standard 1.1: Hygiene Promotion.**

  People are aware of key public health risks related to water, sanitation and hygiene, and can adopt individual, household and community measures to reduce them.

  - **SPHERE, Hygiene promotion standard 1.2: Identification, access and use of hygiene items.**

    Appropriate items to support hygiene, health, dignity and well-being are available and used by the affected people.

    - **SPHERE, Hygiene promotion standard 1.3: Menstrual hygiene management and incontinence.**

    Women and girls of menstruating age, and males and females with incontinence, have access to hygiene products and WASH facilities that support their dignity and well-being.
Water Supply

- SPHERE, Water supply standard 2.1: Access and water quantity.

People have equitable and affordable access to a sufficient quantity of safe water to meet their drinking and domestic needs.

- SPHERE, Water supply standard 2.2: Water quality.

Water is palatable and of sufficient quality for drinking and cooking, and for personal and domestic hygiene, without causing a risk to health.

Excreta Management

- SPHERE, Excreta management standard 3.1: Environment free from human excreta.

All excreta is safely contained on-site to avoid contamination of the natural, living, learning, working and communal environments.

- SPHERE, Excreta management standard 3.2: Access to and use of toilets

People have adequate, appropriate and acceptable toilets to allow rapid, safe and secure access at all times.


Excreta management facilities, infrastructure and systems are safely managed and maintained to ensure service provision and minimum impact on the surrounding environment.

Vector Control

- SPHERE, Vector control standard 4.1: Vector control at settlement level.

People live in an environment where vector breeding and feeding sites are targeted to reduce the risks of vector-related problems.

- SPHERE, Vector control standard 4.2: Household and personal actions to control vectors.

All affected people have the knowledge and means to protect themselves and their families from vectors that can cause a significant risk to health or well-being.

Solid Waste Management

- SPHERE, Solid waste management standard 5.1: Environment free from solid waste.

Solid waste is safely contained to avoid pollution of the natural, living, learning, working and communal environments.
SPHERE, Solid waste management standard 5.2: Household and personal actions to safely manage solid waste. People can safely collect and potentially treat solid waste in their households.

SPHERE, Solid waste management standard 5.3: Solid waste management systems at community level.

Designated public collection points do not overflow with waste, and final treatment or disposal of waste is safe and secure.

WASH in disease outbreaks and healthcare settings

SPHERE, WASH standard 6: WASH in healthcare settings. All healthcare settings maintain minimum WASH infection prevention and control standards, including in disease outbreaks.

Protection Risks

WASH interventions have positive effects in numerous areas and address important protection risks.

- Girls, children and women who walk long distances to water points are at risk of sexual violence.
- When refugees do not have safe access to sufficient water of good quality, and sanitation, they are exposed to public health and nutrition risks (water related diseases and risks of malnutrition).
- Refugees who do not have safe access to sufficient water of good quality, and sanitation, may adopt risky coping mechanisms.

Other risks

If adequate WASH facilities are not available in rural dispersed areas:

- The host community may compete with refugees for resources, increasing tensions. Evictions may occur (often under-reported because refugees fear harassment, lack personal protection, etc.).
- Security risks may increase (riots, demonstrations, violent behaviour).
- Harmful short and long-term effects on health are likely, including severe diarrhoea, dehydration, malnutrition, and even death.

Key decision points

Refugees living in rural dispersed areas must always have access to safe water and sanitation, and structures to promote hygiene.
Where local and national water and sanitation services are available and adequate UNHCR should encourage local authorities to grant refugees access to them. Where services are not adequate, UNHCR should work with local authorities, ministries responsible for water, environment, infrastructure, and energy, as well as UNICEF/UNDP/UN-Habitat and other development actors, to create new services or improve those that exist, for the benefit of refugees and host communities.

WASH interventions must always be:

- **Evidence-based.** Activities should be planned and implemented, based on the findings of the initial assessment.
- **Needs-based.** Interventions should be scaled and resources should be allocated to meet the needs of the population.
- **Technically sound.** Services should be based on current scientific evidence and operational guidance, and implemented by skilled staff.
- **Impact oriented.** UNHCR promotes the comprehensive WASH approach, which ensures that essential safe water, sanitation and hygiene needs of the entire population.
- **Priority-based.** Emergency WASH interventions and services should be prioritised to achieve maximum impact across the population. Interventions to address immediate health and WASH risks, such as disease outbreaks and malnutrition, must be priorities.
- **Integrated.** Avoid setting up costly parallel services. Assist the national waters authorities to extend its services to refugees.
- **Rights-based.** Water and sanitation are recognized human rights, which means they also extend to refugees as well as to people living in rural environments. The rights are specified by the five criteria, availability, quality, acceptability, accessibility and affordability.

**Key steps**

- To improve the effectiveness of WASH interventions, develop a clear WASH strategy as early as possible. All WASH actors should participate in this exercise.
- Ensure that the strategy sets priorities and targets the needs of refugees appropriately. Focus on (a) geographic location - mapping where refugees are concentrated and WASH services are poor; (b) groups with specific needs; and (c) individuals and households who have poor socio-economic status.
- Establish strong co-ordination with municipalities, district/regional authorities and the ministries responsible for water, environment, infrastructure, infrastructure, and energy, and development WASH actors, and municipalities to ensure wherever possible that national water and sanitation services are made available to refugees, and that all needs are covered, gaps identified, and follow-up is assured. Map services, including those provided by the private sector.
- Refugees residing in rural dispersed areas must have access to WASH services that comply with national standards. The services should be comparable with those available to the host population. Where services do not exist or are inadequate, UNHCR and partners should encourage their creation or improvement, if necessary by enhancing the capacity of municipal services (for example by seconding experts).
Ensure that refugees have access to information about services, know where WASH services can be obtained, and who is responsible for operating and managing them.

Refugees with specific needs, who require assistance to access or use WASH services should be supported and prioritized.

AGD: Apply an age-gender-diversity perspective and use community-based approaches in assessment and response analysis.

Site selection and WASH

Site selection. Assess sites jointly with physical planning and national authorities to ensure sufficient water can be provided throughout the year, keeping in mind seasonal differences and the needs of local communities.

AGD: Apply an age-gender-diversity perspective and use community-based approaches in assessment and response analysis.

Water

Refugees may have to pay for their water in rural dispersed areas. Ensure that (through multi-purpose cash grants for example) those who have few resources can pay for their water needs.

Experience has shown that water supplied by municipalities is cheaper than bottled water in shops or water sold by private vendors, and ecologically more viable. Where fees are levied for maintenance or other water costs, seek to negotiate the charges with municipalities and water companies.

Sanitation

Protection of water sources. No excreta containment systems (pits, tanks, seepage, sewerage or spillage) should contaminate surface water or shallow groundwater sources. Toilets must be located at least 30 metres from groundwater sources. Additional measures should be taken in locations that have a high water table or are prone to flooding. The bottom of pits and soak-always must be at least 1.5 metres above the groundwater table.

Toilet access. Toilets should be evenly dispersed throughout the settlement and no dwelling should be more than 50 meters from the nearest toilet. Each household should have access to a latrine at a ratio of 1 latrine per 5 persons.

Universal access. Make sure that all toilets can be used safely by all refugees and members of the local community, including children, older persons, and pregnant women. Collect data on users who have disabilities and construct dedicated toilet facilities as near to them as possible, considering the results from community consultations and relevant guidelines.

Hand-washing. Ensure that all public toilets, communal toilets, shared toilets and household toilets have hand-washing facilities, with soap (or a clean rubbing agent), and that arrangements are in place to ensure they remain functional.

Gender-balanced representation. Ensure that programmes are developed and run in cooperation with the refugee and host population. Women must be consulted on the design and location of toilet facilities. All programmes should have active gender-balanced and representative sanitation or hygiene committees.

Protection considerations. Ensure that the location and design of all toilet facilities
eliminate threats to the security of users, especially women and girls, day and night.

- **Household latrines.** Ensure as soon as possible that refugees and host populations have the means, tools, materials and appropriate technical guidance to construct, maintain and clean household toilets.
- **Bathing and laundry facilities.** Ensure that refugees and host populations have access to facilities for bathing, and laundering clothes and bedding. These facilities should provide privacy and dignity. If this cannot be achieved at household level, design and locate communal facilities in consultation with users, notably women, adolescent girls, and **persons with disabilities**.
- **Drainage.** Ensure that wastewater (from tap stands, bathing, laundring) is disposed of in properly designed drainage systems. In arid zones, runoff water may be re-used in subsurface irrigation systems, e.g. for gardening purposes.
- **Waste disposal.** Ensure waste disposal is properly managed, to avoid health hazards (injuries to children, mosquito breeding sites, etc.). Medical waste generated by health centres is a hazard. Access to medical sanitary services should be well controlled, and waste (used syringes and needles, contaminated bandages, laboratory specimens, etc.) should be treated separately without delay. When planning distributions and kit items, make every effort to reduce the use of packaging and non-biodegradable materials, to limit households waste that subsequently goes to landfill.
- **Monitoring.** Ensure that water and sanitation facilities are monitored regularly. Progress reports should be communicated transparently at regular intervals to refugees, local authorities and donors. A complaints and follow-up system must be established.
- **Accountability.** Ensure that feedback on the WASH facilities from refugees is invited and considered. Such feedback can also be sought through the WASH refugee feedback app.

### Sustainable WASH Programming

- To satisfy principles of sustainability, when you plan any WASH intervention in rural dispersed situations, analyse carefully the long term consequences and draft an exit strategy. To avoid disruption in service provision when partners pull out, establish a strategy to handover services to local authorities.
- Involve local stakeholders and service providers from the start, so that they can take over. Make sure that UNHCR transparently informs village/district and regional authorities of all the contractual or financial responsibilities that they may be expected to assume.
- Ensure that a clear exit strategy exists from the start. Planning should consider the operation, maintenance, transition and eventual decommissioning of water and toilet infrastructures. Where it is appropriate, these should be handed over to the national authorities or national actors.

### Hygiene promotion

- **Enable a hygiene-promoting environment.** Hygiene promotion does not only address knowledge and skills but also ALL other determinants of health and hygiene such as environmental and socio-economic barriers and enablers. Ensuring access to water, sanitation and hygiene facilities is as much part of of hygiene promotion as fluencing attitudes and mind-sets.
- Key hygiene messages. Too much focus on disseminating one-way messages and too much
focus on designing promotional materials without listening properly to the views of the population is considered a common pitfall in hygiene promotion. Once the most important messages have been identified, they should be in local languages (or pictorials if literacy rates are low) and should target practices that are responsible for the most critical hygiene risks. Do not attempt to communicate too many messages. Concentrate on practices that are most responsible for transmitting diseases and on interventions to prevent them.

- **Household surveys.** During an emergency and as soon as population figures stabilize, conduct a rapid household survey to evaluate access to WASH services. In post-emergency phases, a KAP (Knowledge, Attitude and Practice) survey should be carried out at least once a year (see also WASH needs assessment).
- **Empowerment.** Develop and run hygiene promotion programmes in full cooperation with refugees and the host population.
- **A hygiene promotion strategy.** With UNHCR field staff and partners, define and develop a WASH strategy for hygiene promotion (Who, What, Where, When, How and Why). Focus on priority groups at risk, risky practices, key interventions, and key indicators. The plan should be prepared in the first three months of displacement, and should be revised every six months based on monitoring feedback. It should be developed jointly by the WASH sector, the health and protection sector and national/local authorities.
- **Water-borne diseases.** If outbreaks of water-borne diseases (such as cholera) occur, establish a specific task force composed of the WASH and Health sectors and national or local authorities. It should meet weekly to make sure messages are consistent and harmonized.
- **High risk vectors.** UNHCR field staff and partners must ensure that the environment is free of high-risk disease vectors. Take steps to drain bodies of stagnant water, and clean up any dumps of organic solid waste, faeces, or other potential breeding sites for disease vectors. Elimination of high-risk disease vectors should be given the same priority as water supply, excreta management, solid waste management and hygiene promotion.

### Key management considerations

Early coordination and collaboration with the government, NGOs, and development partners is especially important. Where national WASH services do not exist or are inadequate, UNHCR and other UN agencies (UNICEF, UN-Habitat, UNDP) should encourage their creation or improvement, to the benefit of refugees and the host community. When national programmes are overwhelmed by exceptional need, UNHCR and partners should establish additional services to complement national WASH programmes.

Given that UNHCR has an overall accountability for the refugee response, UNHCR should deploy WASH staff as soon as possible to support the assessment, relevant WASH strategy and support the operational response.

UNHCR should ensure that the WASH situation in dispersed rural settlements is monitored and that relevant stakeholders receive regular reports of progress, so that they can respond rapidly if the situation changes. In the first phase of the emergency, to report, use the Emergency form of
the WASH monthly report card. Instructions on how to fill the form are available on the UNHCR WASH website, wash.unhcr.org. Access can be granted by the HQ team. Contact: HQWASH@unhcr.org.

Resources and partnerships

Staff

○ Experienced UNHCR WASH officer to support and coordinate the WASH response, as well as develop the WASH strategy.

Partners

○ Close collaboration with village, district and national water authorities is crucial.
○ Work closely with and link to development, bilateral and UN supported (UNICEF) programmes for WASH.
○ Experienced WASH partners and technical staff from partner organisations.
○ Establish predictable partnership agreements at field level at an early date, so that interventions can be implemented rapidly.
○ Community outreach workers from the community and from WASH partner organisations.

Annexes

UNHCR WASH Manual

WASH, Protection, and Accountability

Hygiene Promotion Guidelines

3. Links

4. Main contacts

Contact DRS/WASH unit. At: HWASH@unhcr.org.

WASH in urban areas

14 May 2020

Key points

• Ensure that all WASH actors in the area, and local and national WASH-related ministries and authorities, are coordinated and collaborate.

• Ensure that all urban refugees have safe access to safe drinking water and adequate and equitable sanitation and hygiene.

• Monitor access to WASH services regularly, integrating this monitoring where possible into the national systems.

1. Overview

WASH interventions in urban areas aim to provide refugees with safe access to water of sufficient quality and quantity, and good quality sanitation; to improve hygiene practices; and improve WASH in hospitals, health and nutrition centres, schools and other institutions, in order to achieve the same quality of services as host communities and ultimately reach national WASH service standards.

This entry discusses WASH responses in urban areas. WASH interventions help to improve hygiene and health and reduce morbidity and mortality among both refugees and host populations. In the first phases of an emergency, a WASH response focuses on identifying WASH infrastructural gaps and needs, and software components required, as well as monitoring the WASH situation. The best outcome is to provide urban refugees with full access to national services. To achieve this, it is crucial to collaborate closely from the beginning with the ministries responsible for water, environment, and infrastructure, as well as with municipalities and development actors such as UNICEF, UN-Habitat, and bilateral donors.

The WASH sector works closely with health and nutrition to address potential causes of waterborne diseases and malnutrition, and reduce public health risks associated with poor
services and practices with respect to water, sanitation and hygiene. At the start of an emergency, in addition, WASH works closely with physical/site planning and local authorities to select and allocate infrastructure and facilities that can accommodate refugees (unfinished buildings, schools, informal tented settlements, etc.).

It is frequently difficult to provide basic WASH facilities and a sustainable hygienic environment in urban situations, because official approval is difficult to obtain from local authorities or private landowners.

2. Main guidance

Protection objectives

- To ensure that refugees and host populations in urban areas have safe access to sufficient water of good quality.
- To ensure that refugees and host populations in urban areas have safe access to sanitation and hygiene of good quality.
- To respect the right to safe water and sanitation.
- To ensure that women and girls of menstruating age, and males and females with incontinence, have access to hygiene products and WASH facilities that support their dignity and well-being.

Underlying principles and standards

UNHCR’s Public Health Strategic Objectives 2014-2018:
1. Refugees have safe access to water of sufficient quality and quantity.
2. Refugees have access to quality sanitation.
3. Refugees have improved hygiene.
4. Improved WASH in institutions.

UNHCR and its partners should comply with the SDG standards of universal and equitable access to safe and affordable drinking water (6.1), and adequate and equitable sanitation and hygiene for all, ending all practices of open defecation (6.2). The specific targets linked to achievement of this standard should be in alignment with the local/national development plan and established targets.

During an emergency phase, UNHCR applies the globally recognized SPHERE standards. Following the 2018 update to the SPHERE manual, the following standards are directly linked to UNHCR’s WASH Monitoring System:

Hygiene Promotion standard 1.1: People are aware of key public health risks related to water, sanitation and hygiene, and can adopt individual, household and community measures to reduce them
Hygiene Promotion Standard 1.3: Women and girls of menstruating age, and males and females with incontinence, have access to hygiene products and WASH facilities that support their dignity and well-being.

Water Supply Standard 2.1: People have equitable and affordable access to a sufficient quantity of safe water to meet their drinking and domestic needs.

Water Supply Standard 2.2: Water is palatable and of sufficient quality for drinking and cooking, and for personal and domestic hygiene, without causing a risk to health.

Sanitation Standard 3.1: All excreta is safely contained on-site to avoid contamination of the natural, living, learning, working and communal environments.

Solid Waste Management Standard 5.2: People can safely collect and potentially treat solid waste in their households.

The revised SPHERE Manual has 14 separate standards for WASH, with a total of 53 indicators. The above list of 6 standards which can be reported on using the 17 key indicators included in UNHCR’s WASH Monitoring System. There are many other indicators which may be relevant to the particular context or emergency. UNHCR should work with partners to identify which other standards must be tracked as part of their monitoring programme.

Protection Risks

In urban refugee operations, accessible and adequate WASH interventions have positive effects in numerous areas, and address important protection risks.

- When refugees do not have safe access to sufficient water of good quality, and sanitation, they are exposed to public health and nutrition risks (water related diseases and risks of malnutrition).
- Refugees who do not have safe access to sufficient water of good quality, and sanitation, may adopt risky coping mechanisms.

Other risks

If adequate WASH facilities are not available in urban areas:

- The host community may compete with refugees for resources, increasing tensions. Evictions may occur (often underreported because refugees fear persecution and lack personal protection).
- Security risks increase (riots, demonstrations, violent behaviour).
- Harmful short and long-term effects on health are likely, including severe diarrhoea, dehydration, malnutrition, and even death.
Key decision points

Refugees living in urban areas must always have access to safe water and sanitation, and structures to promote hygiene.

Where local and national water and sanitation services are available and adequate, UNHCR should encourage local authorities to grant refugees access to them. Where services are not adequate, UNHCR should work with local authorities, ministries responsible for water, environment, infrastructure, and energy, as well as UNICEF/UNDP/UN-Habitat and other development actors, to improve and/or extend those that exist, or create new structures for the benefit of refugees and host communities.

WASH interventions must always be:

- Evidence-based. Activities should be planned and implemented, based on the findings of the initial assessment.
- Needs-based. Interventions should be scaled and resources should be allocated to meet the needs of the population.
- Technically sound. Services should be based on current scientific evidence and operational guidance, and implemented by skilled staff.
- Impact oriented. UNHCR promotes the comprehensive WASH approach, which ensures that essential safe water, sanitation and hygiene needs of the entire population.
- Priority-based. Emergency WASH interventions and services should be prioritised to achieve maximum impact across the population. Interventions to address immediate health and WASH risks, such as disease outbreaks and malnutrition, must be priorities.
- Integrated. Avoid setting up costly parallel services. Assist the national waters authorities to extend its services to refugees.

Key steps

To improve the effectiveness of WASH interventions, develop a clear WASH strategy as early as possible. All WASH actors should participate in this exercise.

Ensure that the strategy sets priorities and targets the needs of refugees appropriately. Focus on (a) geographic location - mapping where refugees are concentrated and WASH services are poor; (b) groups with specific needs; and (c) individuals and households who have poor socio-economic status.

- Establish strong co-ordination with municipalities, the ministries responsible for water, environment, infrastructure, and energy, development WASH actors, and municipalities to ensure wherever possible that national water and sanitation services are made available to refugees, and that all needs are covered, gaps identified, and follow-up is assured. Map services, including those provided by the private sector.

- Refugees residing in urban areas must have access to WASH services that comply with
national standards. The services should be comparable with those available to the surrounding population. Where services do not exist or are inadequate, UNHCR and partners should encourage their creation or improvement, if necessary by enhancing the capacity of municipal services (for example by seconding experts).

- Ensure that refugees have access to information about services, know where WASH services can be obtained, and who is responsible for operating and managing them.
- Refugees with specific needs, who require assistance to access or use WASH services should be supported and prioritized.

**Water**

- Refugees may have to pay for their water in urban areas. Ensure that (through multi-purpose cash grants for example) those who have few resources can pay for their water needs.
- Experience has shown that water supplied by municipalities is cheaper than bottled water in shops or water sold by private vendors. Where fees are levied for maintenance or other water costs, seek to negotiate the charges with municipalities and water companies.

**Hygiene promotion**

- In urban areas, hygiene practices should be marketed, not just promoted. Develop a hygiene promotion strategy based on a strong urban social marketing strategy that makes use of local communication channels. Use consultative processes to make sure that issues of gender are taken fully into account: the strategy should reflect the different needs, vulnerabilities, interests, capacities and coping strategies of women and men, girls and boys of all ages. Where possible ensure that refugees are included into ongoing hygiene programmes and campaigns, but take note of language obstacles and literacy levels.
- In urban areas, UNHCR and partners should map, explore and agree if assistance is provided through cash grants, vouchers or material incentives in relation to WASH services (to cover the costs of hygiene and baby kits, maintaining water and sanitation structures, cleaning, etc.).
- UNHCR and partners should work closely with the ministry of health to make sure that hygiene messages are harmonized, notably those disseminated via mass media channels.

**Sanitation**

- If toilets are not in place, and no connection to the existing sewage network is possible, new toilets should be constructed. They should be evenly dispersed through the location in question. No dwelling should be more than 50 metres from a toilet facility.
- The usability of toilets inside dwellings should be verified. Check their connection to the sewage system or on-site final disposal point. Upgrade them if required.
- Ensure that all toilets can be used safely by all refugees and members of the host
community, including children, older persons, and pregnant women. Gather data on refugees with disabilities and construct dedicated toilet facilities as near to them as possible.

**Waste water and solid waste management**

- Wastewater is likely to be the most challenging sanitation-related issue in urban areas. Work closely with the ministry responsible for infrastructure to determine national standards for sewage discharge into the ground, after treatment in grease traps, soakpits or septic tanks. In highly populated areas, wastewater systems should be fully sealed and wastewater should be conveyed to and processed by a treatment system, to protect both the environment and public hygiene. Economies of scale offset the capital cost of building a treatment system; it is not sustainable to evacuate large volumes of wastewater by means of small, private drainage pits, septic tanks, etc.
- If demand exceeds the capacity of the wastewater network, consider upgrading its piping system, pumping stations, or de-sludging capacity. Subject to national regulations, treated wastewater may be used for irrigation purposes.
- As the density of urban populations rises, to control the risk of disease it is essential to remove solid waste regularly. Subject to funding, UNHCR can support municipal efforts to achieve this goal.
- When planning distributions and kit items, make every effort to reduce the use of packaging and non-biodegradable materials, to limit household waste that subsequently goes to landfill. Special consideration should be given to solid waste management for disposal menstrual hygiene materials. Women and girls should be consulted in the design of sanitation facilities and in the structuring of services for managing the related waste.

**Sustainable WASH programming**

- To satisfy principles of sustainability, when you plan any WASH intervention in urban areas, analyse carefully the long term consequences and draft an exit strategy. To avoid disruption in service provision when partners pull out, establish a strategy to handover services to local authorities.
- Involve local stakeholders and service providers from the start, so that they can take over. Make sure that UNHCR transparently informs municipalities of all the contractual or financial responsibilities that they may be expected to assume.
- In urban areas, donors tend to focus on a mix of emergency relief, development and blended (relief and development). Draw their attention to gaps in in the humanitarian response.

**Monitoring and evaluation**

- Conduct regular WASH surveys to monitor the situation (baseline assessments and ad-hoc household surveys during the emergency phase, subsequently KAP once a year). These make it possible to target and adjust WASH responses.
- In urban areas, WASH indicators are the biggest monitoring challenge because the upgrading of WASH facilities does not generate easily quantifiable results (number of people served, litres per person per day).
The emergence and evolution of coping strategies among refugees certainly improves standards; but these improvements too are often not quantifiable. Use household assessment and utilization surveys to monitor the degree to which refugees are able to access water and sanitation.

**Key management considerations**

Early coordination and collaboration with the government, NGOs, and development partners is especially important. Where national WASH services do not exist or are inadequate, UNHCR and other UN agencies (UNICEF, UN-habitat, UNDP) should encourage their creation or improvement, to the benefit of refugees and the host community. When national programmes are overwhelmed by exceptional need, UNHCR and partners should establish additional services to complement national WASH programmes. The World Bank and bilateral donors may play a critical role in this.

Though the preferred option is to integrate refugees in national WASH services, challenges may arise. National services may be uneven, programmes may lack staff, access may be difficult (because of distance, for example), data may be lacking, and oversight of refugee access and health status may be weak.

Given that UNHCR has an overall accountability for the refugee response, UNHCR should deploy WASH staff as soon as possible to support the assessment, relevant WASH strategy and support the operational response.

WASH services and activities in urban areas should respect the guidance of the forthcoming UNHCR WASH Manual.

**Resources and partnerships**

The inputs required to set up and implement a WASH response in urban areas depend on the nature of the emergency and the degree to which refugee needs can be met by available national WASH programmes and services. Initially, an experienced WASH specialist should be present to assess the situation and need. If it is found that a comprehensive WASH response is necessary, the inputs below will be required:

**Staff**

- Experienced UNHCR WASH officers to support and coordinate the WASH response, as well as develop the WASH strategy.
- Experienced WASH partners, who also provide technical staff.
- Community outreach workers with experience in urban areas.

**Partners:**
Close collaboration with municipal and national water authorities is crucial.
If it is necessary to establish new WASH services, WASH partners should be identified in association with the ministries responsible for water, infrastructure, and energy.
Work closely with and link to development and UN supported programmes for WASH.
Consider working with experiences foundations of city water councils from other countries.

Annexes


WASH, Protection, and Accountability

Hygiene Promotion Guidelines

Urban WASH Planning Guidance and Case Studies

3. Links

Guidelines Forms Monitoring System Resources UNHCR WASH Manual Resources Standard design

4. Main contacts

UNHCR DPSM/PH Section. At: HQWASH@unhcr.org

Nutrition in transit centres

18 May 2019

Key points

- Ensure coordination and collaboration between all those who are involved in a transit centre's nutrition activities.
- Ensure that all refugees in transit centres have access to food.
Screen all arriving children for acute malnutrition using MUAC measurements and refer malnourished children for treatment.

Ask all arriving families with an infant younger than 6 months if it is breastfed, and refer infants that are not breastfed to a health centre or health workers.

Establish programmes to treat acute malnutrition, or effective referral mechanisms.

1. Overview

Food security and nutrition interventions in transit centres aim to improve the immediate food security, health and nutritional well-being of displaced populations, mainly by tackling the immediate and underlying causes of malnutrition. A person's nutritional status is highly influenced by his or her environment, water sanitation and hygiene (WASH), access to health services, food and nutrition security and care, and shelter. Where these are inadequate, risk of malnutrition increases.

Nutrition interventions in transit centres aim to prevent malnutrition among arriving populations, especially among women, young children and other groups with specific needs; to identify, refer and treat malnutrition in individuals; and to monitor the nutrition situation of those who have newly arrived. Nutrition interventions in transit centres are part of the public health services and are closely linked to the WASH services.

2. Main guidance

Protection objectives

- To ensure that refugees in transit centres have access at all times to safe and nutritious food, sufficient to maintain a healthy and active life.
- To respect the right to food and the right to health.
- To ensure that refugees in transit centres receive appropriate treatment for moderate acute malnutrition (MAM) and severe acute malnutrition (SAM).
- To ensure adequate protection, promotion and support for breastfeeding of infants and young children are available in transit centres, that infants and young children have access to adequate complementary feeding and infants younger than 6 months who are not breastfed have access to alternative food that is appropriate and adequate.

Underlying principles and standards

UNHCR, Global Strategy for Public Health 2014-2018:
Food security and nutrition objective 2.
- Sets standards for treating acute malnutrition that ensure quality treatment and adequate coverage.
- Guides an effective food security and nutrition response in emergencies.

UNHCR has developed a comprehensive Public Health strategy that applies to emergency and non-emergency operations in camp and out-of-camp settings. To tailor its interventions more efficiently to emergency situations, UNHCR recommends the use of SPHERE standards during emergency operations.

**Sphere, Management of malnutrition standard 2.1:** Moderate acute malnutrition. Moderate acute malnutrition is prevented and managed.

**Sphere, Management of malnutrition standard 2.2:** Severe acute malnutrition. Severe acute malnutrition is treated.

**Sphere, Micronutrient deficiencies standard 3:** Micronutrient deficiencies. Micronutrient deficiencies are corrected.

**Sphere, Infant and young child feeding standard 4.1:** Policy guidance and coordination. Policy guidance and coordination ensure safe, timely and appropriate infant and young child feeding.

**Sphere, Infant and young child feeding standard 4.2:** Multi-sectoral support to infant and young child feeding in emergencies. Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks, is culturally sensitive and optimises nutrition, health and survival outcomes.

**UNHCR, Global Strategy for Public Health 2014-2018: Food security and nutrition objective 1.** Addresses the prevention of under-nutrition and micronutrient deficiencies through the provision of access to food, cash and/or vouchers to the general population, and special nutritional products for vulnerable groups, as well as promotion of and support to adequate infant and young child feeding and care practices.

**UNHCR and Save the Children, Infant and Young Child Feeding in Refugee Situations: A Multi-Sectoral Framework for Action. 2018.** Provides guidance on how to consider the particular vulnerabilities of children under 2 and pregnant and nursing mothers in a multitude of sectors.

**Protection Risks**

In emergency response operations, protection, food security and nutrition are closely linked.

- If refugees cannot obtain food in transit centres, they are likely to become food insecure and malnourished and may adopt unsafe coping mechanisms that endanger their security.
- If refugee new arrivals are not screened for acute malnutrition or malnutrition programmes
are unavailable, individuals with acute malnutrition will not be identified or treated, making it more likely that they will die or that their nutritional status will deteriorate.

- If transit centres do not assist infants and mothers who have difficulty breastfeeding, those infants are at greater risk of serious malnutrition and death.
- If transit centres do not identify and support infants younger than 6 months who are not breastfed, those infants face a higher risk of serious malnutrition and death, as a result of eating inappropriate or contaminated food.

**Other risks**

Failure to provide adequate food or nutritional rehabilitation may generate indirect or longer term risks.

- The security of transit centres may be compromised, by riots, demonstrations, or violent behaviour.
- Refugees may take risks to acquire food, or adopt unsafe coping strategies.
- Malnourished individuals may suffer long-term effects, such as impeded growth or development.

**Key decision points**

Wherever required, UNHCR and WFP should provide appropriate food assistance, including fortified foods, to refugees in transit centres.

Wherever required, UNHCR and partners must ensure that transit centres offer appropriate treatment programmes for acutely malnourished persons, either by establishing facilities or making facilities in the host community available to refugees.

UNHCR and partners must ensure that transit centres and other institutions offer breastfeeding support or alternatives to breastfeeding for infants younger than 6 months with established needs.

Public health and nutrition interventions must always be:

- Evidence-based. Activities should be planned and implemented, based on the findings of the initial assessment.
- Needs-based. Interventions should be scaled and resources should be allocated to meet the needs of the population.
- Technically sound. Services should be based on current scientific evidence and operational guidance, and implemented by skilled staff.
- Impact oriented. UNHCR promotes the primary health care approach, which ensures that essential health services address the health and nutrition needs of the entire population.
- Priority-based. Emergency nutrition interventions and services should be prioritised to achieve maximum impact across the population. Interventions to address immediate
health risks, such as disease outbreaks and malnutrition, must be priorities.

- Integrated. Avoid setting up costly parallel services. Assist the national health system to extend its services to refugees.

**Key steps**

1. Establish strong co-ordination to ensure the response covers all needs, and that referrals across services as well as individual follow-up are assured. At the very start of the emergency, make sure that arriving refugees immediately receive minimum food rations or food assistance, to prevent their nutritional status from deteriorating.

2. At the start of an emergency, conduct an initial rapid nutrition assessment to identify levels of malnutrition, in transit centres and other arrival points.

3. Continue to screen for acute malnutrition, both to monitor levels of nutrition and detect individuals who need treatment.

4. Where moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) are identified, establish treatment programmes. All malnourished individuals detected on arrival should be referred to them. Young children and pregnant and lactating women are especially vulnerable to malnutrition. Programme design should reflect needs and available resources.

5. Programmes to treat SAM should build on and support existing health provision, wherever possible. If transit centres cannot treat SAM, or treatment centres are inaccessible, make arrangements to refer cases rapidly to other treatment facilities (for example, in camps).

6. Supplementary feeding programmes to tackle MAM may be targeted or blanket. The choice should reflect the degree of malnutrition, the caseload, the risk that acute malnutrition will increase, available resources, and capacity to screen and monitor. Targeted supplementary feeding programmes generally require more screening and monitoring; blanket delivery usually requires less expertise but more food. Supplementary programmes may provide wet or dry rations. In most situations dry rations are to be preferred; but wet may be more suitable if transit centres are overcrowded or food is difficult to prepare. The choice should be made by an experienced nutritionist.

7. Infant feeding programmes at the start of an emergency can save many vulnerable infants and young children, and play a key role in preventing malnutrition and micronutrient deficiencies. Transit centres should provide basic infant feeding assistance, emphasizing protection, support and promotion of breastfeeding for infants aged less than 6 months. Staff should respond quickly to reports that infants in that age range are having difficulty breastfeeding or eating substitute foods. Infants younger than 6 months who are not breastfed should be identified, receive urgent support, and referred for assessment by skilled personnel. Ensure that rest areas in transit centres include secluded areas for breastfeeding and that skilled breastfeeding support is available to help stressed mothers and acutely malnourished infants. It may be necessary to refer trauma cases to psychosocial services.
8. Refugees with specific needs who require assistance to access or use nutrition services should be supported and prioritised.

**Key management considerations**

Nutrition programmes are normally part of the basic health services in the transit centre. Given the multitude of actors in transit centres, it is vital to ensure that the health and nutrition programmes are well coordinated.

UNHCR must ensure that transit centres provide adequate food assistance, programmes to treat acute malnutrition, and infant feeding support. These services are normally provided by NGO partners in collaboration with WFP and UNICEF.

Given that UNHCR has an overall accountability for the refugee response, UNHCR should ensure that public health or nutrition staff are available as soon as possible to support the assessment, relevant health and nutrition strategy and support the operational response. In situations where malnutrition is a severe problem, UNHCR should deploy nutrition staff directly.

It should also ensure that the nutrition situation of arrivals in transit centres is monitored and reported regularly, using the Basic Indicator Report format in iRHis, so that partners can respond quickly if the situation changes. The iRHis team is available to provide remote and direct support. Contact HQHIS@unhcr.org.

Infant feeding programmes in transit centres must respect the UNHCR’s standard operating procedure for breastmilk substitutes (BMS). UNHCR actively discourages inappropriate distribution and use of BMS, which are not to be included in general or untargeted distributions, and are only provided to specific infants after a professional assessment. UNHCR does not accept unsolicited donations of BMS. Inappropriate handling of milk products can negatively affect feeding practices and increase infant morbidity and mortality.

**Resources and partnerships**

**Staff**

- In cases of severe under-nutrition a UNHCR nutritionist should be present; a nutritionist from UNHCR or a partner organisation can lead in less severe situations; where under-nutrition and infant feeding problems are a minor feature of the response, the UNHCR public health officer will support the partners in this case.
- An experienced nutritionist should lead the nutrition response of the programme.
- Community outreach workers provide support in the surrounding community, and nutrition/health assistants in transit centres.

**Partners**

- Ministry of Health and/or nutrition partners in collaboration with UNHCR implement initial
rapid nutrition assessments, screenings, and nutrition programmes. Partners include NGOs (international and national) and UN agencies such as WFP and UNICEF (for child and maternal health, vaccination, and nutrition)

Annexes

Global Nutrition Cluster, Moderate Acute Malnutrition- A decision tool for emergencies, 2014

UNHCR and WFP, Guidelines for selective feeding- the management of malnutrition in emergencies, 2011

UNHCR policy related to the acceptance, distribution and use of milk products in refugee settings, 2006

UNHCR, Operational guidance on the use of special nutritional products to reduce micronutrient deficiencies and malnutrition in refugee situations, 2011

The Sphere Project

3. Links

Refugee Health Data Global Nutrition Cluster The Sphere Handbook

4. Main contacts

UNHCR Public Health Section, Division of Programme Support and Management (DPSM). At: hqphn@unhcr.org.

Nutrition in camps

18 May 2019

Key points
• Ensure coordination and collaboration between all those involved in a camp's nutrition activities.

• Ensure that all refugees in a camp have access to food.

• Establish programmes to treat acute malnutrition and effective referral mechanisms (to services in the camp or in the host community where refugees have access to these services).

• Establish infant and young child feeding programmes.

• Within the first 3 months conduct a SENS nutrition surveys and conduct regular MUAC screenings to monitor the nutrition situation.

1. Overview

Food security and nutrition interventions in camps aim to improve the immediate food security and nutritional well-being of refugees, mainly by tackling the immediate and underlying causes of malnutrition. A person's nutritional status is highly influenced by his or her environment, water sanitation and hygiene (WASH), access to health services, food and nutrition security and care, and shelter. Where these are inadequate, risk of malnutrition increases.

This entry provides advice on nutrition provision in camps. Nutrition interventions aim to prevent malnutrition in the refugee population, especially among women, young children and other groups with specific needs; to identify, refer and treat malnutrition in individuals; and to monitor the nutrition situation in camps. The food security and nutrition sectors work closely with many sectors including the livelihoods sector to find longer term solutions, promote self-reliance, and improve nutrition opportunities.

2. Main guidance

Protection objectives

◦ To ensure that refugees in refugee camps have access at all times to safe and nutritious food, sufficient to maintain a healthy and active life.
◦ To respect the right to food and the right to health.
◦ To ensure that refugees in camps receive appropriate treatment for moderate acute malnutrition (MAM) and severe acute malnutrition (SAM).
◦ To ensure adequate protection, promotion and support for breastfeeding of infants and young children are available, that infants and young children have access to adequate complementary feeding and that infants younger than 6 months who are not breastfed have access to alternative food that is appropriate and adequate.
Underlying principles and standards

Sphere, Food security and nutrition assessments standard 1.2: Nutrition assessment. Nutrition assessments use accepted methods to identify the type, degree and extent of undernutrition, those most at risk and the appropriate response.

Sphere, Management of malnutrition standard 2.1: Moderate acute malnutrition. Moderate acute malnutrition is prevented and managed.

Sphere, Management of malnutrition standard 2.2: Severe acute malnutrition. Severe acute malnutrition is treated.

Sphere, Micronutrient deficiencies standard 3: Micronutrient deficiencies. Micronutrient deficiencies are corrected.

Sphere, Infant and young child feeding standard 4.1: Policy guidance and coordination. Policy guidance and coordination ensure safe, timely and appropriate infant and young child feeding.

Sphere, Infant and young child feeding standard 4.2: Basic and skilled support. Multi-sectoral support to infant and young child feeding in emergencies. Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks, is culturally sensitive and optimises nutrition, health and survival outcomes.

UNHCR, Global Strategy for Public Health 2014-2018: Food security and nutrition objective 1. Addresses the prevention of undernutrition and micronutrient deficiencies through the provision of access to food, cash and/or vouchers to the general population, and special nutritional products for vulnerable groups, as well as promotion of and support to adequate infant and young child feeding and care practices.


UNHCR and Save the Children, Infant and Young Child Feeding in Refugee Situations: A Multi-Sectoral Framework for Action. 2018. Provides guidance on how to consider the particular vulnerabilities of children under 2 and pregnant and nursing mothers in a multitude of sectors.

Protection Risks

In emergency refugee response operations, protection, food security and nutrition are closely linked.
If refugees cannot obtain food in camps, they are likely to become food insecure and malnourished and may adopt unsafe coping mechanisms that endanger their security.

If refugees in camps are not screened (where applicable), for acute malnutrition, or malnutrition programmes are not available, individuals with acute malnutrition will not be identified or treated, making it more likely that they will die or that their nutritional status will deteriorate.

If infants and mothers who have difficulty breastfeeding are not assisted, those infants are at greater risk of serious malnutrition and death.

If infants younger than 6 months, who are not breastfed are not identified and supported, such infants face a higher risk of serious malnutrition and death, as a result of eating inappropriate or contaminated food.

If programmes do not promote and support good feeding and caring practices for infants and children younger than 24 months, infants and young children are at greater risk to be malnourished and to die.

Other risks

Failure to provide adequate food or nutritional rehabilitation may generate indirect or longer term risks.

- The security of camps may be compromised, by riots, demonstrations, or violent behaviour.
- Refugees may take risks to acquire food, or adopt unsafe coping strategies. These may adversely affect feeding and care (including breastfeeding) of infants and young children.
- Malnourished individuals may suffer long-term effects, such as impeded growth or development.

Key decision points

Wherever required, UNHCR and WFP should provide appropriate food assistance, including fortified foods, to refugees in camps.

UNHCR and partners must ensure that appropriate treatment programmes for acutely malnourished camp-based refugees are available, by establishing new facilities or making facilities in the host community accessible to them.

Public health and nutrition services and infrastructures in camps should also be accessible to the host community to ensure peaceful coexistence and inclusion in services.

Support services and facilities for infant and young child feeding should always be available to refugees living in refugee camps (facilities based in the camp or by making facilities in the host community available to them). Skilled support and counselling should be on hand, as well as safe, baby-friendly spaces in which mothers can feed and interact comfortably with their infants.

UNHCR and partners must ensure that services and support are available for individuals who
require help to breastfeed and infants younger than six months who need alternatives to breastmilk.

Public health and nutrition interventions must always be:

- Evidence-based. Activities should be planned and implemented, based on the findings of the initial assessment.
- Needs-based. Interventions should be scaled and resources should be allocated to meet the needs of the population.
- Technically sound. Services should be based on current scientific evidence and operational guidance, and implemented by skilled staff.
- Impact oriented. UNHCR promotes the primary health care approach, which ensures that essential health services address the health and nutrition needs of the entire population.
- Priority-based. Emergency nutrition interventions and services should be prioritised to achieve maximum impact across the population. Interventions to address immediate health risks, such as disease outbreaks and malnutrition, must be priorities.
- Integrated. Avoid setting up costly parallel services. Assist the national health system to extend its services to refugees.

**Key steps**

1. Establish strong co-ordination with all relevant partners of public health and nutrition programmes in camps to ensure they cover all needs and that referrals across services as well as individual follow-up are assured.
2. Ensure refugees have access to information and know where services are available and are able to voice their opinions.
3. Make sure that all refugees in a camp have adequate access to food. To prevent their nutritional status from deteriorating, help them become self-sufficient or provide food assistance.
4. As refugees are arriving in camps, ensure that initial rapid nutrition (MUAC) screenings are conducted, where applicable, in order to determine the extent of the malnutrition situation.
5. Conduct regular nutrition surveys, following UNHCR’s most up to date Standardised Expanded Nutrition Survey (SENS) guidelines, to monitor the nutrition situation in camps. During an emergency, nutrition surveys should be conducted bi-annually or annually, depending on the level of malnutrition, the risk of deterioration, and available resources.
6. Continue to screen for acute malnutrition in the community, both to monitor levels of nutrition and identify individuals who need treatment. Community outreach workers should integrate screening in their regular routines.
7. All refugees residing in camps should be able to access programmes for treating moderate and severe acute malnutrition, and individuals who are undernourished should be referred to them.
8. Treatment programmes should follow the principles of community-based management of acute malnutrition (CMAM), according to national treatment guidelines or WHO/UNICEF protocols. Strong links should be established between the different components of CMAM programmes, as well as with health and prevention services.
9. To treat severe acute malnutrition (SAM), inpatient and outpatient services should be made available, wherever possible in collaboration with UNICEF, to secure the supply of products and
training. Wherever possible, programmes should support and build on existing health system capacity.

10. To treat moderate acute malnutrition (MAM), outpatient services should be provided; WFP normally provides the food products required. Supplementary feeding programmes may provide wet or dry rations. To tackle malnutrition effectively and identify individuals who are malnourished, it is crucial to inform the community about malnutrition and engage the population in efforts to improve nutrition.

11. During emergencies, infant and young child feeding in Emergencies (IYCF-E) programmes help to save the lives of numerous vulnerable infants and young children, and play a key role in preventing malnutrition and micronutrient deficiencies, even when acute malnutrition is not a general concern. Camp managers should adopt a comprehensive approach to IYCF assistance that protects, promotes and supports exclusive breastfeeding for infants younger than 6 months, and combines appropriate complementary feeding for older infants and children with continued breastfeeding. Community outreach workers and staff in health and nutrition centres should respond quickly to reports that infants younger than 6 months are having difficulty breastfeeding or eating substitute foods. Infants of the same age who are not breastfeeding should be identified and urgently referred to skilled personnel for assessment and action. Set up information and demonstration programmes on child nutrition, and establish baby friendly spaces and community-based support networks in camps.

12. Where the diet of pregnant and lactating women (PLW) lacks nutrients, it may lead to pregnancy complications, maternal mortality, low birth weight infants and lower concentrations of certain nutrients in the breastmilk. PLW should receive complementary food and micronutrient supplements in line with international recommendations. Mothers should be encouraged to exclusively breastfeed their new-born infants, and skilled breastfeeding counselling should be integrated in PLW programmes.

13. Micronutrient deficiencies are mainly prevented through food security programmes. Where a population receives food assistance, a suitable micronutrient-fortified food should be included in the general ration; blanket provision of complementary food for children or other vulnerable groups may be needed. It is also vital to control diseases, notably respiratory infections, measles and parasitic infections like malaria and diarrhoea that deplete micronutrient stores. The provision of water and appropriate sanitation and shelter facilities is essential.

14. Refugees with specific needs who require assistance to access or use nutrition services should be supported and prioritised.

15. Apply an age-gender-diversity perspective and use community based approaches in assessments, response analysis and programme implementation.

**Key management considerations**

UNHCR must ensure that adequate food assistance, programmes to treat acute malnutrition, and infant feeding support are provided to refugees residing in camps. These services are normally provided by NGO partners in collaboration with WFP and UNICEF and the Ministry of Health.

UNHCR should also ensure that the nutrition situation in camps is monitored and reported regularly, using the Basic Indicator Reporting format and other reporting forms in iRHiS, so that partners can respond quickly if the situation changes. The iRHiS team is available to provide remote and direct support. Contact HQHIS@unhcr.org.
Infant feeding programmes in camps must respect UNHCR’s standard operating procedure on breastmilk substitutes (BMS). UNHCR actively discourages inappropriate distribution and use of BMS, which are not to be included in general or untargeted distributions, and are only provided to specific infants after a professional assessment. UNHCR does not accept unsolicited donations of BMS. Inappropriate handling of milk products can negatively affect feeding practices and increase infant morbidity and mortality.

**Resources and partnerships**

**Staff**

- A trained UNHCR public health officer, with knowledge of nutrition, to coordinate the response.
- An experienced nutritionist from UNHCR to lead the nutrition response in cases of severe under-nutrition, ensuring that refugees are integrated in available national services, or that services are created or improved; an experienced nutritionist from UNHCR or a partner organisation where nutrition features heavily yet is not so severe and where under-nutrition and infant feeding problems are a more minor feature of the response, the UNHCR public health officer will support the partners.
- Community outreach workers provide support in the camp (or surrounding community), and nutrition/health assistants at the nutrition centres, either from UNHCR or a partner organisation.

**Partners**

- Nutrition partners to implement or support nutrition surveys, screenings, and nutrition programmes may include relevant the ministry of health, NGOs (international or national) and UN agencies such as WFP and UNICEF.
- Establish partnership agreements at field level early on so that interventions can be implemented rapidly.

**Annexes**

UNHCR, *UNHCR policy related to the acceptance, distribution and use of milk products in refugee settings, 2006*

UNHCR, *Operational guidance on the use of special nutritional products to reduce micronutrient deficiencies and malnutrition in refugee situations, 2011*

**3. Links**
4. Main contacts

UNHCR Public Health Section, Division of Programme Support and Management (DPSM). At: hqphn@unhcr.org.

Nutrition in rural areas

18 May 2019

Key points

- Ensure coordination and collaboration between all those involved in nutrition activities.
- Ensure that all refugees have access to food either through their own means or food assistance.
- Ensure that refugees can access national nutrition services, including IYCF and treatments for malnutrition.
- Conduct a SENS or ensure refugees are included in national nutrition surveys.

1. Overview

Food security and nutrition interventions in rural dispersed situations aim to improve the immediate food security and nutritional well-being of refugees, mainly by tackling the immediate and underlying causes of malnutrition. A person’s nutritional status is highly influenced by his or her environment, water sanitation and hygiene (WASH), access to health services, food and nutrition security and care, and shelter. Where these are inadequate, risk of malnutrition increases.

This entry provides advice on nutrition provision for refugees living in rural dispersed settings, where it is best to include them into the national nutrition services used by host populations. To do this, early and strong collaboration with the Ministry of Health, UNICEF, WFP and other actors is crucial. Nutrition interventions aim to prevent malnutrition, especially among women, young children and other groups with specific needs; to identify, refer and treat malnutrition in individuals; and to monitor the nutrition situation. The food security and nutrition sectors work closely with many sectors including the livelihoods sector to find longer term solutions and
promote self-reliance and improve nutrition opportunities.

2. Main guidance

Protection objectives

- To ensure that refugees in rural settings have access at all times to safe and nutritious food, sufficient to maintain a healthy and active life.
- To respect the right to food and the right to health.
- To ensure that refugees receive appropriate treatment for moderate acute malnutrition (MAM) and severe acute malnutrition (SAM).
- To ensure that adequate protection, promotion and support for breastfeeding of infants and young children are available, that infants and young children have access to adequate complementary feeding and that infants younger than 6 months who are not breastfed have access to alternative food that is appropriate and adequate.

Underlying principles and standards

Note that UNHCR has developed a comprehensive public health strategy that applies to emergency and non-emergency operations in camp and out-of-camp settings. In rural dispersed situations settings, UNHCR aims to integrate refugees into national services, and therefore UNHCR and its partners should apply national public health and nutrition standards where these exist and are appropriate.

**Sphere, Management of malnutrition standard 2.1: Moderate acute malnutrition.** Moderate acute malnutrition is prevented and managed.

**Sphere, Management of malnutrition standard 2.2: Severe acute malnutrition.** Severe acute malnutrition is treated.

**Sphere, Micronutrient deficiencies standard 3: Micronutrient deficiencies.** Micronutrient deficiencies are corrected.

**Sphere, Infant and young child feeding standard 4.1: Policy guidance and coordination.** Policy guidance and coordination ensure safe, timely and appropriate infant and young child feeding.

**Sphere, Infant and young child feeding standard 4.2: Multi-sectoral support to infant and young child feeding in emergencies.** Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks, is culturally sensitive and optimises nutrition, health and survival outcomes.

**UNHCR, Global Strategy for Public Health 2014-2018: Food security and nutrition objective 1.** Addresses the prevention of undernutrition and micronutrient deficiencies through
the provision of access to food, cash and/or vouchers to the general population, and special nutritional products for vulnerable groups, as well as promotion of and support to adequate infant and young child feeding and care practices.

**UNHCR, Global Strategy for Public Health 2014-2018: Food security and nutrition objective 2.** Sets standards for treating acute malnutrition that ensure quality treatment and adequate coverage.

**UNHCR, Global Strategy for Public Health 2014-2018: Food security and nutrition objective 4.** Guides an effective food security and nutrition response in emergencies.

**UNHCR and Save the Children, Infant and Young Child Feeding in Refugee Situations: A Multi-Sectoral Framework for Action. 2018.** Provides guidance on how to consider the particular vulnerabilities of children under 2 and pregnant and nursing mothers in a multitude of sectors.

### Protection Risks

In emergency refugee operations, protection, food security and nutrition are closely linked.

- If refugees living in rural dispersed settings cannot obtain enough food, they are likely to become food insecure and malnourished and may adopt unsafe coping mechanisms that endanger their security.
- If refugees are not screened for acute malnutrition or malnutrition programmes are not available, individuals with acute malnutrition will not be identified or treated, making it more likely that they will die or that their nutritional status will deteriorate.
- If infants and mothers who have difficulty breastfeeding do not receive assistance and skilled support, those infants are at greater risk of serious malnutrition and death.
- If programmes do not promote and support good feeding and caring practices for infants and children younger than 24 months, infants and young children are more likely to become malnourished and to die.

### Other risks

Refugees in dispersed rural settings face additional indirect or long term risks if they do not have access to sufficient food or treatment for malnutrition.

- They may take risks to acquire food, or adopt unsafe coping strategies.
- Women and girls who need to travel long distances to collect water, firewood or food may be assaulted, and they have less time to care for and feed (including breastfeed) their infants and young children.
- Malnourished individuals may suffer long-term effects, such as impeded growth or development.
Key decision points

Wherever required, UNHCR and WFP should provide appropriate food assistance, including fortified foods, to refugees in rural dispersed settings.

Treatment programmes for acutely malnourished refugees, and support services and facilities for infant and young child feeding should always be available to refugees living in rural dispersed settings. UNHCR should encourage the authorities to grant refugees access to national services, where these are available and adequate. Where they are not, UNHCR should collaborate with the local Ministry of Health, UNICEF and other relevant actors to establish new services or improve those that exist, for the benefit of both refugee and host populations.

Where individuals require help to breastfeed or infants younger than six months need alternative foods to breast milk, appropriate services and support must be made available.

Public health and nutrition interventions must always be:

- Evidence-based. Activities should be planned and implemented, based on the findings of the initial assessment.
- Needs-based. Interventions should be scaled and resources should be allocated to meet the needs of the population.
- Technically sound. Services should be based on current scientific evidence and operational guidance, and implemented by skilled staff.
- Impact oriented. UNHCR promotes the primary health care approach, which ensures that essential health services address the health and nutrition needs of the entire population.
- Priority-based. Emergency nutrition interventions and services should be prioritised to achieve maximum impact across the population. Interventions to address immediate health risks, such as disease outbreaks and malnutrition, must be priorities.
- Integrated. Avoid setting up costly parallel services. Assist the national health system to extend its services to refugees.

Key steps

1. Establish strong co-ordination with the Ministry of Health (MOH), NGOs, UNICEF, WFP and other relevant actors to ensure refugees are integrated into available national nutrition services. In rural dispersed settings, UNHCR will need to rely even more on available services than in camp and camp-like settings.
2. Ensure refugees have access to information and know where services are available and are able to voice their opinions.
3. Make sure that all needs are covered and that referrals across services as well as individual follow-up are assured, given the many actors involved and the distance that may separate facilities in rural dispersed settings.
4. Make sure that all refugees living in rural dispersed settings have adequate access to food. To prevent their nutritional status from deteriorating, assist them to be self-sufficient or provide
5. Conduct regular nutrition surveys to monitor the situation. Either include refugees in rural dispersed settings in national/regional nutrition surveys, or conduct specific nutrition surveys that follow UNHCR's Standardised Expanded Nutrition Survey (SENS) guidelines. During an emergency, nutrition surveys should be conducted bi-annually or annually, depending on the level of malnutrition, the risk of deterioration, and available resources.

6. Where the nutrition situation is of concern, continue to screen for acute malnutrition among refugees, both to monitor levels of nutrition and identify individuals who need treatment. If the host community is screened, make sure that refugees are included.

7. All refugees living in rural dispersed settings should be able to access programmes for treating moderate and severe acute malnutrition, and individuals who are undernourished should be referred to them. Refugees should preferably be included in national programmes where these exist. Where they do not, UNHCR should encourage and support the creation of services that will benefit both refugees and the host community. Programmes should align with principles of CMAM (community-based management of acute malnutrition) and be linked to national health and nutrition services.

8. To treat severe acute malnutrition (SAM), inpatient and outpatient services should be available to refugees, wherever possible through national programmes, in collaboration with the Ministry of Health and UNICEF.

9. To treat moderate acute malnutrition (MAM), outpatient services should be provided wherever possible through national programmes; WFP normally provides the food products required.

10. To tackle malnutrition effectively and identify individuals who are malnourished, it is crucial to inform the community about malnutrition and engage the population in efforts to improve nutrition.

11. During emergencies, infant and young child feeding (IYCF) programmes help to save the lives of numerous vulnerable infants and young children and play a key role in preventing malnutrition and micronutrient deficiencies. Refugees living in rural dispersed settings should have access to services that compare with those available to the host community, preferably by their inclusion in national services, in collaboration with the Ministry of Health and UNICEF. Where services do not exist or are inadequate, UNHCR and partners should encourage their creation or improvement. Adopt a comprehensive approach to IYCF assistance that protects, promotes and supports exclusive breastfeeding for infants younger than 6 months, and combines appropriate complementary feeding for older infants and children with continued breastfeeding.

12. Where the diet of pregnant and lactating women (PLW) lacks nutrients, it may lead to pregnancy complications, maternal mortality, low birth weight infants and lower concentrations of certain nutrients in the breastmilk. PLW should be able to access relevant services in the host community. Where such services do not exist, UNHCR should encourage their establishment, in collaboration with the Ministry of Health, UNICEF and other relevant agencies.

13. Micronutrient deficiencies are mainly prevented through food security programmes. Where a population receives food assistance, a suitable micronutrient-fortified food should be included in the general ration; blanket provision of complementary food for children or other vulnerable groups may be needed. It is also vital to control diseases, notably respiratory infections, measles, and parasitic infections like malaria and diarrhoea that deplete micronutrient stores. The provision of water and appropriate sanitation facilities is essential. Where relevant, refugees should be integrated in national malnutrition programmes.

14. Refugees with specific needs who require assistance to access or use nutrition services
should be supported and prioritised.

15. Apply an age-gender diversity perspective and use community based approached in assessments, response analysis and programme implementation.

**Key management considerations**

Where refugees live in rural dispersed settings side by side with host communities, early coordination and collaboration with the government, NGOs, UNICEF, WFP and other partners is especially important. UNHCR must ensure that refugees have access to adequate food, programmes to treat acute malnutrition, and infant feeding support. UNHCR should encourage the integration of refugees in national programmes and services that are available.

Where national services do not exist or are inadequate, UNHCR and UNICEF should encourage their creation or improvement, to the benefit of both refugees and the host community. When national programmes are overwhelmed by exceptional need, for instance during food or nutrition emergencies, UNHCR and partners must establish additional services and provision to complement national programmes.

Though the preferred option is to integrate refugees within national services, it must be recognized that challenges may arise. For instance, the services delivered may be uneven, programmes may lack staff, access may be difficult (because of distance, for example), data may be lacking, and oversight of refugee access and nutritional status may be weak.

It should also ensure that the nutrition situation of refugees in rural dispersed situations is monitored and reported regularly, using the Basic Indicator Report format in iRHiS, so that partners can respond quickly if the situation changes. The iRHiS team is available to provide remote and direct support. Contact [HQHIS@unhcr.org](mailto:HQHIS@unhcr.org).

Infant feeding programmes must respect the UNHCR’s standard operating procedure on breast milk substitutes (BMS). UNHCR actively discourages inappropriate distribution and use of BMS, which are not to be included in general or untargeted distributions, and are only provided to specific infants after a professional assessment. UNHCR does not accept unsolicited donations of BMS. Inappropriate handling of milk products can negatively affect feeding practices and increase infant morbidity and mortality.

**Resources and partnerships**

The inputs required to set up and implement a nutrition response in rural dispersed settings depend on the nature of the emergency and the degree to which refugee needs can be met by available national programmes and services. Initially, an experienced nutritionist or public health specialist should be present to assess the situation and need. If it is found that a comprehensive nutrition response is necessary, the inputs below will be required.

**Staff**
A trained UNHCR public health officer, with knowledge of nutrition, to coordinate the response.
An experienced nutritionist from UNHCR to lead the nutrition response in cases of severe under-nutrition, ensuring that refugees are integrated in available national services, or that services are created or improved.
Community outreach workers to work in the community and nutrition/health assistants to staff nutrition centres, from UNHCR or partner organisations. In some cases, staff will be available in sufficient numbers; however, after a refugee influx, staff may need to be recruited or trained.

Partners

If it is necessary to establish new services or to strengthen existing services, nutrition partners must be identified in partnership with the Ministry of Health, UNICEF and WFP, to screen for malnutrition, implement nutrition programmes, and conduct nutrition surveys.
Predictable partnership agreements must be established with relevant NGOs (International and national) and UN agencies such as WFP and UNICEF.

Annexes

UNHCR, UNHCR policy related to the acceptance, distribution and use of milk products in refugee settings, 2006

UNHCR, Operational guidance on the use of special nutritional products to reduce micronutrient deficiencies and malnutrition in refugee situations, 2011

UNHCR and WFP, Guidelines for selective feeding, the management of malnutrition in emergencies, 2011

Global Nutrition Cluster, Moderate Acute Malnutrition, A decision tool for emergencies, 2014

3. Links

UNHCR SENS UNHCR Data Website The Sphere Handbook Nutrition Cluster - Training package

4. Main contacts

UNHCR Public Health Section, Division of Programme Support and Management (DPSM). At: hqphn@unhcr.org.
Nutrition in urban areas

18 May 2019

Key points

- Ensure coordination and collaboration between all those involved in nutrition activities.
- Ensure that all refugees have access to food either through their own means or food assistance.
- Ensure that refugees can access national nutrition services, including IYCF and treatments for malnutrition.
- Conduct a SENS nutrition surveys or ensure refugees are included in national nutrition surveys.

1. Overview

Food security and nutrition interventions in urban areas aim to improve the immediate food security and nutritional well-being of refugees, mainly by tackling the immediate and underlying causes of malnutrition. A refugee's nutritional status is highly influenced by his or her environment, water sanitation and hygiene (WASH), access to health services, food and nutrition security and care, and shelter. Where these are inadequate, risk of malnutrition increases.

This brief provides advice on nutrition provision for refugees living in urban areas. For this group, the best option is to meet their nutrition needs by making available to them the national services used by host populations. To do this, early and strong collaboration with the Ministry of Health, UNICEF, WFP and other actors is crucial. Nutrition interventions in urban areas aim to prevent malnutrition in the refugee population, especially among women, young children and other vulnerable groups; to identify, refer and treat malnutrition in individuals; and to monitor the nutrition situation. The food security and nutrition sectors work closely with many sectors including the livelihoods sector to find longer term solutions and promote refugee self-reliance and improve nutrition opportunities.

2. Main guidance
Protection objectives

- To ensure refugee populations in urban areas have access at all times to safe and nutritious food, sufficient to maintain a healthy and active life.
- To respect the right to food and the right to health.
- To ensure refugees receive appropriate treatment for moderate acute malnutrition (MAM) and severe acute malnutrition (SAM).
- To ensure adequate protection, promotion and support for breastfeeding of infants and young children are available, that infants and young children have access to adequate complementary feeding and that infants younger than 6 months who are not breastfed have access to alternative food that is appropriate and adequate.

Underlying principles and standards

Note that UNHCR has developed a comprehensive public health strategy that applies to emergency and non-emergency operations in camp and out-of-camp settings. In urban settings, UNHCR aims to integrate refugees into national services, and therefore UNHCR and its partners should apply national public health and nutrition standards where these exist and are appropriate.

**Sphere, Management of malnutrition standard 2.1: Moderate acute malnutrition.** Moderate acute malnutrition is prevented and managed.

**Sphere, Management of malnutrition standard 2.2: Severe acute malnutrition.** Severe acute malnutrition is treated.

**Sphere, Micronutrient deficiencies standard 3: Micronutrient deficiencies.** Micronutrient deficiencies are corrected.

**Sphere, Infant and young child feeding standard 4.1: Policy guidance and coordination.** Policy guidance and coordination ensure safe, timely and appropriate infant and young child feeding.

**Sphere, Infant and young child feeding standard 4.2: Multi-sectoral support to infant and young child feeding in emergencies.** Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks, is culturally sensitive and optimises nutrition, health and survival outcomes.

**UNHCR, Global Strategy for Public Health 2014-2018: Food security and nutrition objective 1.** Addresses the prevention of under-nutrition and micronutrient deficiencies through the provision of access to food, cash and/or vouchers to the general population, and special nutritional products for vulnerable groups, as well as promotion of and support to adequate infant and young child feeding and care practices.

**UNHCR, Global Strategy for Public Health 2014-2018: Food security and nutrition...**
**objective 2.** Sets standards for treating acute malnutrition that ensure quality treatment and adequate coverage.

**UNHCR, Global Strategy for Public Health 2014-2018: Food security and nutrition objective 4.** Guides an effective food security and nutrition response in emergencies.

**UNHCR and Save the Children, Infant and Young Child Feeding in Refugee Situations: A Multi-Sectoral Framework for Action. 2018.** Provides guidance on how to consider the particular vulnerabilities of children under 2 and pregnant and nursing mothers in a multitude of sectors.

### Protection Risks

In emergency refugee operations, protection, food security and nutrition are closely linked.

- If refugees living in urban areas cannot obtain enough food, they are likely to become food insecure and malnourished and may adopt unsafe coping mechanisms that endanger their security.
- If refugees are not screened for acute malnutrition, or malnutrition programmes are not available, individuals with acute malnutrition will not be identified or treated, making it more likely that they will die or that their nutritional status will deteriorate.
- If infants and mothers who have difficulty breastfeeding do not receive assistance and skilled support, those infants are at greater risk of serious malnutrition and death.
- If programmes do not promote and support good feeding and caring practices for infants and children younger than 24 months, infants and young children are more likely to become malnourished and to die.

### Other risks

Refugees in urban areas face additional indirect or long term risks if they do not have access to sufficient food or treatment for malnutrition.

- Security may be compromised, by riots, demonstrations, or violent behaviour.
- Refugees may take risks to acquire food, or adopt unsafe coping strategies. These may adversely affect feeding and care (including breastfeeding) of infants and young children.
- Malnourished individuals may suffer long-term effects, such as impeded growth or development.

### Key decision points

Wherever required, UNHCR and WFP should provide appropriate food assistance, including fortified foods, to refugees in urban areas.

Treatment programmes for acutely malnourished refugees, and support services and facilities for infant and young child feeding, should always be available to refugees living in urban areas.
UNHCR should encourage the authorities to grant refugees access to national services, where these are available and adequate. Where they are not, UNHCR should collaborate with the Ministry of Health, UNICEF, WFP and other relevant actors to establish new services or improve those that exist, for the benefit of both refugee and host populations.

Where individuals require help to breastfeed or infants younger than six months need alternative foods to breast milk, appropriate services and support must be made available.

Public health and nutrition interventions must always be:

- Evidence-based. Activities should be planned and implemented, based on the findings of the initial assessment.
- Needs-based. Interventions should be scaled and resources should be allocated to meet the needs of the population.
- Technically sound. Services should be based on current scientific evidence and operational guidance, and implemented by skilled staff.
- Impact oriented. UNHCR promotes the primary health care approach, which ensures that essential health services address the health and nutrition needs of the entire population.
- Priority-based. Emergency nutrition interventions and services should be prioritised to achieve maximum impact across the population. Interventions to address immediate health risks, such as disease outbreaks and malnutrition, must be priorities.
- Integrated. Avoid setting up costly parallel services. Assist the national health system to extend its services to refugees.

**Key steps**

- Establish strong co-ordination with the Ministry of Health (MOH), NGOs, UNICEF, WFP and other relevant actors to ensure refugees are integrated into available national nutrition services. In urban areas, UNHCR will need to rely even more on available services than in camp and camp-like settings.
- Ensure refugees have access to information and know where services are available and are able to voice their opinions.
- Ensure that all needs are covered and referrals between services and individual follow-up are assured, given that urban settings sometimes have more complex service delivery structures.
- Make sure that all refugees living in urban areas have adequate access to food. To prevent their nutritional status from deteriorating, assist them to be self-sufficient or provide (temporary) food assistance.
- Conduct regular nutrition surveys to monitor the situation. Either include urban refugees in national/regional nutrition surveys, or conduct specific nutrition surveys that observe UNHCR's Standardised Expanded Nutrition Survey (SENS) guidelines. During an emergency, nutrition surveys should be conducted bi-annually or annually, depending on the level of malnutrition, the risk of deterioration, and available resources.
- Where the nutrition situation is of concern, continue to screen for acute malnutrition among refugees, both to monitor levels of nutrition and identify individuals who need treatment. If the host community is screened, make sure that refugees are included.
All refugees living in urban areas should be able to access programmes for treating moderate and severe acute malnutrition. Refugees should preferably be included in national programmes where these exist. Where they do not, UNHCR should encourage and support the creation of services that will benefit both refugees and the host community. Programmes should align with principles of CMAM (community-based management of acute malnutrition) and be linked to national health and nutrition services.

To treat severe acute malnutrition (SAM), inpatient and outpatient services should be available to refugees, wherever possible through national programmes, in collaboration with the Ministry of Health and UNICEF.

To treat moderate acute malnutrition (MAM), outpatient services should be provided, linked to national programmes; WFP should provide the food products required.

To tackle malnutrition effectively and identify individuals who are malnourished, it is crucial to inform the community about malnutrition and engage the population in efforts to improve nutrition.

During emergencies, infant and young child feeding (IYCF) programmes help to save the lives of numerous vulnerable infants and young children and play a key role in preventing malnutrition and micronutrient deficiencies. Refugees living in urban areas should have access to services that compare with those available to the host community, preferably by their inclusion in national programmes in collaboration with the Ministry of Health and UNICEF. Where services do not exist or are inadequate, UNHCR and partners should encourage their creation or improvement. Programmes should protect, promote and support exclusive breastfeeding for infants younger than 6 months, and combine appropriate complementary feeding for older infants and children with continued breastfeeding.

Where the diet of pregnant and lactating women (PLW) lacks nutrients, it may lead to pregnancy complications, maternal mortality, low birth weight infants and lower concentrations of certain nutrients in the breastmilk. PLW should be able to access relevant services in the host community. Where such services do not exist, UNHCR should encourage their establishment, in collaboration with the Ministry of Health, UNICEF and other relevant agencies.

Micronutrient deficiencies are mainly prevented through food security programmes. Where a population receives food assistance, a suitable micronutrient-fortified food should be included in the general ration; blanket provision of complementary food for children or other vulnerable groups may be needed. It is also vital to control diseases, notably respiratory infections, measles, and parasitic infections like malaria and diarrhoea that deplete micronutrient stores. The provision of water and appropriate sanitation facilities is essential. Where relevant, refugees should be integrated in national malnutrition prevention and treatment programmes.

Refugees with specific needs who require assistance to access or use nutrition services should be supported and prioritised.

Apply an age-gender diversity perspective and use community based approached in assessments, response analysis and programme implementation.
Key management considerations

Where refugees live in urban areas side by side with host communities, early coordination and collaboration with the government, NGOs, UNICEF, WFP and other partners is especially important. UNHCR must ensure that refugees have access to adequate food, programmes to treat and prevent acute malnutrition, and infant feeding support. UNHCR should encourage the integration of refugees in national programmes and services to which their host communities have access.

Where national services do not exist or are inadequate, UNHCR and UNICEF should encourage their creation or improvement, to the benefit of both refugees and the host community. When national programmes are overwhelmed by exceptional need, for instance during food or nutrition emergencies, UNHCR and partners must establish additional services and provision to complement national programmes.

Given that UNHCR has an overall accountability for the refugee response, UNHCR should ensure that public health or nutrition staff are available as soon as possible to support the assessment, relevant public health and nutrition strategy and support the operational response. In situations where malnutrition is a severe problem, UNHCR should deploy nutrition staff directly.

Though the preferred option is to integrate refugees within national services, it must be recognized that challenges may arise. For instance, the services delivered may be uneven, programmes may lack staff, access may be difficult (because of distance, for example), data may be lacking, and oversight of refugee access and nutritional status may be weak.

Infant feeding programmes must respect the UNHCR’s standard operating procedure on breast milk substitutes (BMS). UNHCR actively discourages inappropriate distribution and use of BMS, which are not to be included in general or untargeted distributions, and are only provided to specific infants after a professional assessment. UNHCR does not accept unsolicited donations of BMS. Inappropriate handling of milk products can negatively affect feeding practices and increase infant morbidity and mortality.

Resources and partnerships

The inputs required to set up and implement a nutrition response in urban areas depend on the nature of the emergency and the degree to which refugee needs can be met by available national programmes and services. Initially, an experienced public health officer, with nutrition experience should be present to assess the situation and need. If it is found that a comprehensive nutrition response is necessary, the inputs below will be required.

Staff

- A trained UNHCR public health officer, with knowledge of nutrition, to coordinate the response.
- An experienced nutritionist from UNHCR or standby partner to lead the nutrition response.
in cases of severe under-nutrition, ensuring that refugees are integrated in available national services, or that services are created or improved;
  ○ Community outreach workers to provide support in the community and nutrition/health assistants to staff nutrition centres, from UNHCR or partner organisations. In some cases, staff will be available in sufficient numbers; however, after a refugee influx, staff may need to be recruited or trained.

**Partners**

  ○ If it is necessary to establish new services or to strengthen existing services, nutrition partners must be identified in partnership with the Ministry of Health, UNICEF and WFP, to screen for malnutrition, implement nutrition programmes, and conduct nutrition surveys.
  ○ Predictable partnership agreements must be established with relevant NGOs (international and national) and UN agencies such as WFP and UNICEF.

**Annexes**

UNHCR, *UNHCR policy related to the acceptance, distribution and use of milk products in refugee settings, 2006*

UNHCR, *Operational guidance on the use of special nutritional products to reduce micronutrient deficiencies and malnutrition in refugee situations, 2011*

UNHCR and WFP, *Guidelines for selective feeding the management of malnutrition in emergencies, 2011*

Global Nutrition Cluster, *Moderate Acute Malnutrition_ A decision tool for emergencies, 2014*

**3. Links**

UNHCR SENS UNHCR Official Data Website The Sphere Handbook

**4. Main contacts**

UNHCR Public Health Section, Division of Programme Support and Management (DPSM). At: hqphn@unhcr.org.
1. Overview

Global Acute Malnutrition (GAM) is a measure of acute malnutrition in refugee children aged between 6 and 59 months. GAM provides information on the percentage of all children in this age range in a refugee population who are classified with low weight-for-height and/or oedema. It is obtained by combining the number of children in this age range who have moderate acute malnutrition and severe acute malnutrition. GAM is also often referred to as wasting.

GAM indicates short term (recent) nutritional history in children aged between 6 and 59 months. The measure is important because acute malnutrition increases the risk of illness and death, and children of this age are particularly vulnerable to it. GAM is also considered an indicator of the overall food and nutrition situation of the general population.

GAM is not to be confused with another measurement of acute malnutrition, mid-upper arm circumference (MUAC). MUAC is a rapid screening tool that is commonly used to select individuals for nutrition programmes and nutrition surveillance. Its measurements do not provide a formal threshold of the severity of a situation at population level. MUAC measurements should not be considered as a proxy for GAM either, because acute malnutrition based on MUAC cannot be directly converted into acute malnutrition based on weight-for-height.

2. Main guidance
Emergency standard

Classification of the severity of global acute malnutrition (GAM) in refugee settings

<table>
<thead>
<tr>
<th>Prevalence thresholds GAM/ Wasting (%)</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 2.5</td>
<td>Very Low</td>
</tr>
<tr>
<td>2.5 - &lt; 5</td>
<td>Low</td>
</tr>
<tr>
<td>5 - &lt; 10</td>
<td>Medium</td>
</tr>
<tr>
<td>10 - &lt; 15</td>
<td>High</td>
</tr>
<tr>
<td>&gt; 15</td>
<td>Very High</td>
</tr>
</tbody>
</table>

The UNHCR standard is < 10% global acute malnutrition (GAM) or wasting in a refugee population, meaning that when GAM is less than 10% in a given population the severity of the situation is considered to be of low or medium public health concern. When GAM is 10% or more, the severity of the situation is considered to be of high public health concern and immediate actions must be taken (see table above). This standard applies to both shorter and longer-term situations.

GAM results must clearly explain how children have been selected for inclusion in GAM surveys, how the measurements were taken, and how the data were analysed. The selection procedure should generate a sample that represents the child population as a whole, or otherwise should state clearly the extent to which the poll is representative (for example, representative of one camp, of refugee children in transit centres, etc.). Only children aged between 6 and 59 months may be included. Measurements of weight, height, age and oedema must be taken using internationally recognized methods. Analysis of the results should use specialized software, such as ENA for SMART or Epi Info/ENA.

The term ‘global acute malnutrition' must never be used in the context of MUAC assessments (see the overview above).
Annexes

Guidelines for selective feeding. The management of malnutrition in emergencies

Moderate Acute Malnutrition. A decision tool for emergencies

Picture of Measurement of height and weight for children

3. Links

UNHCR Global Strategy for Public Health UNHCR SENS

4. Main contacts

UNHCR Public Health Section, Division of Programme Support and Management. At: hqphn@unhcr.org.

Nutrition programme performance standards

18 May 2020

Key points

- Programmes that treat moderate and acute malnutrition must be monitored regularly.
- Use UNHCR's standard IrHIS format to monitor.

1. Overview

Acute malnutrition in refugee situations should be managed by applying the principles of community-based management of acute malnutrition (CMAM), in accordance with the relevant national treatment guidelines or WHO/UNICEF protocols. Treatment of severe acute malnutrition (SAM) should be provided by means of a Therapeutic Feeding Programme (TFP), offering inpatient and outpatient services, wherever possible in collaboration with the Ministry of Health.
and UNICEF. Treatment of moderate acute malnutrition (MAM) should be provided by means of a Supplementary Feeding Programme (SFP) offered to outpatients; WFP normally provides the food products required. All treatment programmes should happen in the context of robust prevention and detection activities.

It is vital to monitor treatment programmes to ensure that their outcome and coverage are satisfactory, and to be able to quickly react if problems arise. Use UNHCR’s Integrated Refugee Health Information System (IrHiS) to monitor.

2. Main guidance

Emergency standard

The standard below applies to both emergencies and long-term situations.

**Indicators for assessing the effectiveness of feeding programmes for children in refugee settings who are less than 5 years old**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>SFP (Management of MAM)</th>
<th>TFP (Management of SAM)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>&gt;50%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>Urban</td>
<td>&gt;70%</td>
<td>&gt;70%</td>
</tr>
<tr>
<td>Camps</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Recovered</td>
<td>&gt;75%</td>
<td>&gt;75%</td>
</tr>
<tr>
<td>Defaulted</td>
<td>&lt;15%</td>
<td>&lt;15%</td>
</tr>
<tr>
<td>Died</td>
<td>&lt;3%</td>
<td>&lt;10%</td>
</tr>
</tbody>
</table>

*Therapeutic Feeding Programmes include both inpatient and outpatient facilities.

**Coverage.** Coverage should usually be monitored be means of a coverage survey. In emergency situations, a proxy for coverage can be estimated by calculating the proportion of eligible
individuals enrolled in programmes (number of eligible individuals enrolled / number of all eligible individuals in the target population). This can be done during a Standardised Expanded Nutrition Survey (SENS).

**Recovered.** The proportion of beneficiaries who have reached the discharge criteria of success defined by the programme.

**Defaulted.** The proportion of beneficiaries who are absent for three consecutive weeks (two consecutive weighings) or depending on in-country specific protocols. Defaults may be confirmed or non-confirmed.

**Death.** The proportion of beneficiaries who died from any cause while registered in the programme.

**Annexes**

UNHCR and WFP, Guidelines for selective feeding. The management of malnutrition in emergencies, 2011


UNHCR and WFP, Guidelines for selective feeding. The management of malnutrition in emergencies, 2011

**3. Links**

UNHCR Global Strategy for Public Health  UNHCR SENS Refugee Health Data  The Sphere Handbook

**4. Main contacts**

UNHCR Public Health Section, Division of Programme Support and Management. At: hqphn@unhcr.org.
Emergency water standard

28 January 2020

Key points

- Interpret indicators with care when population size fluctuates significantly.
- The volume of water produced daily includes leakages, spillage and waste. Since 10-35% of water is normally lost to these causes, it is advisable to take spillage into account when assessing a water distribution system's performance. Seasonality also affects water availability. More water is usually available in the rainy season and less in the dry season. In addition, water needs rise with air temperature and increased physical activity. To establish an accurate average level of water availability, take readings in different seasons throughout the year.
- When selecting locations for testing water quality, prioritize water points that are furthest from and closest to the water treatment point, and locations situated at joints or branch points in the piping network.
- To assess the number of houses and their distance from water points, use either a camp layout map or GIS mapping procedures (if these exist). Plot functioning water points on a scaled camp map to calculate the number of households within the distances recommended for emergencies or post-emergency situations.

1. Overview

Water is essential to life, health and dignity and access to it is a basic human right. All refugees should have assured access to adequate water of good quality, to sanitation facilities, and hygiene promotion practices. In emergencies a WASH response is critical, to reduce mortality and morbidity, and enhance refugees’ protection, dignity and quality of life.

It is vital to monitor water indicators, to ensure that the coverage and outcomes of WASH programmes are appropriate. Programme monitoring should use the UNHCR WASH Monitoring System (WMS).

Standard / indicators
The main water supply standards below, defined by Sphere, have been endorsed by UNHCR.

- Access and water quantity. People have equitable and affordable access to sufficient quantity of safe water to meet their drinking and domestic needs.
- Water quality. Water is palatable and of sufficient quality for drinking and cooking, and for personal and domestic hygiene without causing a risk to health.

UNHCR WASH indicators in emergencies and post-emergency situations:

**Objective:** Supply of potable water increased or maintained

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit</th>
<th>Emergency Standard</th>
<th>Post Emergency Standard</th>
<th>Camp</th>
<th>Out of Camp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average # litres of potable water /person/day.</td>
<td>l/p/d</td>
<td>&gt;=15</td>
<td>&gt;=20</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Average # l/p/d of potable water collected at household level.</td>
<td>l/p/d</td>
<td>&gt;=15</td>
<td>&gt;=20</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Tests with 0 faecal coliforms/100 ml of water (at non-chlorinated water collection locations).</td>
<td>%</td>
<td>&gt;=95</td>
<td>&gt;=95</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Tests showing free residual chlorine 0.2-2 mg/l and NTU&lt;5 (at chlorinated water collection locations).</td>
<td>%</td>
<td>&gt;=95</td>
<td>&gt;=95</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Number of persons per usable water tap.</td>
<td>Person/tap</td>
<td>&lt;=250</td>
<td>&lt;=100</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Number of users per usable handpump/well</td>
<td>Person/handpump or Person/well</td>
<td>=&lt; 500</td>
<td>=&lt;250</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Households collecting drinking-water from protected/treated sources</td>
<td>%</td>
<td>&gt;=70</td>
<td>&gt;=90</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Distance from dwellings to taps/water collection locations.</td>
<td>meters</td>
<td>=&lt;500</td>
<td>=&lt;200</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>% Households with at least 10 litres/person potable water storage capacity</td>
<td>%</td>
<td>&gt;=70</td>
<td>&gt;=80</td>
<td>yes</td>
<td>yes</td>
</tr>
</tbody>
</table>

2. Main guidance

Emergency standard

UNHCR has selected 9 key indicators to monitor emergency WASH programmes. They focus on access to water and its quantity and quality, and need to be monitored during the first six months of an emergency.

Five indicators should be collected every week during emergencies:

- **Litres/person/day.** 15 litres per person per day.
- **Users per usable well / hand pump.** The litres per person per day indicator can be linked to this indicator, which declares that in emergencies no hand pump or well should be used by more than 500 persons.
- **Water quality (faecal coliforms).** This tests for the presence of faecal coliforms at non-chlorinated water collection locations. The standard requires that more than 95% of 100ml water samples should show nil faecal coliforms (0 coliforms/100ml of water >=95%).
- **Water quality (residual chlorine).** This tests chlorinated water collection locations for the presence of free residual chlorine (FRC), as well as the clarity (turbidity) of water expressed in terms of nephelometric turbidity units (NTU). Samples should have less than 5 NTUs (NTU < 5) per litre of water, and 95% of samples should have more than 0.2 mg and
less than 2 mg/l of free residual chlorine per litre of water (FRC 0.2-2 mg/l &<5NTUs; >=95%).

- **Persons per usable water tap.** In emergencies, no water tap should be used by more than 250 people.

Four indicators should be collected at least during the emergency phase, by using the rapid household survey method and mapping.

- Households (HHs) collecting drinking water from protected/treated water sources. More than 70% of households should be collecting their drinking water from protected/treated water sources.
- Average # l/p/d of potable water collected at household level. In emergency situations, households should be collecting on average at least 15 litres of water per person per day (l/p/d). When populations fluctuate significantly, it is essential to monitor the actual use of water, and to establish how many households are able to meet the accepted international standard for minimum daily water quantity in emergencies (≥ 15 litres).
- Households with at least 10 litres/person potable water storage capacity. More than 80% of households should have storage capacity for at least 10 litres of potable water storage per person.
- Distance from dwelling to water points. In emergency situations, the maximum distance from dwellings to taps or water collection locations should be 500m. (A water collection location is a set of taps/faucets.) This indicator measures access to water.

Apply national standards to out of camp situations (such as settlements and dispersed or scattered rural and urban locations), with regard to distances to water points or unmetered water sources, and number of persons per tap. Where no national standards are in place, work towards UNHCR indicators or towards the achievement of nationally defined targets under the sustainable development goal framework.

**Longer-term standard**

The same indicators are collected in post-emergency situations, but different standards are applied.

- **Litres/person/day.** In post-emergency refugee situations, the minimum allocation of water is 20 litres per person per day. This standard covers domestic and individual needs only. If agricultural activities are planned, additional amounts of water for livestock and plants must be considered.
- Supplementary and therapeutic feeding programmes, hospitals, clinics, and schools need water in addition to the daily supply, for basic hygiene and preparing food. (In health centers, the minimum is 10 litre/outpatient/day and 40-60 litres/inpatient/day. In feeding centres the minimum is 20-30 litres/inpatient/day and 15 litres per caregiver/day. In
school, the minimum is 3 litres/pupil/day. In mosques, the minimum is 2-5 litres/person/day).  
- **Users per usable well or hand pump.** No hand pump or well should be used by more than 250 persons.
- **Households (HHs) collecting drinking water from protected/treated water sources.** More than 95% of households should collect their drinking water from protected water sources (piped, protected springs, tapstands, handpumps with apron and sanitary seal).
- **Persons per usable water tap.** No water tap should be used by more than 100 persons.
- **Distance from dwelling to water points.** Dwellings should be no further than 200m from water points.
- **Households with at least 10 litres/person potable water storage capacity.** At least 85% of households should be using narrow-necked containers or covered containers with a tap.

Apply national standards to out of camp situations (settlements and dispersed or scattered rural and urban locations), with regard to distances to water points and unmetered water sources, and number of persons per tap. Where no national standards are in place, work towards UNHCR indicators or towards the achievement of nationally defined targets under the sustainable development goal framework.

**Annexes**

- [UNHCR indicators guidance](#)
- [Sphere Handbook (2018)](#)

**3. Links**


**4. Main contacts**

- [HQWASH@unhcr.org](#)
Key points

- Interpret indicators with care when population size fluctuates significantly.
- When calculating sanitation-related indicators, clarify whether population figures include or exclude the host community.
- Information on reported defecation in toilets or open defecation observations can be compared with this indicator. If the number of people per toilet is high, this may indicate that the problem may lie in insufficient toilets. If there are sufficient toilets, it can indicate that people are not using them.

1. Overview

Safe excreta disposal is an essential element of any WASH programme, because it helps to reduce direct and indirect disease transmission. To improve safe access to sanitation it is necessary to meet standards of privacy and safety using sanitation structures that are locally or culturally acceptable. The 2018 Sphere manual specifies: "Household toilets are considered the ideal in terms of user safety, security, convenience and dignity and the demonstrated links between ownership and maintenance [...] communal or shared toilets can be designed and built with the aim of ensuring household toilets in the future". Providing equal access to sanitation can be achieved through the distribution of sanitation infrastructure or cash-for-latrine programming and proper monitoring.

Programme monitoring should use the UNHCR WASH standards and indicators from the UNHCR WASH manual, and UNHCR's WASH Monitoring System (WMS).

Standard / indicators

The main excreta disposal standards, defined by Sphere, have been endorsed by UNHCR.

- Environment free from human excreta: All excreta is safely contained on-site to avoid contamination of the natural, living, learning, working and communal environments.
- Access to and use of toilets: People have adequate, appropriate and acceptable toilets to allow for rapid, safe and secure access at all times.
- Management and maintenance of excreta collection, transport, disposal and treatment:
Excreta management facilities, infrastructure and systems are safely managed and maintained to ensure service provision and minimum impact on the surrounding environment.

UNHCR sanitation-related indicators in emergencies and post-emergency situations:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Output Objective</th>
<th>Indicator</th>
<th>Unit</th>
<th>Standard</th>
<th>Camp</th>
<th>Out of Camp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population lives in satisfactory conditions of sanitation and hygiene.</td>
<td>Refugees have safe access to quality sanitation.</td>
<td>Number of persons per toilet/latrine</td>
<td># of Persons</td>
<td>&lt;=50</td>
<td>=&lt;20 (aiming for 1 latrine/household as soon as possible)</td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of persons per toilet/latrine</td>
<td>%</td>
<td>&gt;=60</td>
<td>&gt;=85</td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of persons per toilet/latrine</td>
<td>%</td>
<td>-</td>
<td>&gt;=85</td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of persons per toilet/latrine</td>
<td># of Persons</td>
<td>50 (30 girls per toilet, 60 boys per toilet – add urinals for boys)</td>
<td>50 (30 girls per toilet, 60 boys per toilet – add urinals for boys)</td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health centres</td>
<td># of Persons</td>
<td>20 outpatients per toilet/latrine</td>
<td>20 outpatients per toilet/latrine</td>
<td>yes</td>
</tr>
</tbody>
</table>
2. Main guidance

Emergency standard

- Persons per toilet or latrine. No latrine should be used by more than 50 persons during the first phase of an emergency. The count is made per drophole. Only latrines that are cleanable, guarantee privacy and are structurally safe should be counted. Latrines that are full or do not comply with UNHCR standards should not be counted.

The indicator can be reported in a Refugee WASH sector situation report (sitrep) every week, or in the frequency that sitreps are produced by the emergency operation. In addition, the indicator shall be reported once a month through the emergency form of the WASH monitoring system.

As soon as possible after the onset of an emergency

- Households who report defecating in a toilet. At least 60% of households should report that they defecate in a toilet. The principles, definitions and recommendations with respect to this indicator apply to both emergencies and post-emergency situations. In an emergency situation, this indicator can be obtained by conducting a rapid WASH assessment.

In out of camp situations (settlements and dispersed or scattered rural and urban locations), use UNHCR standards as a guidance for emergency response and work with local authorities towards achieving national standards and sanitation national targets derived from the Sustainable Development Goals. Advocate for the right to sanitation, which is a human right.

Longer-term standard

The following sanitation standards apply to post-emergency situations and should be monitored once a month through the monthly report card (access indicators) or once a year (household indicators) through an annual household survey also known as "WASH KAP (knowledge, attitude and practices) survey". WASH actors should aim to carry out an initial KAP baseline survey survey within the first 6 months of the emergency and at least once a year (ideally twice a year if there are distinct rainy and dry seasons). A set of tools is available to plan and conduct the survey, as well as tools for easy data analysis at:

More information about the monitoring requirements of these indicators can be found in the UNHCR WASH manual or on the UNHCR WASH website.

- Persons per toilet or latrine. No toilet should be used by more than 20 persons. The count is
made per drophole. Only latrines that are cleanable, guarantee privacy and are structurally safe should be counted. Latrines that are full or do not comply with UNHCR Standards should not be counted. The objective should be to achieve 1 latrine per household (maximum 6 people).

- Households who defecate in a toilet. At least 85% of households should report that they defecate in a toilet. The principles, definitions and recommendations with respect to this indicator apply to both emergencies and post-emergency situations. In a post-emergency situation, this indicator can be obtained through an annual household survey.
- Households with a household toilet/latrine. At least 85% of households should have access to household toilets/latrines. Schools and health facilities with compliant WASH structures. Schools should provide 1 toilet for every 30 girls and 1 toilet for every 60 boys. Health centres should provide 1 toilet for every 20 users in in-patient departments (IPDs) and 1 latrine each for staff, females, males, and children in out-patient departments (OPDs).

In out of camp situations (settlements and dispersed or scattered rural and urban locations), use UNHCR standards as a guidance for emergency response and work with local authorities towards achieving national standards and sanitation national targets derived from the Sustainable Development Goals. Advocate for the right to sanitation, which is a human right. The telephone-based health access utilization survey (HAUS) for out-of-camp settings also includes a WASH module that can be used to understand the WASH situation in out-of-camp settings.

Annexes

Sphere Handbook (2018)

3. Links


4. Main contacts

Contact DRS/PH Section. At: HQWASH@unhcr.org.
Waste management standards

27 January 2020

Key points

- Solid waste management is a joint responsibility of field coordination (camp coordination and camp management), as well as the WASH and health sectors.
- In urban and out-of-camp settings, national systems should be employed and, where necessary, strengthened.
- Ensure that refugee communities are involved in solid waste collection at household and community level.

1. Overview

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

Because most of the garbage that persons of concern generate is organic, it is frequently not considered a problem: the issue tends to be neglected, even though the volume and weight of household and market-place garbage can be significant, and includes non-organic materials such as packaging, cans and plastics.

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

If food is distributed to refugees in metal cans, their disposal should be given particular attention, not only for aesthetic reasons but because they pose a health hazard (injuries to children, potential breeding sites for mosquitoes, etc.). In addition, they are not biodegradable.

The medical waste generated by health centres is also a hazard (used syringes and needles, contaminated bandages, laboratory specimens, etc.). Access to medical sanitary services should be well controlled, and waste should be treated separately, without delay.

Routines should be established for the storage, collection and disposal of garbage. This is particularly important in high-density sites.

Solid waste management is a joint responsibility of field coordination (camp coordination and camp management), as well as the WASH and health sectors. In urban and out of camp settings,
national systems should be employed and, where necessary, strengthened.

2. Main guidance

Emergency standard

- Storage. One (100 litre) container should be provided per 10 families. Metal 200 litre drums cut in half are often used. If possible, containers should have lids and drainage holes in the bottom. Containers should be placed throughout the site at a maximum distance of 15 metres from each dwelling. It is not economical or practical to use concrete bins: they are difficult to empty, encourage rodents, and disperse garbage round the area.
- Collection and transportation. Garbage should be collected regularly from containers, at least twice a week. Camps near a city may benefit from local refuse services. It is expensive to use tractors with trailers and this should be a last option, employed only in large and densely populated camps. Wheelbarrows or carts, hauled by hand or animals, are usually more appropriate.
- Frequency of collection. UNHCR field staff and their partners must ensure that domestic, market, commercial, and medical waste collection points are emptied at least twice a week and more frequently if required. This is an essential requirement, to break fly-breeding cycles and ensure waste does not fester and become a nuisance.
- Market waste. UNHCR field staff and partners must ensure that waste from market places is collected and managed in a timely, efficient, and hygienic manner. Special arrangements may be required for slaughterhouse and fish waste.
- Hazardous substances. Lead-acid batteries, used paints and oils, and broken electrical equipment can pose serious risks to public health and the environment, even in small quantities. In all settings, UNHCR field staff and their partners must make arrangements to collect such waste separately. Prioritize interventions that prevent hazardous substances from entering the domestic waste stream over management of relatively inert domestic waste.
- Medical waste. UNHCR health partners must ensure that all medical waste is collected, handled, treated and disposed of with the least possible risk to health-care staff, waste management staff, and persons of concern. All infectious waste, non-infectious waste, sharps, and hazardous waste must be managed in strict compliance with national protocols and (in their absence) global WHO protocols. Transporting waste creates additional risks and it is highly recommended that medical waste is therefore managed and disposed of on-site, using simple methods.

Longer-term standard

The same standards apply to emergency and long term situations.

Annexes

UNHCR, indicators guidance
3. Links


4. Main contacts

Contact DRS/Wash Unit. At: HQWASH@unhcr.org.

Hygiene Standards

18 May 2020

Key points

- During outbreaks of waterborne diseases (cholera, HepE), it may be necessary to increase the number of hygiene promoters (HP), to ensure soap is distributed regularly and used, knowledge about handwashing is increased, and household-water treatment and safe storage is demonstrated and promoted.

- In protracted or post-emergency situations, a KAP survey is recommended at least once a year. (Ideally, conduct one KAP in the dry and another in the rainy season). In emergencies, undertake a baseline survey as soon as the population stabilizes (in location and number), to collect households indicators and adjust WASH interventions and strategy.

- The standardized expanded nutrition survey (SENS) which happens in many operations includes a short WASH module, and covers the core WASH household indicators. In order to use resources efficiently and avoid survey fatigue, liaise with a public health/nutrition officer on whether a SENS is already planned.

- Monitor disease trends and outbreaks (diarrhoea, HepE, cholera) in camps and health centres. The information gathered can guide efforts to prioritize WASH interventions. Within iRHIS, a tool used both by the WASH monitoring system as well as public health programming, WASH trends and water-related disease trends can be compared.
1. Overview

Hygiene promotion is a planned, systematic approach that enables people to act in a manner that ensures that water, sanitation and hygiene facilities and services have a positive impact on health. The approach also promotes participation, accountability and monitoring, because it emphasizes the importance of listening, and employs dialogue and discussion.

Habitat hygiene, food hygiene and personal hygiene are integral elements of sanitation; and are relevant to wider health education and community concerns. It is therefore worth constantly repeating that water and sanitation activities are most effective when visible, specific and participatory hygiene programmes complement them on the ground.

Standard / indicators

The main hygiene promotion standards, defined by Sphere, focus on knowledge and behaviour.

- Hygiene promotion: People are aware of key public health risks related to water, sanitation and hygiene, and can adapt individual, household and community measures to reduce them.
- Identification, access to and use of hygiene items: Appropriate items to support hygiene, health, dignity and well-being are available and used by the affected people.
- Menstrual hygiene management and incontinence: Women and girls of menstruating age, males and females with incontinence, have access to hygiene products and WASH facilities that support their dignity and well-being.

The table below summarizes UNHCR hygiene-related indicators in emergencies and post-emergency situations:

Environmental health and hygiene campaigns implemented.
| Population lives in satisfactory conditions of sanitation and hygiene. | Environmental health and hygiene campaigns implemented. | Number of persons per bath shelter/shower | # of POC | <=50 | <=20 aiming for 1 bath shelter or shower per household as soon as possible | yes | yes |
| Number of persons per hygiene promoter. | # of POC | <=500 | <=1000 | yes | no |
| % of Households with access to soap | % | >=70 | =>90 | yes | yes |
| % of recipients women of reproductive age who are satisfied with menstrual hygiene management materials and facilities | % | >=70 | =>90 | yes | Yes |
| Soap for personal hygiene and laundry | Grams/person/month | =>450 | =>450* | yes | yes |
| Soap for menstrual hygiene management (in addition to soap for personal hygiene and laundry) | Grams/females of reproductive age/month | =>200 | =>200 | yes | yes |

2. Main guidance
Emergency standard

During the initial phase of an emergency operation, at minimum the following hygiene-related standards or indicators should be reported:

- **Number of persons per bath shelter/shower:** No bath shelter/shower should be used by more than 50 persons during the first phase of an emergency. Only bath shelters/showers that are cleanable, guarantee privacy and are structurally safe should be counted.
- **Number of persons per hygiene promoter:** At least one hygiene promoter should be available for every 500 refugees. This indicator measures the potential reach of hygiene education and messaging, with respect to use, monitoring and maintenance of WASH facilities, and good hygiene practices.
- **% of Households with access to soap:** In an emergency situation 70% of the households should have access to soap. In an emergency situation, this indicator can be obtained by conducting a rapid WASH assessment.
- **% of recipients women of reproductive age who are satisfied with menstrual hygiene management materials and facilities:** In an emergency situation, 70% or more of women of reproductive age should be satisfied with menstrual hygiene management materials and facilities. In an emergency situation, this indicator can be obtained by conducting a rapid WASH assessment.
- **Soap:** To maintain health, dignity and well-being, at least 450 grams of soap should be available per person per month (Sphere indicator). 250g is for personal hygiene; 200g is for laundry and other washing purposes. For women and girls of reproductive age, an additional 250g of soap must be available per month for menstrual hygiene management.

The indicator can be reported in a Refugee WASH sector situation report (sitrep) every week, or in the frequency that sitreps are produced by the emergency operation. In addition, the indicator "Number of persons per bath shelter/shower:" shall be reported once a month through the emergency form of the WASH monitoring system.

Longer-term standard

The following hygiene standards apply to post-emergency situations and should be monitored once a month through the monthly report card (access indicators) or once a year (household indicators) through an annual household survey also known as "WASH KAP (knowledge, attitude and practices) survey". WASH actors should aim to carry out an initial KAP baseline survey survey within the first 6 months of the emergency and at least once a year (ideally twice a year if there are distinct rainy and dry seasons). A set of tools is available to plan and conduct the survey, as well as tools for easy data analysis at: [http://wash.unhcr.org/wash-monitoring-system/wash-kap-survey-modules/](http://wash.unhcr.org/wash-monitoring-system/wash-kap-survey-modules/)

- **Number of persons per bath shelter/shower:** No bath shelter/shower should be used by
more than 20 persons during a protracted situation. Ideally, there should be one bath
shelter/shower per household to achieve the best possible outcome in terms of user safety,
security, convenience and dignity. Only bath shelters/showers that are cleanable,
guarantee privacy and are structurally safe should be counted.

- Number of refugees per hygiene promoter. At least one hygiene promoter should be
  available for every 1000 refugees. This indicator measures the potential reach of hygiene
  education and messaging, with respect to use, monitoring and maintenance of WASH
  facilities, and good hygiene practices.
- % of Households with access to soap: In a post-emergency situation 70% of the households
  should have access to soap. In a post-emergency situation, this indicator can be obtained
  by conducting an annual household survey, also known as WASH KAP (knowledge, attitude
  and practices) survey.
- % of recipients women of reproductive age who are satisfied with menstrual hygiene
  management materials and facilities: In an emergency situation, 70% or more of women of
  reproductive age should be satisfied with menstrual hygiene management materials and
  facilities. In an emergency situation, this indicator can be obtained by conducting a rapid
  WASH assessment.
- Soap. To maintain health, dignity and well-being, at least 450 grams of soap should be
  available per person per month (Sphere indicator). 250g is for personal hygiene; 200g is for
  laundry and other washing purposes. For women and girls of reproductive age, an
  additional 250g of soap must be available per month for menstrual hygiene management.

More information about the monitoring requirements of these indicators can be found in the
UNHCR WASH manual or on the UNHCR WASH website.

Out-of-camp
The telephone-based health access utilization survey (HAUS) also includes a WASH module that
can be used to understand the WASH situation in out-of-camp settings.

Annexes
Sphere Handbook (2018)

3. Links
UNHCR WASH Manual UNHCR WASH monitoring system - Monthly Report Card UNHCR Hygiene
Promotion Guidelines UNHCR WASH, Protection and Accountability UNHCR WASH website WHO &
UNHCR WASH indicators UNHCR WASH monitoring system - Annual household survey Rapid
Methods for Assessing Water, Sanitation and Hygiene (WASH) Services in Em...
4. Main contacts

DRS/PH Section. At: HOWASH@unhcr.org.

Alternatives to camps - response in urban and rural settings

18 May 2015

Key points

- When the refugee emergency risk is medium or high, always undertake contingency planning and advanced preparedness actions.
- Prioritise registration, assessment, profiling and information management from the start, to ensure effective delivery of core protection functions.
- Identify local partners, including local municipalities and community-based organisations, and build an outreach and referral network as soon as possible.
- Do not set up camps or parallel delivery systems. Wherever possible, mainstream refugees into national systems and structures.
- Seek efficient and adapted delivery mechanisms. Prefer cash-based approaches; draw on new technologies and innovative approaches. Focus on what refugees want.
- Activate coordination mechanisms at once. Do so in a transparent and well-documented manner.
- Invest in market-based livelihood strategies early on in the emergency.
- Consider that spatial planning and design can serve as a critical enabler and platform for aligning coordination and prioritization efforts in preparing for a refugee / IDP influx and addressing their needs in short, medium and long term.

1. Overview

Millions of refugees have settled peacefully in rural and urban areas, living on land or in housing that they rent, own or occupy informally, or benefiting from hosting arrangements in communities or families. For refugees, such settlements present obvious advantages over
camps: they can be anonymous, can earn money, and construct a future. They also present dangers: refugees often live in the poorest areas, may lack legal documents, are vulnerable to exploitation, arrest and detention, and can find it difficult to find safe livelihood opportunities.

During a refugee influx, national and local authorities have a primary role in ensuring that refugees are protected and assisted and can find durable solutions. UNHCR should encourage all states to exercise this responsibility and provide the necessary support. In an emergency situation, however, states are often in greater need of operational support by the humanitarian community to fulfil this responsibility. In such context, UNHCR must pursue proactive and innovative approaches that strengthen the protection of all age, gender and diversity categories within a refugee population to settle safely outside of camps, whenever possible, and that support access to adequate shelter, basic services (health, water, sanitation and education) and safe and decent jobs. This can only be achieved in an enabling protection environment through a high degree and new forms of collaboration with governments, civil society, development actors as per UNHCR global compact and partners aimed at building on the capacity and independence of refugees themselves.

In this entry, 'urban and rural' refers to all populations living outside planned / managed camps, including those who live in cities and rural areas.

2. Main guidance

Context characteristics and risks associated

- Host governments may lack an enabling national legal and policy framework (permitting freedom of movement and the right to work, for example).
- Host governments are concerned about national security, and the economic and social impacts of a refugee presence, as well as the costs and impact of eventual solutions. For these reasons, they often tend to restrict refugees to camps.
- Refugees may place a strain on local services (education, healthcare and infrastructure, including housing), which are often already under strain. They may arrive in rural areas which lack infrastructure, land and basic services.
- In urban areas displaced persons are often subjected to low incomes (if any), low levels of access to housing, water, sanitation, education & health services and malnutrition.
- Creative approaches (to registration and protection, monitoring, support, and services) are required in order to know where and who refugees are, bring hidden problems to light, and resolve them.
- Refugees often find it difficult to access basic services, such as health care and education. Giving them documents that attest their identity and status can enable them to move freely, obtain access to basic services, protect themselves from exploitation and abuse, and gain access to justice.
- Refugees in urban areas may be subject to xenophobic attacks and treated with mistrust by host communities. UNHCR and partners need to adopt a comprehensive approach that includes working with host communities.
- When refugees decide to settle outside camps, they may face new threats, including the
risk of detention. These may cause them to avoid contact with UNHCR (the hidden displaced). Protection risks are particularly acute when refugees are officially excluded from urban areas and the labour market.

- It is often assumed that refugees in urban areas enjoy easy access to UNHCR. This is not necessarily the case. Refugees are often concentrated in slum areas, shanty towns or suburbs, which are usually a long and expensive journey away from the nearest UNHCR office.
- In large-scale emergencies, the number of different actors potentially involved in programming may make it difficult to coordinate a refugee response effectively and transparently.
- Coordinating a refugee response outside camps is particularly complex. Refugee needs and the humanitarian response need to adopt a comprehensive and integrated approach, taking into consideration the needs and absorption capacity of host communities and families.
- Coordinating the refugee response outside of camps is more complex and requires situating UNHCR's work within the broader framework of national development, international development cooperation, and the humanitarian response to different populations living in the same area, rather than addressing humanitarian and development concerns in an entirely separate and "stove-piped" manner.
- Efforts to provide, protect, and promote livelihoods for refugees must create and build links with the local economy, and avoid undermining local livelihoods and growth.
- Finally, refugee needs and the associated humanitarian response can seem less visible in a non-camp situation, which can impact on international interest and donor support.

**Context-specific protection objectives**

- Refugees live in an enabling protection environment where the legal, policy and administrative framework of the host country grants them freedom of movement and residence, permission to work and access to basic services and social safety nets.
- Refugees are not exposed to refoulement, eviction, arbitrary detention, deportation, harassment or extortion by the security services or other actors.
- Refugees enjoy harmonious relationships with the host population, other refugees and migrant communities.
- Refugees reside outside camps and are in a position to take more responsibility for their lives and for their families and communities.
- Refugees have access to employment and education and, with greater mobility, enjoy more opportunities to build their livelihood assets and skills and send home remittances.
- Refugees retain their independence, retain and increase their skills, and develop sustainable livelihoods, thereby strengthening their resilience and their ability to overcome future challenges, whatever solution is available to them.
- Refugees are able to benefit from voluntary repatriation, local integration, and resettlement programmes.
- Refugees of all ages, genders and diversity categories are consulted and have the opportunity to describe their situation, their problems and needs, and suggest possible solutions.
- Refugees enjoy police protection and can obtain justice.
Housing, Land and Property (HLP) rights for displaced persons is a vital issue for consideration. If not they can be triggers for discontent between displaced and host communities and are vitally important when considering matters of self-determination and peaceful co-existence.

**Principles and policy considerations for the emergency response strategy in this context**

The emergency response strategy should be anchored in the objectives of policies set out in:


Cities are legitimate places for refugees to reside and exercise their rights; protection space for urban refugees and humanitarian organisations that support them should be maximized.

- UNHCR, Policy on Alternatives to Camps, 2014.

Commits UNHCR staff to pursue alternatives to camps, whenever possible, while ensuring that refugees are protected and assisted effectively. Wherever possible, field managers should respond to refugee needs without establishing camps and, where camps must be established, they should be phased out as soon as possible or become sustainable settlements. This policy extends the principal objectives of urban refugee policy to all operational contexts. Consider referencing the following: DESS to decide what’s relevant for this revised entry and include as appropriate:


The entire Handbook was reviewed from an "urban response" lens. The premise remains that the Sphere standards are applicable in all contexts, including urban settings. Where appropriate, specific guidance was added in the technical chapters.

- Global compact on Refugees (December 2018) / New York declaration.

Consider incorporating implications as per GCR to act as a basis for predictable and equitable burden and responsibility sharing

- Sustainable development Goals

Particular interest SDG # 11 ‘to make cities inclusive, safe, resilient & sustainable’.

When responding to refugee needs in emergencies, the following key principles should be
Refugee rights. Refugees are entitled to protection and solutions wherever they live and must be able to exercise the human rights to which they are entitled under international law.

State responsibility. UNHCR should encourage states to fulfil their responsibility to protect refugees.

Partnerships. In particular a non-camp response requires UNHCR to establish effective working relationships with a wide range of different stakeholders.

Age, gender and diversity. All aspects of the response must be based on Age, Gender and Diversity (AGD) approach.

Equity. UNHCR should ensure that all refugees are protected and treated in a consistent manner by UNHCR.

Community orientation. UNHCR must apply a community-based approach, strengthen the capacity of refugees and their communities, and foster harmonious relationships among them.

Interaction with refugees. UNHCR must meet refugees regularly, regardless of distance and any problems locating them.

Self-reliance. UNHCR will make every effort to ensure that refugees have access to livelihood opportunities, which are a condition of finding durable solutions.

Priority operational delivery mode and responses in this context

- When the risk of a refugee / IDP emergency is medium or high, always prepare contingency plans in close association with Government, development actors and partners. Focus on national legal and policy frameworks; and assess the extent to which communities, the national economy and infrastructures, administrative structures, service delivery systems, and housing, land and other resources, can manage or absorb a refugee influx. Identify key interventions needed to increase preparedness.
- Develop projects and deploy teams to assess the situation of the refugee population. Adopt approaches that are appropriate for complex urban and rural environments (home visits, vulnerability and socio-economic assessments).
- Operationalize protection from the beginning. Identify local partners at an early stage and build an outreach and referral network that will make case management effective.
- Mainstream refugees in national, local and community-based systems and structures (health care, education), and adopt efficient and appropriate delivery mechanisms (such as
cash-based interventions).

- Prioritise registration, assessment, profiling, and information management to ensure that core protection functions are delivered effectively. Use biometric and registration approaches adapted to urban contexts, such as mobile registration teams.
- Use a wide range of media to communicate, collect data and ensure accountability (mobile technology, crowdsourcing, mapping). Do not collect unnecessary data. Triangulate information with local and national sources.
- Activate coordination mechanisms. Do so transparently; keep records. Consider deploying specialized staff to coordinate large-scale emergencies.
- Explore partnerships with a wide range of non-traditional partners, such as the private sector, municipalities, local community associations, and religious groups.
- Develop advocacy strategies to explain why everyone will benefit if refugees are self-reliant and have freedom of movement. Focus on outcomes and adopt an evidence-based approach.
- Build on the strengths and capacities of refugees, displaced people and host communities. Develop market-based livelihood strategies that will enable refugees to take advantage of employment and self-employment opportunities.
- Encourage local and regional mobility, wherever possible.
- Work with national authorities at all levels to make sure that legitimate security and protection concerns are addressed.
- Combine the skills and resources of UNHCR and partner activities to make the best use of resources available in cities and rural areas. All activities should be in line with government plans and build long-term resilience.
- If resources are tight, target spending. Prioritize support to refugees who are most at risk.
- Consider that spatial planning and design can serve as a critical enabler and platform for aligning coordination and prioritization efforts in preparing for a refugee / IDP influx and addressing their needs in short, medium and long term.

**Priority actors and partners in this context**

- Work in synergy with national development planning and international development cooperation. Pursue integrated approaches that integrate the refugee response in national and local development efforts. To ensure that expenditure has long term value, activities should strengthen urban resilience.
- Develop strong, broad-based partnership models. Expand collaboration with national line ministries, municipal and local government authorities, national and international NGOs, community-based organizations and other civil society actors, the private sector, development-oriented UN agencies (including UNDP, WFP, UNICEF, UN-Habitat, WHO, ILO, FAO, IFAD), the World Bank, and bilateral and traditional donors, globally and nationally.
- Partnerships should be consistent with UNHCR's [Refugee Coordination Model](#) and should complement, reinforce and create synergies with UNHCR's protection and assistance programmes.
- Consider also the IASC Global coordination mechanisms of particular interest when UNHCR has lead role in activated clusters e.g. Shelter, Protection, CCCM.

**Annexes**
3. Learning and field practices

4. Links


5. Main contacts

The Division of International Protection and the Division of Programme Support and Management are working to improve the toolbox on out of camp responses and reinforce expertise in this area.
For technical advice, support missions or tools and guidance, contact: HQATC@unhcr.org.

WASH needs assessment in refugee emergencies

12 December 2023

Key points

- Conduct an initial rapid WASH assessment within the first 3 days from the onset of the emergency
- The initial rapid WASH assessment should be coordinated and supervised by an experienced WASH professional and jointly undertaken with WASH actors and local stakeholders already present in the area
1. Overview

The main principle of an emergency WASH response is to ensure consideration of water supply, sanitation and hygiene at the site selection and planning stages while coordinating the response closely with physical planning, public health and environment.

Ideally following the multi-cluster/sector initial rapid needs assessment (MIRA) or needs assessment for refugee emergencies (NARE), a more detailed initial WASH rapid assessment of local WASH-related resources in relation to the needs/demand is essential. This includes assessment of water resources (quantity and quality) for water sources and distribution options, and assessment of soil conditions - in terms of infiltration rate and type of soil for sanitation options.

Assessments should be carried out by sectoral technical experts with appropriate qualifications and relevant experience. Involvement of local stakeholders to gather secondary data on water sources and sanitation is crucial.

2. Relevance for emergency operations

WASH services are fundamental/basic rights that contribute to the achievement of other personal and development goals. Access to adequate WASH services during emergencies is important to reduce disease transmission and public health outbreaks. Conducting an initial rapid WASH needs assessment paints a picture of the situation - needs, risks and resources needed. It is also important for immediate planning and as a baseline for monitoring of progress and further assessment.

3. Main guidance

An initial rapid WASH assessment should be carried out within the first three days of any refugee emergency / start of an emergency, to identify needs and resources. It should estimate the number of people affected, quantify immediate needs, the availability of local resources, and the need for external resources.

Depending on the scale of the emergency and the time and resources available, this exercise should be completed in a maximum of one day. Following the rapid WASH needs assessment, needs should be prioritized into those that are lifesaving and must be met on an emergency basis and those that need a medium or longer term approach.
The assessment should be coordinated and supervised by an experienced WASH officer. Assessing the water resources and soil conditions requires expertise in, water engineering, sanitation, hygiene, and in some cases environment 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. A joint assessment with site planning is recommended in order to integrate WASH/site planning intervention approach and agree on technical findings (i.e. flooded prone areas, drainage, and sanitation).

Objectives of an initial rapid WASH assessment

- To identify available water sources (yield estimation, flow, seasonal variations, recharge, taboos, water quality and potential pollution risks) and soil conditions in the affected area (primary data collection)
- To assess ground conditions and environmental factors (e.g. presence of rocky ground, high ground water table, etc) which may affect decisions on appropriate sanitation options.
- To assess key hygiene practices in terms of water needs and sanitation habits (secondary data, key informants)
- To identify cultural habits among the refugee population that might affect their hygiene / sanitation preferences, for example, sitting or squatting and - whether they would practice anal cleansing with water or with dry material (secondary data, key informants)
- To identify specific vulnerabilities, for example disabilities and people with specific diseases to tailor WASH services accordingly (secondary data, key informants).
- To assess national and local capacity to lead or support the response (key informants, observation).

Methodology
Information should be collected by carrying out the following activities:

- Key informant interview(s)
- Focus group discussion(s)
- Observation walk(s)
- Assessment of existing WASH infrastructure conditions
- Assessment of existing WASH management arrangements

During the assessment information should be collected from as many different gender, diversity-and age balanced sources as possible, and the information should be triangulated. Relevant secondary data is often available and can be complemented by interviewing key informants. Key sources of secondary data include:

- Water/Energy/Environmental Ministries & Local Authorities
- Global satellite images providers (UNITAR/UNOSAT)
- UNHCR’s databases and reports
- Other UN agencies, notably UN-Habitat and UNICEF
- NGOs that work in the area
- Key informants working in the above areas
- Knowledgeable refugees & host villagers
The UNHCR borehole database

A typical checklist of secondary data to be retrieved when carrying out initial rapid WASH assessments would include:

- Procurement and studying of local maps, aerial photos, satellite imagery etc. to determine topography, geological context, hydrogeological features 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 (including availability of local building material)
- Legal issues in the area as well as ownership rights etc.
- Costs and operations and maintenance requirements and opportunities in the area

Additional examples and considerations can also be found in the chapter "Assessment" of the UNHCR WASH manual.

Assessment of existing WASH infrastructure conditions
Calculate the water requirement based on the designed planned population size of the site and organize an immediate assessment of water supply possibilities; the calculation should be based on a total of 20 litres per person per day (excluding leakage) and must also include the communal building needs.

Assessment of the condition and service ability of existing toilet infrastructure is an essential part of any needs assessment especially in contexts where there is insufficient or aging infrastructure (for example in urban areas). In some contexts, the assessment of existing sanitary infrastructure will be minimal, especially if toilet infrastructure has not yet been constructed (e.g. new refugee camps).
When assessing existing waste management infrastructure, it is essential to describe how each separate waste stream is treated, starting at the point of waste creation and moving through each stage in the process (including collection, storage, handling, and processing) until final disposal or reuse. At each step, the key characteristics and condition of the infrastructure and resources (including any transportation and labour) should be noted, along with risks to public health, and corrective actions to bring the system back into serviceability. Some large-scale waste infrastructure can be complex to assess and may require specialized expertise

Presentation of results
The findings of the initial rapid WASH assessment should be reported using the approach in Rapid Methods for Assessing WASH services in Emergency Settings - and should be systematically filed to ensure that such data will be available for future reference.

Post emergency phase
The findings of an initial rapid WASH assessment should guide the level and type of WASH intervention that are offered in transit centres and where refugees finally settle.

An initial rapid WASH assessment is a preliminary estimate. It should be succeeded by a more comprehensive rapid household survey as soon as the situation allows, and no later than 3-6 months after an emergency starts. A KAP (Knowledge, Attitude and Practice) survey is afterwards needed (at least once a year) to assess and adjust the WASH intervention strategy and should be based on the Global WASH KAP tools (accessible to UNHCR staff only) (global, but adaptable questionnaire; WASH KAP analyser; WASH KAP mapper; WASH KAP report template). WASH related key informant questions & suggestions for Focus Group Discussions can be found in the UNHCR WASH Assessment Primer Questions (2015) on the UNHCR WASH website.

**WASH Needs Assessment in refugee emergencies checklist**

- Experienced UNHCR and Partner organization WASH Officers

- Community outreach workers from immediate users and host community

- Key technical stakeholders such as line ministries (water, health, regional development, local authorities, International and national NGOs, as well as UN agencies such as UNICEF, IOM, WHO UNFPA etc.

- Relevant materials and equipment including but not limited to GPS, Camera, distometer, bucket of known capacity, rapid assessment WASH questionnaire.

**Annexes**


UNHCR WASH Assessment for primer questions for key informant interviews and focus groups, 2015

**4. Links**


UNHCR, Urban WASH Planning Guidance and Case Studies UNHCR, Hygiene Promotion Guidelines
5. Main contacts

Contact Division of Resilience and Solutions (DRS)/Technical Support Section (TSS) at: HQWASH@unhcr.org

WASH in transit centres

29 January 2020

Key points

- Ensure all WASH actors in transit centres are well coordinated and collaborate with one another.
- Ensure that every refugee in transit centres has safe access to water, sanitation and hygiene.
- Monitor key WASH indicators regularly, and the WASH situation.

1. Overview

WASH interventions in transit centres aim to meet the basic needs of newly arrived refugees for safe access to sufficient water of good quality, safe access to emergency sanitation, and hygiene promotion.

This entry discusses the WASH response in transit centres. The WASH sector works closely with health and nutrition to prevent diseases outbreaks and reduce public health risks associated with poor water, sanitation and hygiene services and practices, as well as providing a favourable environment for protection of nutrition status and food security.

2. Main guidance
Protection objectives

- To ensure that refugees in transit centres have safe access to sufficient water of good quality.
- To ensure that refugees in transit centres have safe access to emergency sanitation and are aware of basic principles of hygiene.
- To respect the right to safe water and sanitation.

Underlying principles and standards

UNHCR's Public Health Strategic Objectives 2014-2018:
1. Refugees have safe access to water of sufficient quality and quantity.
2. Refugees have access to quality sanitation.
3. Refugees have improved hygiene.
4. Improved WASH in institutions.

Note that UNHCR has developed a comprehensive Public Health strategy that applies to emergency and non-emergency operations in camp and out-of-camp settings. To tailor its interventions more efficiently to emergency situations, UNHCR recommends the use of SPHERE standards during emergency operations:

Hygiene Promotion

- SPHERE, Hygiene promotion standard 1.1: Hygiene Promotion.

People are aware of key public health risks related to water, sanitation and hygiene, and can adopt individual, household and community measures to reduce them.

- SPHERE, Hygiene promotion standard 1.2: Identification, access and use of hygiene items.

Appropriate items to support hygiene, health, dignity and well-being are available and used by the affected people.

- SPHERE, Hygiene promotion standard 1.3: Menstrual hygiene management and incontinence.

Women and girls of menstruating age, and males and females with incontinence, have access to hygiene products and WASH facilities that support their dignity and well-being.

Water Supply

- SPHERE, Water supply standard 2.1: Access and water quantity.

People have equitable and affordable access to a sufficient quantity of safe water to meet their drinking and domestic needs.
SPHERE, Water supply standard 2.2: Water quality.

Water is palatable and of sufficient quality for drinking and cooking, and for personal and domestic hygiene, without causing a risk to health.

Excreta Management

- SPHERE, Excreta management standard 3.1: Environment free from human excreta.

All excreta is safely contained on-site to avoid contamination of the natural, living, learning, working and communal environments.

- SPHERE, Excreta management standard 3.2: Access to and use of toilets

People have adequate, appropriate and acceptable toilets to allow rapid, safe and secure access at all times.


Excreta management facilities, infrastructure and systems are safely managed and maintained to ensure service provision and minimum impact on the surrounding environment.

Vector Control

- SPHERE, Vector control standard 4.1: Vector control at settlement level.

People live in an environment where vector breeding and feeding sites are targeted to reduce the risks of vector-related problems.

- SPHERE, Vector control standard 4.2: Household and personal actions to control vectors.

All affected people have the knowledge and means to protect themselves and their families from vectors that can cause a significant risk to health or well-being.

Solid Waste Management

- SPHERE, Solid waste management standard 5.1: Environment free from solid waste.

Solid waste is safely contained to avoid pollution of the natural, living, learning, working and communal environments.

- SPHERE, Solid waste management standard 5.2: Household and personal actions to safely manage solid waste. People can safely collect and potentially treat solid waste in their households.

- SPHERE, Solid waste management standard 5.3: Solid waste management systems at community level.
Designated public collection points do not overflow with waste, and final treatment or disposal of waste is safe and secure.

WASH in disease outbreaks and healthcare settings

- SPHERE, WASH standard 6: WASH in healthcare settings. All healthcare settings maintain minimum WASH infection prevention and control standards, including in disease outbreaks.

**Protection Risks**

In emergency operations, WASH interventions have positive effects in numerous areas. They address important protection risks.

- Young girls/children and women who walk long distances to water points are at risk of sexual violence.
- When refugees do not have safe access to sufficient water of good quality, and sanitation, they are exposed to public health and nutrition risks (such as water related diseases and risks of malnutrition).
- Refugees who do not have safe access to sufficient water of good quality, hygiene items and sanitation, may adopt risky coping mechanisms. (They may purchase water from unreliable vendors; women and girls are at risk of sexual abuse if they defecate in the open, etc.).

**Other risks**

If transit centres do not provide adequate WASH facilities:

- Security risks increase (riots, demonstrations, violent behaviour).
- Harmful short and long-term effects on health are likely, including severe diarrhoea, dehydration, malnutrition, and even death.

**Key decision points**

WASH interventions must always be:

- Evidence-based. Activities should be planned and implemented, based on the findings of the initial assessment.
- Needs-based. Interventions should be scaled and resources should be allocated to meet the needs of the population.
- Technically sound. Services should be based on current scientific evidence and operational guidance, and implemented by skilled staff.
- Impact oriented. UNHCR promotes the comprehensive WASH approach, which ensures that essential safe water, sanitation and hygiene needs of the entire population.
Priority-based. Emergency WASH interventions and services should be prioritised to achieve maximum impact across the population. Interventions to address immediate health and WASH risks, such as disease outbreaks and malnutrition, must be priorities.

Integrated. Avoid setting up costly parallel services. Assist the national waters authorities to extend its services to refugees.

Decision points with respect to transit centres:

- Emergency WASH services, including hygiene promotion activities, must always be available to refugees arriving in transit centres.
- Because transit centres are transitory, investment in WASH infrastructure should be limited to emergency installations (emergency latrines, even trench latrines; centralized water bladders with temporary pipeline connections, etc.).

Key steps

1. Refugees arriving in transit centres must have adequate minimum access to WASH services.

Water

2. Water Supply. In the early phases of an emergency, it may be necessary to restrict the supply of water per person, to ensure equitable access and meet the urgent survival needs of the entire affected population. UNHCR aims to meet the Sphere minimum standard for water supply of 15 litres per person per day.

3. Water safety. The most acute human health risks associated with water consumption are due to contamination by human or animal faecal matter. Water safety is assessed using a risk assessment approach, such as water safety planning and may include sanitary inspections. It is measured by testing for residual chlorine and microbiological indicators of faecal contamination. To be considered as safe, water must be: free from faecal contamination; acceptable to users in terms of its taste; colourless and odourless; free of visible suspended solids. When safe water is not acceptable to users, it may be rejected in favour of more acceptable but less safe sources of water. To be considered safe, a water source must reliably supply sufficient quantities of water to satisfy users' needs, be physically protected from contamination, and equipped with lifting technology to prevent contamination during water collection. All water supplied to the transit facility should be chlorinated and regularly tested to ensure adequate free residual chlorine.

4. Safe water. Though transit centres are temporary, emergency WASH facilities should be soundly constructed and interventions should include sanitary inspections, disinfection with chlorine, clean water storage containers, and hygiene promotion regarding the safe water chain.

5. Adequate supply. Ensure that sufficient safe water is available in health posts, nutritional centres, cooking areas, and registration areas.

6. Water quality. Ensure that all water supplies in transit centres, regardless of their intended use, are fit for human consumption. All water supplies must be free of faecal coliforms at the point of storage, delivery and consumption. All settings receiving displaced populations must possess on-site water quality testing equipment, such as: turbidity tubes or electronic turbidity meter to measure turbidity; simple or electronic pool-testers to measure free residual chlorine;
and kits for microbial tests (e.g. compartment bag tests, portable microbiology kits or more elaborate field-testing kits for water quality which are available from different suppliers.) The emergency operation must also ensure sufficient availability of test consumables to ensure test can be conducted as frequent as necessary in line with a risk-based approach.

7. Water storage. Ensure that persons of concern have access to at least 10 litres of water storage capacity per person, on their arrival at the transit centre and throughout the displacement emergency. Safe water containers should have narrow openings and lids to prevent secondary contamination.

Sanitation
8. Protection of water sources. Excreta containment systems (including pits, tanks, seepage, sewerage or spillage) must not contaminate surface water or shallow groundwater sources. Toilets must be located at least 30 metres from any groundwater source. Additional measures must be taken where the water table is high or floods occur. The bottom of any pit or soak-away must be at least 1.5 meters above the groundwater table.

9. Toilets and bathing/showers. Toilets and baths/showers should be evenly dispersed throughout the transit centre; no toilet/bathing/shower facility should be further than 50 metres from a dwelling. In transit centres, communal toilets are the most common facility.

10. Disaggregated distribution. Plan to install three female toilets for every male toilet, which should be complemented with urinals. Toilet blocks must be segregated by sex and marked with culturally appropriate signage.

11. Gender balanced representation. All programmes must have active gender-balanced and representative sanitation or hygiene committees.

12. Protection considerations. Ensure that the location and design of all toilet facilities eliminate threats to the security of users, especially women and girls, day and night.

13. Universal access. Ensure that all toilets can be used safely by all members of the population, including children, older persons and pregnant women. Dedicated toilet facilities for people with disabilities should be foreseen and constructed considering the results from community consultations and relevant guidelines.

14. Hand-washing. Ensure that all communal toilets have hand-washing facilities, with soap, and that arrangements are in place to ensure they remain functional.

15. Toilet cleaning and maintenance. Because transit centres are temporary, WASH agencies should take responsibility for cleaning and maintaining communal toilets, at least three times per day.

16. Bathing and laundry facilities. Ensure that the refugee population has access to bathing facilities and can launder clothes and bedding. These facilities should provide privacy and dignity. They should be disaggregated by sex. The ratio for bathing/showering facilities should be the same as for toilets.

17. Drainage. Ensure wastewater (from tap stands, bathing and laundering) is disposed of in properly designed drainage systems. In arid zones, runoff may be reused in sub-surface irrigation systems (e.g. for gardening purposes).

18. Monitoring. Ensure that sanitation services and systems are monitored regularly (for coverage, access, cleanliness, security, use and condition, etc.). Progress reports must be communicated transparently at regular intervals to beneficiaries, local authorities and donors. A functional complaints and follow-up system must be established.

19. Accountability. Ensure that feedback on the WASH facilities from refugees is invited and
considered, even if the duration of stay in the transit centre is short. Such feedback can also be sought through the WASH refugee feedback app.

20. **Exit strategies.** Ensure that a clear exit strategy exists from the start. Planning should consider the operation, maintenance, transition and eventual decommissioning of water and toilet infrastructures.

**Hygiene promotion**

21. **Immediate dissemination of key hygiene messages.** UNHCR field staff and their partners must ensure that refugees receive clear hygiene messages on their arrival in transit centres. Messages must be in their own language, and must focus on key risk practices that generate the most critical hygiene risks. Do not attempt to communicate too many hygiene messages. Concentrate on the practices that are most responsible for disease transmission and interventions to prevent them.

22. **Monitoring.** Continue to monitor hygiene practices in transit centres, to detect unhealthy or risky hygiene behaviour and misuse of WASH infrastructures. Community outreach workers should monitor communal WASH infrastructures as one of their routine activities in the refugee community.

23. **Solid Waste Management.** Ensure solid waste is managed through regular collection and safe disposal at managed disposal sites.

24. **Eliminating high-risk disease vectors.** Ensure that high-risk disease vectors are adequately controlled, using safe vector control techniques (especially flies which tend to breed rapidly in pit latrines, mosquitos and vermin). Clean up dumps of organic solid waste, faeces, or other potential breeding sites for disease vectors. The elimination of high-risk disease vectors should be given the same priority as water supply, excreta management, and hygiene promotion. Work closely with site planners to identify dumping sites for solid waste disposal and to drain any stagnant waters within the transit center.

**Key management considerations**

Given the multitude of actors in transit centres, it is vital to ensure that WASH programmes are strongly coordinated, so that all needs are covered and follow-up assured.

UNHCR must ensure that adequate WASH services are available in transit centres. To this end, collaborate closely with national water authorities (and, where relevant, owners of the transit site).

Given that UNHCR has an overall accountability for the refugee response, UNHCR should deploy WASH staff as soon as possible to support the assessment, relevant WASH strategy and support the operational response.

UNHCR should ensure that the WASH situation in transit centres is monitored and that relevant stakeholders receive regular reports, and can therefore respond rapidly if the situation changes. The Emergency form of the WASH monthly report card should be used. The HQ team is available to provide remote and direct support. Contact HQWASH@unhcr.org.
Resources and partnerships

Staff

- Experienced WASH officers from UNHCR.

Partners

- Close collaboration with the national water authorities is crucial
- Relevant NGOs (international and national,) and UN agencies such as UNICEF
- Establish predictable partnership agreements at field level at an early date, so that interventions can be implemented rapidly.

Annexes

Sphere Handbook (2018)


3. Links

http://wash.unhcr.org/wash-guidelines-and-forms-for-refugee-settings/
http://wash.unhcr.org/download/unhcr-wash-equipment-specifications/
http://www.unhcr.org/refworld/docid/3dede3434.html
https://wedc-knowledge.lboro.ac.uk/my-resources/graphics.html UNHCR WASH indicators Updated WHO/WEDC Technical notes on WASH in Emergencies WASH for children in emergencies

4. Main contacts

Contact the DRS/WASH unit at: HQWASH@unhcr.org
WASH in camps

27 January 2020

Key points

- Ensure coordination and collaboration between all WASH actors in a camp.
- Ensure safe access to water, sanitation and hygiene in camps.
- Monitor key WASH indicators regularly, and the WASH situation.

1. Overview

WASH interventions in refugee camps aim to meet basic needs and improve safe access to water of sufficient quality and quantity; sanitation; hygiene practices; and WASH in hospitals, health and nutrition centres, schools and other institutions.

This entry provides guidance on WASH responses in refugee camps. A WASH intervention helps to improve hygiene and health status and reduces morbidity and mortality in a refugee population. At the start, it focuses on identifying WASH infrastructural gaps and needs, the need for software components, and monitoring the WASH situation in camps. The WASH sector works closely with public health and nutrition to address potential causes of waterborne disease and malnutrition, and reduce the (public) health risks associated with poor water, and poor sanitation and hygiene services and practices. At the start of emergencies WASH should also link with physical and site planning when sites are selected and allocated.

2. Main guidance

Protection objectives

- To ensure refugee populations in camps have safe access to water of sufficient quantity and quality.
- To ensure refugee populations in camps have safe access to quality sanitation and hygiene.
- To respect the right to safe water and sanitation.
Underlying principles and standards

- UNHCR's Public Health Strategic Objectives 2014-2018:
  1. Refugees have safe access to water of sufficient quality and quantity.
  2. Refugees have access to quality sanitation.
  3. Refugees have improved hygiene.
  4. Improved WASH in institutions.

Note that UNHCR has developed a comprehensive Public Health strategy that applies to emergency and non-emergency operations in camp and out-of-camp settings. To tailor its interventions more efficiently to emergency situations, UNHCR recommends the use of SPHERE standards during emergency operations:

Hygiene Promotion

- SPHERE, Hygiene promotion standard 1.1: Hygiene Promotion.

People are aware of key public health risks related to water, sanitation and hygiene, and can adopt individual, household and community measures to reduce them.

- SPHERE, Hygiene promotion standard 1.2: Identification, access and use of hygiene items.

Appropriate items to support hygiene, health, dignity and well-being are available and used by the affected people.

- SPHERE, Hygiene promotion standard 1.3: Menstrual hygiene management and incontinence.

Women and girls of menstruating age, and males and females with incontinence, have access to hygiene products and WASH facilities that support their dignity and well-being.

Water Supply

- SPHERE, Water supply standard 2.1: Access and water quantity.

People have equitable and affordable access to a sufficient quantity of safe water to meet their drinking and domestic needs.

- SPHERE, Water supply standard 2.2: Water quality.

Water is palatable and of sufficient quality for drinking and cooking, and for personal and domestic hygiene, without causing a risk to health.

Excreta Management

- SPHERE, Excreta management standard 3.1: Environment free from human excreta.
All excreta is safely contained on-site to avoid contamination of the natural, living, learning, working and communal environments.

- SPHERE, Excreta management standard 3.2: Access to and use of toilets

People have adequate, appropriate and acceptable toilets to allow rapid, safe and secure access at all times.


Excreta management facilities, infrastructure and systems are safely managed and maintained to ensure service provision and minimum impact on the surrounding environment.

Vector Control

- SPHERE, Vector control standard 4.1: Vector control at settlement level.

People live in an environment where vector breeding and feeding sites are targeted to reduce the risks of vector-related problems.

- SPHERE, Vector control standard 4.2: Household and personal actions to control vectors.

All affected people have the knowledge and means to protect themselves and their families from vectors that can cause a significant risk to health or well-being.

Solid Waste Management

- SPHERE, Solid waste management standard 5.1: Environment free from solid waste.

Solid waste is safely contained to avoid pollution of the natural, living, learning, working and communal environments.

- SPHERE, Solid waste management standard 5.2: Household and personal actions to safely manage solid waste. People can safely collect and potentially treat solid waste in their households.

- SPHERE, Solid waste management standard 5.3: Solid waste management systems at community level.

Designated public collection points do not overflow with waste, and final treatment or disposal of waste is safe and secure.

WASH in disease outbreaks and healthcare settings

- SPHERE, WASH standard 6: WASH in healthcare settings. All healthcare settings maintain minimum WASH infection prevention and control standards, including in disease outbreaks.
The following table of indicators shall be used for monitoring achievement of the standards.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Emergency (1)Target</th>
<th>Post Emergency Target</th>
<th>Means of Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Water Quantity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average # liters of potable (2) water available per person per day</td>
<td>≥ 15</td>
<td>≥ 20</td>
<td>Monthly Report Card</td>
</tr>
<tr>
<td>Average # l/p/d of potable water collected at household level</td>
<td>≥ 15</td>
<td>≥ 20</td>
<td>Annual KAP</td>
</tr>
<tr>
<td>% Households with at least 10 liters/person potable water storage capacity</td>
<td>≥ 70%</td>
<td>≥ 80%</td>
<td>Annual KAP</td>
</tr>
<tr>
<td><strong>Water Access</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maxim um distance [m] from household to potable water collection point</td>
<td>≤ 500m</td>
<td>≤ 200m</td>
<td>Mapping</td>
</tr>
<tr>
<td>Number of persons per usable hand pump / well / spring (3)</td>
<td>≤ 500</td>
<td>≤ 250</td>
<td>Monthly Report Card</td>
</tr>
<tr>
<td>Number of persons per usable water tap (4)</td>
<td>≤ 250</td>
<td>≤ 100</td>
<td>Monthly Report Card</td>
</tr>
<tr>
<td><strong>Water Quality</strong></td>
<td>% Households collecting drinking water from protected/treated sources</td>
<td>≥ 70%</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>% water quality tests at non chlorinated water collection locations with 0 CFU/100ml</td>
<td>≥ 95%</td>
<td>≥ 95%</td>
<td>Monthly Report Card</td>
</tr>
<tr>
<td>% of water quality tests at chlorinated collection locations with FRC in the range 0.2-2mg/L and turbidity &lt;5NTU (5)</td>
<td>≥ 95%</td>
<td>≥ 95%</td>
<td>Monthly Report Card</td>
</tr>
<tr>
<td><strong>Sanitation</strong></td>
<td>Number of persons per toilet/latrine</td>
<td>≤ 50</td>
<td>≤ 206</td>
</tr>
<tr>
<td>% Households with household toilet/latrine (7)</td>
<td>-</td>
<td>≥ 85%</td>
<td>Annual KAP / MRC</td>
</tr>
<tr>
<td>% Households reporting defecating in a toilet</td>
<td>≥ 60%</td>
<td>≥ 85%</td>
<td>Annual KAP</td>
</tr>
<tr>
<td><strong>Hygiene</strong></td>
<td>Number of persons per bath shelter/shower</td>
<td>≤ 50</td>
<td>≤ 206</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------------------------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>Number of persons per hygiene promoter</td>
<td>≤ 500</td>
<td>≤ 10008</td>
<td>Monthly Report Card</td>
</tr>
<tr>
<td>% Households with access to soap (9 &amp; 10)</td>
<td>≥ 70%</td>
<td>≥ 90%</td>
<td>Annual KAP</td>
</tr>
<tr>
<td>% of recipient women of reproductive age who are satisfied with menstrual hygiene management materials and facilities</td>
<td>≥ 70%</td>
<td>≥ 90%</td>
<td>Annual KAP</td>
</tr>
</tbody>
</table>

| **Solid Waste** | % Households with access to solid waste disposal facility | ≥ 70% | ≥ 90% | Annual KAP |

**UNHCR WASH Standards for Communal Buildings**

**Schools**
- Average 3 liters of potable water available per pupil per day
- 400 of pupils per usable handpump/well
- 200 pupils per usable water tap
- 50 pupils per toilet/latrine (30 girls per toilet, 60 boys per toilet – add urinals for boys)

**Health Clinics / Nutrition Feeding Centre**
- Average 10 liters of potable water available per outpatient per day
- Average 50 liters of potable water available per inpatient/bed per day
- 1 separated water point per health facility
- 20 outpatients per toilet/latrine
- 10 inpatients/beds per toilet/latrine
An emergency is arbitrarily defined as the first six months after the population movement has stabilized. However, this definition is context specific and should only serve as general guidance.

2. Potable water = safe for drinking
3. For decentralized systems
4. For centralized systems
5. Minimum target at water collection point should be 0.5mg/L FRC in general, and 1mg/L FRC during an outbreak
6. Post-emergency standard is 20 persons per toilet/shower, aiming for 1 toilet/shower per household or ≈5 persons
7. Latrines/toilets should be facilities that are cleanable, guarantee privacy and are structurally safe
8. In protracted situations, Hygiene Promoters should be combined with community health workers as much as possible
9. To maintain health, dignity and well-being, at least 450 grams of soap should be distributed per person per month. 250g is for personal hygiene; 200g is for laundry and other washing purposes.
10. To support safe Menstrual Hygiene Management MHM, UNHCR has made a commitment to providing 250g/month of soap in addition to the general soap distribution.

**Protection Risks**

In emergency operations, WASH interventions have positive effects in numerous areas. They address important protection risks.

- Girls, children and women who walk long distances to water points are at risk of sexual violence.
- When refugees do not have safe access to sufficient water of good quality, and sanitation, they are exposed to public health and nutrition risks (such as water related diseases and risks of malnutrition).
- Refugees who do not have safe access to sufficient water of good quality, and sanitation, may adopt risky coping mechanisms. (They may purchase water from unreliable vendors; women and girls are at risk of sexual abuse if they defecate in the open, etc.).

**Other risks**

If adequate WASH facilities are not available in refugee camps:

- Security risks increase (riots, demonstrations, violent behaviour).
- Refugees may adopt risky or unsafe coping strategies to obtain water, sanitation or soap and buckets.
- Harmful short and long-term effects on health are likely, including severe diarrhoea, dehydration, malnutrition, and even death.
Key decision points

WASH infrastructure, including structures to promote hygiene, must always be available to refugees who live in camps. New water and sanitation facilities must be built, and activities started to mobilize the community, or existing facilities must be strengthened, including those of the host communities.

WASH services and infrastructure in camps should also be accessible to the host community to ensure peaceful co-existence.

WASH interventions must always be:

- Evidence-based. Activities should be planned and implemented, based on the findings of the initial assessment.
- Needs-based. Interventions should be scaled and resources should be allocated to meet the needs of the population.
- Technically sound. Services should be based on current scientific evidence and operational guidance, and implemented by skilled staff.
- Impact oriented. UNHCR promotes the comprehensive WASH approach, which ensures that essential safe water, sanitation and hygiene needs of the entire population.
- Priority-based. Emergency WASH interventions and services should be prioritised to achieve maximum impact across the population. Interventions to address immediate health and WASH risks, such as disease outbreaks and malnutrition, must be priorities.
- Integrated. Avoid setting up costly parallel services. Assist the national waters authorities to extend its services to refugees.
- Rights-based. Water and sanitation are recognized human rights, which means they also extend to refugees as well as to people living in camp or rural environments. The rights are specified by the five criteria, availability, quality, acceptability, accessibility and affordability.

Key steps

Throughout

- Strong co-ordination of WASH programmes is vital to ensure that all needs are covered and follow-up assured across the wide range of actors in camps.
- Refugees living in camps must at all times have adequate access to WASH services.
- Refugees with specific needs, who require assistance to access or use WASH services should be supported and prioritized.

Site selection and WASH

1. Site selection. Assess sites jointly with physical planning and local authorities to ensure that new camp sites can provide sufficient water throughout the year, keeping in mind seasonal
differences and needs of the local population (also refer to the Entry on site planning).

2. **Assessment criteria.** Ensure that the selection of hosting sites is based on a thorough investigation. It is vital to analyse secondary data (previous studies, local knowledge, mapping, geological assessments, water quality results, rainfall patterns), and conduct new hydrogeological surveys, pumping tests, water quality analysis, and analysis of seasonal variations in water yield and quality.

3. **Water.** Alternative locations should be sought if there is any risk that the water supply is insufficient or of poor quality, if the soil is poor (rocky or with a poor infiltration rate), or if the site is prone to flooding (poor drainage, no slope).

**Water**

4. **Water Supply.** In the early phases of an emergency, UNHCR aims to meet Sphere minimum standards for water supply. A staged approach to developing water supply systems should increase water availability per capita from 15 l/p/d to 20l/p/d as the operation progresses towards the post-emergency phase. In protracted crises, a minimum per capita volume of 20 l/p/d will need to be achieved.

5. **Water supply systems.** Water supply systems must be designed to deliver 20 l/p/day per person to ensure that they are sustainable in the longer term. Calculations of water needs should also take into account the needs of health centres, feeding centres, schools, and religious centres. Review in addition the needs of animals or potential agriculture projects.

6. **Water safety.** The most acute threats to human health associated with consumption of water are due to contamination by human or animal faecal matter. Assess water safety using a risk assessment approach, such as water safety planning, including sanitary inspections. Test for residual chlorine and microbiological indicators of faecal contamination. To be considered as safe, water must be: free from faecal contamination; acceptable to users in terms of its taste and aesthetic qualities; free from colour or odours; free from visible suspended solids. When safe water is not acceptable to users it may be rejected in favour of more acceptable but less safe sources of water. For a water source to be considered safe, it must be capable of reliably supplying sufficient quantities of water to satisfy users' needs; be physically protected from contamination; and equipped with lifting technology that prevents contamination of the source during water collection.

7. **Key elements of water safety.** To ensure a supply of safe water, the key elements are: sound design and construction practices; sanitary inspections; disinfection with chlorine; clean water storage containers; and hygiene promotion of the safe water chain.

8. **Water quality.** Ensure that all water supplies in transit centres, regardless of their intended use, are fit for human consumption. All water supplies must be free of faecal coliforms at the point of storage, delivery and consumption. All settings receiving displaced populations must possess on-site water quality testing equipment, such as: turbidity tubes or electronic turbidity meter to measure turbidity; simple or electronic pool-testers to measure free residual chlorine; and kits for microbial tests (e.g. compartment bag tests, portable microbiology kits or more elaborate field-testing kits for water quality which are available from different suppliers.) The emergency operation must also ensure sufficient availability of test consumables to ensure test can be conducted as frequent as necessary in line with a risk-based approach.

9. **Water storage.** Ensure that refugees and host families have access to at least 10 litres of safe water storage capacity per person, on their arrival in camps and throughout the emergency phase. Safe water containers should have narrow openings and lids to prevent secondary
contamination. The condition of containers should be closely monitored; they should be cleaned or replaced when necessary.

Sanitation

10. **Protection of water sources.** No excreta containment systems (pits, tanks, seepage, sewerage or spillage) should contaminate surface water or shallow groundwater sources. Toilets must be located at least 30 metres from groundwater sources. Additional measures should be taken in locations that have a high water table or are prone to flooding. The bottom of pits and soak-aways must be at least 1.5 metres above the groundwater table.

11. **Toilet access.** Toilets should be evenly dispersed throughout the camp; no dwelling should be more than 50 meters from the nearest toilet.

12. **Universal access.** Make sure that all toilets can be used safely by all refugees, including children, older persons, and pregnant women. Collect data on users who have disabilities and construct dedicated toilet facilities as near to them as possible, considering the results from community consultations and relevant guidelines.

13. **Hand-washing.** Ensure that all public toilets, communal toilets, shared toilets and household toilets have hand-washing facilities, with soap (or a clean rubbing agent), and that arrangements are in place to ensure they remain functional.

14. **Toilet cleaning and maintenance.** Ensure that toilets are kept clean and maintained, in a manner that does not deter use. Put in place a budget adequate to cover operational and maintenance activities. Particularly in the first phase of an emergency, you may need to offer incentives for toilet cleaning; if so, provide hygiene non-food items rather than cash.

15. **Disaggregated distribution.** Provide three female toilets to every male toilet, based on disaggregated population numbers. Toilet blocks must be segregated by sex and marked with culturally appropriate signage.

16. **Participation and gender-balanced representation.** Ensure that programmes are developed and run in cooperation with the refugee population. Women must be consulted on the design and siting of toilet facilities. All programmes should have active gender-balanced and representative sanitation or hygiene committees.

17. **Protection considerations.** Ensure that the location and design of all toilet facilities eliminate threats to the security of users, especially women and girls, day and night.

18. **Transition out of emergency.** Ensure that emergency excreta management programmes switch into transition programmes as quickly as possible. Construct shared and household toilets aiming for a ratio of 1 latrine per 5 persons if it becomes clear that the humanitarian situation will last for longer than six months.

19. **Household latrines.** Ensure as soon as possible that refugees have the means, tools, materials and appropriate technical guidance to construct, maintain and clean household toilets.

20. **Bathing and laundry facilities.** Ensure that refugees have access to facilities for bathing, and laundering clothes and bedding. These facilities should provide privacy and dignity. If this cannot be achieved at household level, design and locate communal facilities in consultation with users, notably women, adolescent girls, and persons with disabilities. Bathing/showering facilities should be available at household level as soon as possible. For laundry facilities, aim to meet the needs of small private communal groups of up to 16 households; avoid large public wash blocks.

21. **Drainage.** Ensure that wastewater (from tapstands, bathing, laundering) is disposed of in properly designed drainage systems. In arid zones, runoff water may be reused in sub-surface irrigation systems, e.g. for gardening purposes.
22. **Solid Waste disposal.** Ensure solid waste disposal is properly managed, to avoid health hazards (injuries to children, mosquito breeding sites, etc.). While in the emergency phase centralised solid waste management solutions may be appropriate, as the situation moves towards post-emergency then decentralised household level solid waste management solutions should be implemented where possible. Medical waste generated by health centres is a hazard. Access to medical sanitary services should be well controlled, and waste (used syringes and needles, contaminated bandages, laboratory specimens, etc.) should be treated separately without delay.

23. **Monitoring.** Ensure that sanitation facilities are monitored regularly (toilet distribution, use, access, cleanliness, conditions, etc.). Progress reports should be communicated transparently at regular intervals to beneficiaries, local authorities and donors. A complaints and follow-up system must be established.

24. **Accountability.** Ensure that feedback on the WASH facilities from refugees is invited and considered, even if the duration of stay in the transit centre is short. Such feedback can also be sought through the WASH refugee feedback app.

25. **Exit strategy.** Ensure that a clear exit strategy exists from the start. It should consider the operation, maintenance, transition and eventual decommissioning of water and toilet infrastructures. Where appropriate, WASH facilities should be handed over to the national Authorities or national actors.

**Hygiene promotion**

26. **Enable a hygiene-promoting environment.** Hygiene promotion does not only address knowledge and skills but also ALL other determinants of health and hygiene such as environmental and socio-economic barriers and enablers. Ensuring access to water, sanitation and hygiene facilities is as much part of hygiene promotion as influencing attitudes and mind-sets.

27. **Key hygiene messages.** Too much focus on disseminating one-way messages and too much focus on designing promotional materials without listening properly to the views of the population is considered a common pitfall in hygiene promotion. Once the most important messages have been identified, they should be in local languages (or pictorials if literacy rates are low) and should target practices that are responsible for the most critical hygiene risks. Do not attempt to communicate too many messages. Concentrate on practices that are most responsible for transmitting diseases and on interventions to prevent them.

28. **Household surveys.** During an emergency and as soon as population figures and plot allocation stabilize, conduct a baseline survey to evaluate access to WASH services. In post-emergency phases, a knowledge, attitude, practice survey (KAP) survey should be carried out at least once a year (also see the entry on [WASH needs assessment](#)).

29. **Empowerment.** Develop and run hygiene promotion programmes in full cooperation with refugees and the host population.

30. **Concentrate on key risk practices.** Do not attempt to communicate too many messages. Concentrate on practices that are most responsible for transmitting diseases and on interventions to prevent them.

31. **A hygiene promotion strategy.** With UNHCR field staff and partners, define and develop a WASH strategy for hygiene promotion (Who, What, Where, When, How and Why). Focus on priority groups at risk, risky practices, key interventions, and key indicators. The plan should be prepared in the first three months of displacement, and should be revised every six months based on monitoring feedback. It should be developed jointly by the WASH and health sectors.
The strategy development should be reviewed and adjusted from the results of annual KAP surveys.

32. **Water-borne diseases.** If outbreaks of water-borne diseases (such as cholera) occur, establish a specific task force composed of the WASH and health sectors. It should meet weekly to make sure messages are consistent and harmonized.

33. **High risk vectors.** UNHCR field staff and partners must ensure that the environment is free of high-risk disease vectors. Take steps to drain bodies of stagnant water, and clean up any dumps of organic solid waste, faeces, or other potential breeding sites for disease vectors. Elimination of high-risk disease vectors must be given the same priority as water supply, excreta management and hygiene promotion.

### Key management considerations

UNHCR must ensure that adequate WASH services are available in the camps. To this end, collaborate closely from the start with local, district, and national authorities, and with the water ministry.

Where national services are not in a position to extend their services to camps, NGO partners should run WASH services.

UNHCR should ensure that the WASH situation in camps is monitored and that relevant stakeholders receive regular reports of progress, so that they can respond rapidly if the situation changes. To report, use the WASH monthly report card. Instructions on how to fill the forms are available on the UNHCR WASH website, wash.unhcr.org. Access can be granted by the HQ team.

Contact: [HQWASH@unhcr.org](mailto:HQWASH@unhcr.org).

WASH services and activities must respect the provisions of the UNHCR **WASH Manual** and the UNHCR **Well Construction Documentation**. (See Tools, documents and references)

### Resources and partnerships

#### Staff

- Experienced UNHCR WASH officers.

#### Partners

- UNHCR promotes integration of services into national systems. The water authorities (country, regional or district level) remain the key partner for WASH interventions. When possible national public services should be expanded and supported.
- Relevant NGOs and UN agencies such as UNICEF to implement WASH activities. Experienced WASH partners and technical staff from partner organisations. Community outreach workers from the community and from WASH partner organisations.
Establish partnership agreements at field level at an early date, so that interventions can be implemented rapidly.

Annexes


Sphere Handbook (2018)

3. Links


4. Main contacts

Contact DRS, WASH unit. At: HQWASH@unhcr.org

Site planning for transit centres

30 October 2019

Key points

- Assess the suitability of transit centres and ensure that they meet basic standards.
- Develop a comprehensive plan. It should make provision for assessments, include scenarios, and establish indicators, as well as a schedule of operations from inception of the transit...
1. Overview

Options for accommodating refugees include planned camps, collective centres (public or private buildings), and reception or transit centres.

Transit centres are used as temporary shelters for new arrivals and to provide short-term temporary accommodation for displaced populations pending transfer to a more suitable, safe and longer term settlement. They provide a habitable covered living space, a secure and healthy living environment with privacy and dignity to people of concern for a short period (2-5 days) while they wait for new settlements to be constructed or until shelter can be found in other accommodation or host villages. These facilities can be used at the very onset of an emergency or within the context of a repatriation operation, as a staging point for return.

Transit centres are usually constructed on land allocated by Government. They should provide adequate protection, access to water and sanitation, hygiene, health services, and nutrition, in addition to shelter.

2. Main guidance

Protection objectives

- To provide a safe environment for new arrivals and increase the chances of survival of persons of concern.
- To improve understanding of the nature and scale of refugee movement.
- To better adapt the response to immediate needs by gathering information on refugee origin, security, points of entry, vulnerabilities, gender and age composition, etc.
- To gain greater understanding of the settlement options preferred by persons of concern and host communities.
- To safeguard social rights and ensure the availability of adequate shelter, food, clean water and sanitation.
Underlying principles and standards

Universal Declaration of Human Rights, Article 25 (1)

‘Everyone has the right to adequate housing’. This principle applies in all stages of the displacement cycle and is relevant to all people of concern, including women, girls, men, and boys. ‘Adequate housing' covers security of tenure, availability of services, materials, facilities and infrastructure, as well as affordability, habitability, accessibility, location, and cultural adequacy.

For practical advice on how to set up, coordinate and manage transit centres in a manner that will satisfy minimum standards and uphold the rights of displaced people, see the section below on Tools, documents and references.

Protection Risks

Transit centres should not be considered for accommodation longer than 5 unless they offer appropriate support, including privacy, independence, and adequate accommodation. It is important to ensure that smoke from stoves or open fires does not pose a health and disease risk. Transit centres may house a high proportion of older persons, single people, and families. A prolonged period of stay is likely to result in stress and tension, possibly leading to depression, social conflict, friction between or within families, conflicts between clans or ethnic groups, and other individual or psychosocial problems.

Persons of concern in transit centres may face a number of other threats:

- Refoulement
- Arbitrary arrest/detention
- Inadequate shelter, inadequate heat, lack of clothing
- Inadequate food or means to prepare it
- Inadequate water supply (quantity and quality)
- Lack of firewood or fuel
- Epidemics and other threats to public health; poor medical facilities
- Political violence
- Physical violence, sexual and gender-based exploitation and violence, including rape
- Domestic violence, abuse and neglect
- Trafficking

Other risks

Where transit centres provide temporary accommodation for population en-route to a further location, they can stall due to a lack of capacity to receive populations at the end of their journey.
Key decision points

Transit centres are often located in or on the edge of camps to ensure that persons of concern do not have to live in the open on their arrival. They may also be located closer to the border en-route to a camp. They are especially preferred in situations where more than 150 people arrive per day in a steady flow. Local and national authorities are responsible for site selection, which has important consequences.

Transit centres are primarily a life-saving measure. They should be located in a place that is socially and environmentally appropriate and should meet public health norms. Their layout and whether they are located inside or outside camps can significantly influence the safety and well-being of those who stay in them. Other issues that planners should consider include: water (quality, quantity, and access), sanitation, administration and security, food distribution, health, education, community services, and access to income-generating activities.

Particular care must be taken to include persons of concern as the planning phase to reduce the potential for tension and conflict between persons of concern and host populations, and improve settlement and shelter strategies. Persons of concern must be involved as early as possible in decisions that affect them.

Key steps

Management
Managers should take steps to:

- Strengthen coordination between stakeholders.
- Identify (within a short time) the most suitable option or combination of options for refugee accommodation.
- Promote good relations between people within the same transit centre.
- Provide protection and security for residents. (For example, risks of sexual violence may be reduced by providing adequate lighting at night.)
- Provide privacy to residents and make sure they are secure and safe. (Personal spaces should be lockable to increase personal safety. Arrangements should be made for safe evacuation in the event of fire.)
- Ensure registration and issue appropriate documentation to persons of concern.
- Protect the human rights of residents and other persons of concern.
- Assess and monitor exposure to risk. Sexual and gender-based violence (SGBV) may increase in transit centres that lack proper monitoring mechanisms.

Site Planning
Managers and staff should:

- Ensure that appropriate locations are selected. Consider security, accessibility, environmental factors, infrastructure, livelihoods, access to basic services, cultural identity, integration, etc.
Be ready to adapt and maintain transit centres for long term use if necessary.
Uphold UNHCR's protection mandate and apply UNHCR's Age, Gender and Diversity Approach.
Ensure that planning minimise the need for subsequent repair and adjustment.
Ensure that facilities improve the provision of services (ease of use, cost effectiveness).
Ensure the most efficient use of land, resources and time.
Maintain health and safety standards on building sites; make clear who has responsibilities in case of accidents; prepare sites (level, mark out, dispose of construction waste, clear vegetation, lay hard surfaces, provide landscaping, drainage, and utilities, etc.); make arrangements for handover.

Key management considerations

It is important to support and protect persons of concern, distance them from danger, and provide them with appropriate and durable settlement options. These objectives cannot be achieved without regularly updating information on the size and composition of displaced populations. Because large-scale emergencies are usually unpredictable and happen quickly, managers should take steps to:

- Assess available resources and request resources as required.
- Request support from other local or international implementing partners and organisations.
- Improve field co-ordination and avoid duplication and inefficiency.
- Support low-cost self-settlement options (if possible), such as accommodation in host communities.
- Adopt temporary emergency arrangements when required, while preparing longer term solutions that meet international standards.

Resources and partnerships

- Local or central Government authorities (including military officials).
- Community and religious leaders.
- Host communities.
- National and international NGOs.
- IFRC and ICRC.
- Other UN and international organizations.
- National (particularly local language) and international news media.

Annexes

UNHCR, Handbook for the Protection of Internally Displaced Persons, Guidance Note 12, Coordination and Management of camps and other collective settings
3. Links

UNHCR, Guidance Note 12, Coordination and Management of camps and other collect... The Sphere Handbook 2018

4. Main contacts

Contact the Shelter and Settlement Section (SSS), Division of Programme Support and Management (DPSM). At: HQShelter@unhcr.org.

Connectivity for refugees

07 August 2018

Key points

- UNHCR can improve the well-being of refugees and its own response by facilitating refugee connectivity.
- Find out what laws and regulations govern the access of refugees to SIM cards.
- Liaise with mobile network operators in the early stages of an emergency. Make them aware of the location of planned settlements and influx numbers. This will enable them to assess the commercial viability of expanding their infrastructure.
- Make targeted investments in connected facilities such as community centres and schools.
- Programming decisions and actions should consider current and projected connectivity and take account of the expressed priorities, needs, capacities and views of persons of concern.
1. Overview

‘Connectivity is not a luxury. It is a lifeline for refugees.’
(Filippo Grandi, United Nations High Commissioner for Refugees, 2017)

What is this and why is it useful?
In a crisis, people of every age, gender and demographic need to be able to communicate with friends and family. For refugees, this means people in their country of origin and their country of flight. In addition, they need to be able to obtain information and access digital services. Despite this, in many emergencies refugee populations are accommodated in rural locations that lack infrastructure, including mobile networks and connectivity.

Because it has a leadership role in refugee emergencies, UNHCR is in a position to help restore connectivity by partnering with mobile network operators and relevant private sector and community-based organisations. After assessing refugees' connectivity needs and situation, it is sometimes possible through information sharing and advocacy to set up mobile networks where none existed or to establish connection facilities in places like community centres. Digital networks can help to deliver a more efficient and effective humanitarian response by facilitating cash transfers, mobile money, digital education and other services.

2. Main guidance

Underlying policies, principles and/or standards

UNHCR is committed to modernizing humanitarian service delivery and adopting innovative approaches to delivering assistance. Technologies offers one way to do this. As both the Empower and the Innovate pillars of UNHCR’s strategic direction make clear:

UNHCR will actively pursue innovative ways to amplify the voices of the people we work for, and take advantage of new technologies to enhance our ongoing dialogue with them and their connectivity with the global community.

We will aim to design and develop scaled solutions, working towards a world in which refugees can access and manage their own digital identity, gain accredited online education, support their families, and communicate effectively through improved connectivity.

In 2016, UNHCR launched Connecting Refugees, a global initiative that is designed to support this area of work more systematically by setting out UNHCR's vision of connectivity for affected populations, researching the issue with Accenture Development Partnerships, and developing a strategy to achieve agreed goals. In the words of the High Commissioner: UNHCR aims, through creative partnerships and smart investments, to ensure that all refugees, and the communities that host them, have access to available, affordable and usable mobile and internet connectivity in order to leverage these technologies for protection, communications,
education, health, self-reliance, community empowerment, and durable solutions.

Field operations can receive support from the Connectivity for Refugees initiative based in UNHCR's Innovation Service. The secretariat can:

- Provide technical advice and support for strategic, contingency and operational planning.
- Facilitate engagement with specialist technical networks.
- Offer training and capacity-building to UNHCR and partner staff.
- Give coordination and advocacy support.
- Help to identify and recruit skilled technical experts.

Looking ahead, UNHCR's Connectivity for Refugees Portal expects to share capacity-building materials, lessons learned from pilots, and other information and services.

**Note.** Investments in mobile connectivity and associated digital ecosystems also benefit host communities. They benefit from extending mobile network coverage help everyone. Both host and refugee communities may be able to take advantage.

**Note.** In an IDP situation, the Emergency Telecommunications Cluster (ETC) leads delivery of connectivity solutions for communities, through the Services for Communities (S4C) pillar of the strategic approach. Depending on their capacity, ETC members and partners can run a variety of activities, coordinated through UNHCR or the cluster. Potential activities are outlined in the S4C Service Catalogue.

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**Good practice recommendations**

**Connecting refugees: Understanding the legal and regulatory context**

Before starting any connectivity initiative for refugees, it is important to understand the regulatory landscape. Find out how liberalized the sector is, whether specific funding is available to promote rural access, how many mobile network operators there are, and the range and quality of the mobile infrastructure. Information about telecommunications regulators can be found on the ITU portal, and information about the national approach on the national agency’s website. You can also obtain information through the GSMA portal, including its Mobile Connectivity Index.

Establish whether refugees are legally entitled to access SIM cards. This may depend on a number of factors. Find out whether refugees who possess UNHCR registration or UNHCR-issued documentation meet the identification requirements for SIM card registration.

**Understanding the community’s communication needs.**

To learn how people are communicating and the prevalence of connected devices, begin by conducting an information and communication needs assessment. Emergency responders should consult communities to determine what channels of communication they currently use, what
sources they trust, how they would like to talk to humanitarian agencies, and the roles that mobile and digital communication channels play. Connectivity is one aspect of a wider communications ecosystem. Communities will also use many ‘offline' approaches to communicate. The assessment may be led by UNHCR or undertaken jointly with other humanitarian and non-humanitarian actors. UNHCR participatory assessments can include specific sections on information and communications. For more information, see the Entry on Communicating with Communities.

**Mapping connectivity**

You can download a number of tools for assessing the availability and strength of mobile network connections. They include [OpenSignal](#), [NetMonitor Lite](#) and [CellMap](#). At an early stage (possibly during initial site assessments and site planning), 'drive' tests can measure connectivity at key infrastructure locations and across the site. Some tools will help to create an overall connectivity map. Share the results with the multi-functional team and agree where connectivity might bring benefits across the response.

More substantive connectivity assessments require sophisticated equipment and specialist engineers.

**Enhancing mobile coverage.**

Having identified connectivity gaps, take steps to enhance the infrastructure in refugee hosting areas. Start by liaising with mobile network operators. Learn about their infrastructure plans and whether these take account of refugee movements. Where a major refugee influx has occurred, it may be appropriate for the Representative or Senior Emergency Coordinator to write to a senior (C-level) executive of the mobile network operator. For smaller influxes, it may be sufficient for the head of the field office to write to the regional management or technical teams.

Mobile network operators may want to set up a ‘cell on wheels' (COW) infrastructure to test the viability of the business opportunity that larger influxes represent. If rural access is poor, it may be possible to apply to the telecommunications regulator for resources to improve access. Other development actors that invest in connectivity infrastructure may also be willing to redirect or pivot their activities to meet the needs of refugee populations.

**Targeted investment in infrastructure.**

In addition to encouraging commercial solutions, you may be able to obtain emergency funding to invest in temporary connectivity infrastructure. One option is to establish connected community centres, known in UNHCR as CTAs. These are simple conceptually but must be managed and maintained. To achieve education and information goals you set for each centre, you will need to develop specific programmes and budgets for them.

Their sustainability is also important. When emergency funding ceases, it may become difficult to meet their cost. To mitigate this risk, one tactic is to train refugees and members of the host community to take over the maintenance, management and governance of facilities. This may mean that you need to invest in training during the emergency phase.

**Coordinating connectivity initiatives.**
Each year, new organisations and consortia invest in humanitarian technology and connectivity. This growth and investment will benefit refugees; but more actors means that more coordination will be required. UNHCR wants to ensure that all the organizations involved in a response invest wisely, by meeting needs identified in community assessments, avoiding duplication of activities, and achieving sustainability in the longer term.

Considerations for practical implementation

**Determine responsibilities within the multi-functional team.**
UNHCR has not established a standard job profile for work on refugee connectivity. Some operations have appointed community connectivity coordinators; but this work is unlikely to fall neatly within any one person's portfolio. Depending on the context and the operation's capacities, ICT officers may be the natural counterpart for contacts with mobile network operators, because they hold corporate contracts with them. To the extent that the topic is linked to communicating with communities and community-based protection, protection staff may take responsibility for work on connectivity. In other cases, the closest association may be with work on livelihoods or digital financial inclusion.

In sum, senior managers of the response will need to determine which staff address different aspects of connectivity and whether the responsibilities sit together in a single post or are split between a number of staff, based on their technical expertise.

**Inclusive connectivity.**
Discover how the affected population uses available connectivity. When you do so, identify obstacles that might be preventing vulnerable groups from benefiting. Research has shown that women are significantly more likely than men to encounter barriers to getting connected. It may therefore be appropriate to prepare some activities for women, and for specific groups of women, for instance single mothers. Take care to ensure that your interventions do not magnify or exacerbate power imbalances but where possible mitigate them.

**Differentiating between corporate contracts and connecting refugees.**
Mobile network operators will often send their corporate account managers or sales executives to open discussions with international organisations, because they perceive an opportunity to acquire a corporate contract. They may not consider the more strategic need to support populations affected by crisis. Depending on the scale of the crisis, that discussion will require the presence of senior executives, and the involvement of UNHCR Representatives or Senior Emergency Coordinators. It is important to note that sometimes a crossover exists: a corporate contract may enable account executives to advocate inside the company for extra investment to help affected populations.

**Avoiding large bills in the longer term.**
Some say technology is costly; and often they are right. Initiatives that initially look compelling may turn out on closer inspection to be expensive and difficult for an emergency response to support. In particular, we have learned from experience that some interventions can only be
funded during the emergency phase. Once this is over, such interventions become a burdensome drain on resources or even irrelevant. This is particularly likely when connectivity is provided expensively via VSAT. These risks can be mitigated by negotiating transition arrangements with NGOs and other development actors, or including infrastructure issues in discussions with mobile network operators.

**Stimulating investment through services, such as mobile money.**
The business models of many mobile network operators involve more than basic mobile services. Their portfolios span a range of business areas and mobile money is often a key income generator. Where UNHCR plans to use mobile money for cash-based interventions, it can encourage mobile network operators to extend and enhance their infrastructure. Many development actors also now support digital financial inclusion initiatives and may be willing to invest in connectivity infrastructure.

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**Resources and partnerships**

**Staff and partners.**
Though UNHCR has not defined a job profile for this area of work, operations should include connectivity in the responsibilities of their multifunctional teams. Different elements of the work can be distributed between staff. ICT staff can liaise with mobile network operators; staff with experience of communicating with communities (a job profile that UNHCR has recently defined more clearly) can work with communities on connectivity, etc.

**Mobile network operators.**
Mobile network operators are frequently the most obvious entry points to connectivity. In societies where UNHCR is likely to be delivering a humanitarian response, they are far more present than landline providers. Many mobile network operators are signatories to the Humanitarian Connectivity Charter, developed by the GSMA (which represents mobile providers worldwide), and have publicly declared they will support humanitarian organisations in times of crisis. It has been documented that supporting crisis connectivity has helped mobile network operators to develop relationships with their customers and increase customer retention.

**Telecommunications regulator.**
The telecommunication regulator sets the rules with regard to connectivity. Rules on access for refugees, migrants and foreign nationals may differ from the rules for nationals of a country. Talking to regulators helps them to understand the situation of refugees and how to facilitate their access to connectivity. In Nigeria for instance, mobile network operators do their own biometric registration, while in Uganda it is done by the National Identification and Registration Authority, which liaises more broadly with UNHCR regarding refugee registration.

**Global partnerships.**
The UNHCR Innovation Service in Geneva will provide guidance and support to operations that want to increase refugee connectivity or establish links with global efforts to assist refugees.
Communities.
UNHCR emphasizes community-based programming. Though connectivity clearly has a technical dimension, community-based approaches remain highly relevant. Many members of communities have technical communication skills. Rather than outsource expertise, it may make sense to train refugees, give them ownership of local network infrastructures and facilities and generally enhance digital literacy.

Annexes

Connecting Refugees (2016)

Enabling Access to Mobile Services for the Forcibly Displaced (2017)


3. Learning and field practices

4. Links

UNHCR Connectivity for Refugees GSMA Refugee Connectivity Portal Broadband for Refugees
UNHCR, Communicating with Communities Connectivity for Everyone

5. Main contacts

For support on connecting refugees, contact the Connectivity for Refugees global team in the Innovation Service. At: hqconref@unhcr.org

The Innovation Service can be reached at: innovation@unhcr.org.

Managing and supporting spontaneous settlements

14 May 2019
Key points

- Reorganizing, relocating or upgrading spontaneous settlements will require expert support and additional operational capacity.

- Prompt assessment of alternative sites is crucial to protect persons of concern from hazards. Determine the appropriate strategy (support, relocate or move) as soon and carefully as possible. Poor decisions made at the start of an operation are difficult to reverse and have significant consequences as settlements evolve.

- Pursue alternatives to camps whenever possible, while ensuring that persons of concern receive effective protection and assistance.

- Involve local authorities and people of concern in the planning process. An adequate supply of water throughout the year is vital. The settlement's sanitation strategy should reflect the specific soil type at the site.

- In all types of settlement, persons of concern should enjoy sufficient space for shelter and associated basic services. Reference Sphere 2018 p. 240 to 286.

- The layout and organization of spontaneous settlements often reflect the priorities and preferences of their residents. These should be taken into consideration when upgrading or relocating.

- They are often densely settled in the centre and sparsely settled on the edge, complicating efforts to establish communal facilities and infrastructure.

- Once spontaneous settlements have been established, it is difficult to upgrade facilities (sanitation, power, etc.). Upgrading usually also causes the settled population to lose some resources and investment.

1. Overview

Spontaneous settlements occur when persons of concern populate areas without agreement, assistance or guidance from local government or the humanitarian-aid community. Such settlements are located on land the displaced population does not officially have the right to occupy.

A camp's location, layout and available services significantly impact on protection and access to assistance. Initial site selection has an impact on decisions throughout the camp life-cycle. Ideally, UNHCR and partners should be involved in site selection and planning of all camps; however, in reality a large number of settlements are settled spontaneously before support is available. Spontaneous settlements are formed by persons of concern without adequate planning in order to meet immediate needs.
Generally, spontaneous settlements have more disadvantages than advantages. Re-designing the camp is generally necessary (where resources are available) as may be re-location as early as possible, to a well-identified site; especially if there is conflict with local host community. The layout, infrastructure and shelter of a camp will have a major influence on the safety and well-being of its residents. Spontaneous settlements include but are not limited to: empty buildings, vacant land, road sidings, etc.

The permission to settle on these sites is usually informal, often an ad hoc agreement with host community and requires reconsideration or negotiation with authorities or private landowners. In the interests of persons of concern and their security, it is important to recognize existence of traditional or informal land tenure arrangements.

2. Main guidance

Protection objectives

- To provide a secure and healthy living environment with privacy and dignity to persons of concern
- To protect persons of concern from a range of risks, including eviction, exploitation and abuse, overcrowding, poor access to services, safe living environment and unhygienic living conditions.
- To support self-reliance, allowing persons of concern to live constructive and dignified lives.

Spontaneous settlements often occupy land that is unsuitable (such as flood plains), mainly because such land is unwanted and available. Urgent consideration should be given to relocation if the site has been judged to be unsatisfactory. Relocation should be done in coordination with the local authorities and government. The difficulty in moving persons of concern from an unsuitable site increases markedly with time. Even if people already in such spontaneous settlements cannot be moved, consideration should be given to diverting new arrivals to alternative more suitable locations.

Underlying principles and standards

Before considering the upgrading of a spontaneous settlement, determine if it is possible to pursue alternatives which can ultimately be more sustainable and cost-effective, harness the potential of refugees, rationalize service delivery or allow for more targeted assistance to those most in need.

Persons of concern may not have access to basic services. In all types of settlement, persons of
concern should have access to water, sanitation, roads and infrastructure, community spaces, shelter, health, education, food, and livelihoods.

Consider whether the spontaneous settlement should be upgraded and supported in situ, moved to a different location, or persons of concern relocated to a more suitable settlement (such as a planned camp or collective centre/alternative to camp arrangement).

Once the decision to upgrade has been made, the same principles and standards that apply to planned camps will apply to the retrofitting of a spontaneous settlement. SPHERE emergency standards are the key reference to designing settlements. See DEH entry 66. Site planning - planned settlements and camps, and 186. Planned settlements / camp site planning standards.

**Protection Risks**

- The often informal agreements to occupy the land may not protect the persons of concern from abuse, exploitation or forced eviction. The power relationship between landlord and tenant(s) may be unequal.
- The environment of a camp is particularly conducive to exploitative and manipulative activities by people who seek to gain from the persons of concern due to the range of risks they face and specific needs – especially during an emergency. In spontaneous camps it may be even more difficult to identify and protect persons of concern from those elements.

**Other risks**

- Conflict may arise with the host community if the presence of refugees increases strain in local services and makes access to resources such as water more difficult.
- The location, size and the design of camps can contribute to the maintenance of a peaceful environment and the security for refugees and local residents. Spontaneous settlements are often located in high risk areas vulnerable to hazards and tend to have very high density. Overcrowding increases health risks as well as tensions, violence and crime.

**Key decision points**

Take account of the following when you address spontaneous settlements.

- Negotiate with the host Government the best settlement option to ensure persons of concern in spontaneous settlements have equal access to humanitarian assistance.
- Use SWOT analysis to determine the most suitable option to support persons of concern in spontaneous camps. Explore alternatives to camps, relocation of the settlement to a suitable site, relocation of residents, upgrading of the site, rental subsidies, etc.
- Discuss with partners (especially local authorities, community-based organizations and representatives of persons of concern and the host community) the possibilities for persons of concern to integrate into the host community. Agree how they can be assisted to do so.
- Clarify ownership of buildings and land.
- Ensure that persons of concern can safely access all shelters and settlement locations, and
essential services.

- Involve local authorities and persons of concern in planning temporary communal settlements, by family, neighbourhood or village groups as appropriate.
- Ensure adequate fire separation between shelters, in accordance with relevant standards.
- Involve development partners as early as possible.
- Ensure that specialized technical support is in place and that physical site planners are deployed in a timely manner.
- Seek technical support from relevant Government departments and ensure that local authority experts are involved in settlement planning.
- Make use of the settlement's layout and topography to minimize the settlement's adverse impact on the natural environment, and provide adequate drainage.

**Key steps**

1. Determine whether other settlement options are available to persons of concern, such as accommodation with host families or rental support.
2. Determine whether the spontaneous settlement is to be supported in situ or relocated.
3. Put together a team to manage the project; ensure there is good continuity across each phase of the settlement cycle.
4. Work with programmes to identify implementing partners.
5. Conduct a thorough site assessment taking into account topography, land use, climate, soils, geology, hydrology, vegetation, infrastructure and key natural and cultural resources. Conduct soil tests, hydrological surveys, detailed topographical surveys, etc.
6. Acquire a detailed understanding of residents' needs by means of an assessment.
7. Establish coordination mechanisms or working groups with key stakeholders.
8. Consider local guidelines, regulations and practices. Ensure that liaison with local and national Governments is both adequate and effective and that there is inter-sectoral engagement.
9. Conduct an environmental impact assessment and incorporate its findings into plans.
10. Develop designs into working drawings that include detailed specifications.
11. Establish project management plans, checklists, and operating procedures.
12. Work with programmes and logistics on procurement and awarding of contracts.
13. Establish monitoring and evaluation frameworks for continued monitoring.
14. Establish reporting criteria and project tracking mechanisms.
15. Develop completion and handover certification.
16. Develop maintenance and exit plans.

**Key management considerations**

The following issues should be taken into account when addressing spontaneous settlements.
### Setting

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| Rural            | ◦ Opportunities to increase self-sufficiency, if agriculture or grazing is possible.  
                  | ◦ If many persons of concern move into sparsely occupied areas, they may outnumber the original residents.                                   |
| Urban            | ◦ If persons of concern are scattered across urban areas, data on them will be hard to gather.                                                
                  | ◦ Upgrading existing urban settlements is challenging in the absence of a legal framework.                                                  |
| Rural & urban    | ◦ Persons of concern are unlikely to interact with local communities or authorities or aid organisations if they are considered to be illegal.     
                  | ◦ Involve persons of concern in strategic planning and construction.                                                                           
                  | ◦ Assist persons of concern to integrate into the local community, and develop positive coping strategies and some autonomy.                 
                  | ◦ If households can choose who they live next to and how they organize themselves, tension between refugees and the host population is less likely.  
                  | ◦ If persons of concern are forced into illegal work, the incidence of exploitation and abuse will rise.                                   
                  | ◦ Take steps to provide access to housing. Too often, persons of concern can only access sub-standard housing in areas vulnerable to natural hazards, and live in crowded and unsanitary environments.  
                  | ◦ Take steps to protect persons of concern from eviction.                                                                                      
                  | ◦ Be aware that persons of concern become less visible when they are dispersed.                                                              
                  | ◦ Locating those in need of assistance will take time and resources.                                                                             |

Table 1. Issues to bear in mind when considering spontaneous settlements.

### Resources and partnerships

- Local or central Government authorities, including military officials.
- Community and religious leaders.
- Host communities.
- National and international NGOs.
- IFRC and ICRC.
- Other UN and international organizations.
- National (particularly local language) and international news media.
- Private sector as appropriate.

### Annexes

[UNHCR, Global strategy for settlement and shelter 2014-2018](#)
Policy on Alternatives to Camps

Sphere Handbook (2018)

3. Links


4. Main contacts

Consult the Shelter and settlement section, Division of Programme Support and Management. At: HQShelter@unhcr.org.

Health in camps and settlements

03 January 2024

Key points

- Public health programs and services must be established to prevent and manage disease outbreaks and malnutrition in coordination with local authorities and partners
- Services available must include preventive health activities, surveillance and curative care with a focus on the primary level and a referral system for emergencies
- Access to national health services should be prioritized as much as possible
- Ensure intersectoral collaboration and coordination as nutrition and food security, WASH, shelter and protection are closely linked to health outcomes

1. Overview

Ensuring access to health services is one component of an overall public health response to
emergencies. The overall aim of any public health intervention is to prevent and reduce excess mortality and morbidity.

In the first phases of an emergency, the public health response focuses on identifying and addressing life-saving needs. The best outcome is to provide refugees with full access to essential health services and wherever possible to ensure access to functioning national services. To achieve this, it is crucial to collaborate closely with the ministries and local authorities responsible for public health and seek integration in national systems from the onset of an emergency where possible and ensuring minimum standards are met.

Public Health interventions in camp and settlements aim to meet the basic health needs of refugees. Health services are closely linked to nutrition and food security, WASH, shelter and protection services to prevent disease outbreaks and reduce and mitigate public health risks.

2. Relevance for emergency operations

- The main causes of death and diseases in emergency situations are vaccine-preventable and communicable diseases. Vulnerable groups including pregnant and lactating women and children under-five years of age, are at most risk.
- Large-scale population movements may overburden a host area's capacity to cope.
- Reproductive health problems (in particular obstetric complications) are more likely during emergencies.
- Emergency situations amplify the risk of exposure to gender-based violence, especially for women and children.
- Displacement may be associated with armed conflict, resulting in casualties, injuries and affecting mental health.

3. Main guidance

a. Emergency Phase

Public health Interventions save lives and address immediate survival needs. Public health programmes should always be available to refugees living in camp settings and settlements.

UNHCR should encourage the authorities to grant refugees access to national services, where these are available and adequate. Where they are not, UNHCR should collaborate with the local Ministry of Health and other relevant partners in the area to establish new services or improve those that exist, for the benefit of both refugee and host populations.

Health conditions and health risks are associated and depend on many factors, including food security, shelter, WASH and availability of non-food items. Public health interventions are, therefore, multi-sectoral in character. Programmes must be coordinated and linked.

The efficient implementation of public health measures hinges on effective health sector coordination, technical support, and management. Technical expertise is required to provide the
necessary oversight.

Given that UNHCR has an overall accountability for the refugee response, UNHCR should deploy public health staff as soon as possible to support the assessment, develop a public health and nutrition strategy and support the operational response and health coordination.

Public health interventions must always be:

- **Evidence-based.** Activities should be planned and implemented, based on the findings of the initial assessment.
- **Needs-based.** Interventions should be scaled and resources should be allocated to meet the needs of the population.
- **Technically sound.** Services should be based on current scientific evidence and operational guidance and implemented by skilled staff.
- **Impact oriented.** UNHCR promotes the primary health care approach, which ensures that essential health services address the health needs of the entire population.
- **Priority-based.** Emergency public health interventions and services should be prioritized to achieve maximum impact across the population. Interventions to address immediate health risks, such as disease outbreaks and malnutrition, must be prioritized.
- **Integrated.** Avoid setting up costly parallel services. Assist the national health system to extend its services to refugees.

**Key steps**

- Conduct an initial health needs assessment, including 3W (Who? What? Where?). Refer to handbook entry on [Health Needs Assessment](#).
- Determine and map the presence of existing health facilities near camps and settlements and whether these can be used and what support may be required. It is always preferable to use and support national facilities from the outset.
- If integration in existing facilities is not possible, specific PHC facilities will need to be set up in the camp/settlement with partners.
- Develop a priority action plan and 3W matrix with local authorities and partners that focuses on the following programme components:
  - a) Measles, polio vaccination, and vitamin A supplementation.
  - b) Screening for acute malnutrition and provision of nutrition support (in contexts where malnutrition is a problem).
  - c) Communicable disease control, notably:
    1. Prevention (including immunization, distribution of mosquito nets).
    2. Surveillance.
    3. Outbreak preparedness and response planning.
    4. Outbreak control.
    5. Monitoring of disease outbreaks.
  - d) Primary health care services:
1. Screening/triage.
2. Curative health care (out-patient care and limited in patient care, depending on contexts).
3. Immunization (EPI).
5. Mental health and psychosocial support.
6. Reproductive health (RH) and HIV. (See entry on SRH and HIV for detail).
7. Nutrition screening and care. (See Nutrition entries)

<table>
<thead>
<tr>
<th>Where RH services are not yet available</th>
<th>Where the MISP or RH/HIV components already exist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement the minimum initial service package (MISP).</td>
<td>Expand to comprehensive RH services.</td>
</tr>
<tr>
<td>○ 24/7 emergency obstetric and neonatal care.</td>
<td>All of the MISP, plus:</td>
</tr>
<tr>
<td>○ Prevention of gender-based violence (GBV) and clinical management of rape (CMR).</td>
<td>○ Antenatal care</td>
</tr>
<tr>
<td>○ High impact STI/HIV prevention and continuation of ART / EMTCT.</td>
<td>○ Postnatal care</td>
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<td>○ Family planning</td>
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<td>○ Post-abortion care</td>
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<td></td>
<td>○ Fistula detection and management</td>
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<tr>
<td></td>
<td>○ Adolescent sexual and reproductive health services (SRH)</td>
</tr>
<tr>
<td></td>
<td>○ Comprehensive GBV response</td>
</tr>
<tr>
<td></td>
<td>○ Comprehensive HIV services</td>
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Timeframe: 0-6 months. Timeframe: > 6 months.

e) Establish a referral network and mechanisms for life-saving and obstetric referrals, based on country specific standard operating procedures.

f) Establish a community health workforce and priority community-based health prevention activities.

g) Where no health information system has been established, implement UNHCR's integrated refugee health information system (iRHIS) as soon as possible.

h) Where required, identify and select NGO partners to implement these priority actions. Partners should be available, have operational capacity, and possess the required technical expertise and skills.

○ Use UNHCR's procurement and supply system to obtain medicines and medical supplies, in
In high risk settings, maintaining a buffer stock pre emergency is a good practice.

- Refugees with specific needs, who require assistance to access or use health services should be prioritized and supported.
- Ensure refugees have access to information and know where services are available and are able to voice their opinions.
- Apply an Age-Gender-Diversity perspective in programming.
- Ensure links to national programmes (e.g. to treat HIV, TB, malaria, etc.) and inclusion of refugees in these.
- Ensure linkages with partners across sectors, including health, nutrition, WASH and protection.

**Post emergency phase**

In the post emergency phase, services can be expanded e.g., for reproductive health expand from the MISP to more comprehensive reproductive health services.

**Health in camps and settlements checklist**

- Conduct an initial needs assessment including mapping available health facilities and services.

- Set up additional services in coordination with authorities and partners if existing national services cannot be supported to meet refugees’ and host communities’ needs. Engage suitable NGO partners if needed.

- Develop an action plan, with short and long term goals, to meet health needs with immediate focus on immunization, nutrition screening and care.

- Set up a surveillance system and outbreak preparedness and response plan.

- Provide primary care services.

- Ensure that the reproductive health MISP (Minimum Initial Service Package) is in place including referrals for emergency obstetric and neonatal care.
• Set up referrals for emergency and life-saving conditions based on an SOP.

• Set up a community health worker system with prioritized actions.

• Ensure access to essential medicines.

• Ensure communication with refugees on available services.

• Establish links with national programmes (EPI, HIV/TB, malaria).

• Ensure linkages across sectors: nutrition, WASH, shelter, protection.

• Coordinate with local authorities and partners.

• Monitor health access and trends.

4. Standards

  ◦ UNHCR has a comprehensive public health strategy (currently 2021-2025) that applies to emergency and non-emergency operations in both camp and out-of-camp settings.
  ◦ UNHCR and its partners follow national standards wherever available and applicable.
  ◦ The following SPHERE standards (Sphere handbook 2018) are applicable as minimum international standards:

    Health systems standard 1.1: Health service delivery

    People have access to integrated quality healthcare that is safe, effective and patient-centred.

    Health systems standard 1.2: Healthcare workforce

    People have access to healthcare workers with adequate skills at all levels of healthcare.

    Health systems standard 1.3: Essential medicines and medical devices

    People have access to essential medicines and medical devices that are safe, effective and of assured quality.
Health systems standard 1.4: Health financing

People have access to free priority healthcare for the duration of the crisis.

Health systems standard 1.5: Health information management

Healthcare is guided by evidence through the collection, analysis and use of relevant public health data.

Communicable diseases standard 2.1.1: Prevention

People have access to healthcare and information to prevent communicable diseases.

Communicable diseases standard 2.1.2: Surveillance, outbreak detection and early response

Surveillance and reporting systems provide early outbreak detection and early response.

Communicable diseases standard 2.1.3: Diagnosis and case management

People have access to effective diagnosis and treatment for infectious diseases that contribute most significantly to morbidity and mortality.

Communicable diseases standard 2.1.4: Outbreak preparedness and response

Outbreaks are adequately prepared for and controlled in a timely and effective manner.

Child health standard 2.2.1: Childhood vaccine-preventable disease

Children aged six months to 15 years have immunity against disease and access to routine Expanded Programme on Immunization (EPI) services during crises.

Child health standard 2.2.2: Management of newborn and childhood illness

Children have access to priority healthcare that addresses the major causes of newborn and childhood morbidity and mortality.

Sexual and reproductive health standard 2.3.1: Reproductive, Maternal and newborn healthcare

People have access to healthcare and family planning that prevents excessive maternal and newborn morbidity and mortality.

Sexual and reproductive health standard 2.3.2: Sexual violence and clinical management of rape

People have access to healthcare that is safe and responds to the needs of survivors of sexual violence.

Sexual and reproductive health standard 2.3.3: HIV

People have access to healthcare that prevents transmission and reduces morbidity and mortality due to HIV.
Injury and trauma care standard 2.4: Injury and trauma care

People have access to safe and effective trauma care during crises to prevent avoidable mortality, morbidity, suffering and disability.

Mental health standard 2.5: Mental health care

People of all ages have access to healthcare that addresses mental health conditions and associated impaired functioning.

Non-communicable diseases standard 2.6: Care of non-communicable diseases

People have access to preventive programmes, diagnostics and essential therapies for acute complications and long term management of non-communicable diseases.

Palliative care standard 2.7: Palliative care

People have access to palliative and end-of-life care that relieves pain and suffering, maximises the comfort, dignity and quality of life of patients, and provides support for family members.

Annexes

UNHCR/AI/2023/03 Al on Public Health Programming

Guidelines for referral health care in UNHCR country operations, 2022

UNHCR Essential Medicines and Medical Supplies Guidance, 2023

UNHCR, Epidemic Preparedness and Response in Refugee Camp Settings, 2011


5. Links

Health needs assessment Sexual and Reproductive Health Care Standards Nutrition in camps Medical referral care Mortality surveillance threshold Primary health care staffing standards Primary health care coverage standards Vaccination coverage standard Primary health care utilization threshold

6. Main contacts
Health at points of entry and access points

08 January 2024

Key points

- Prioritize vaccination of children against measles and polio as early as possible from the first entry or point of contact (including reception/transit centers)
- Establish mechanisms to implement health screening and identify major health risks and persons with serious medical needs/conditions including malnutrition
- Ensure an effective medical referral system for health emergencies from the beginning
- Support local health facilities to accommodate refugees’ health needs wherever possible rather than establishing parallel services
- Focus on the high impact lifesaving interventions initially that can be scaled up depending on length of stay in reception/ transit centers

1. Overview

Ensuring access to health care services during emergencies remain an integral part of UNHCR’s overall public health approach. The overall aim of public health interventions during emergencies is to prevent and reduce excess mortality and morbidity.

Essential health screening and services should be provided as soon as possible and during population movements.

This may range from borders/ points of entry, transit and reception centres, waypoints or temporary accommodation before refugees reach a settlement.

Reception and transit centres should be equipped to provide health and nutrition services and access to food among the essential services. Additionally, clean water and proper sanitation facilities are essential to maintain hygiene and prevent the spread of infectious diseases. Ensure access to continuation of medication such as antiretroviral therapy for HIV (ART), access to medical referrals for acute life-threatening conditions as well as access to the SRH Minimal Initial Service Package (MISP). Reception and transit centers should have emergency vehicles on standby for referral of emergency cases for more specialized care when available.
promotion and health education to prevent spread of communicable diseases are an essential part of health services in reception/transit centres.

2. Relevance for emergency operations

- The main causes of deaths and diseases in emergency situations are vaccine-preventable, and communicable diseases as well as vector-borne diseases in some geographical areas. Children, especially those under five years of age, are at most risk.
- Access gaps for reproductive health needs (in particular pregnancy and obstetric complications) are increase the likelihood of complications.
- Emergency situations increase the risk of gender-based violence, especially for women and children.
- Displacement may be associated with armed conflict, resulting in casualties, injuries and mental health effects.
- Large-scale population movements may overburden or exceed the response capacity of the host health system.

3. Main guidance

Emergency Phase

The first point of contact with refugees may be border crossing points or temporary access points such as reception centers, transit centres, waystations and temporary accommodation. Forcibly displaced populations should have access to a set of minimum essential health services at each contact point.

Points of entry/ border crossing points

Refugees may arrive exhausted. They may be dehydrated and have acute illnesses or injuries.

Where those border points are accessible, a minimum set of health interventions is recommended to be delivered together with national authorities and partners:

- Triage: screening for severe illnesses that require immediate treatment and/ or referral as well as identification walk in cases with diseases of epidemic potentials (e.g. suspected cholera, measles).
- Vaccinate all children (at minimum, up to 15 years) against measles and polio and provide Vitamin A supplements and deworming if feasible. If not, ensure vaccination as soon as possible e.g. at reception/ transit centres. Treatment for acute illnesses requiring urgent action.
- Referral of emergency cases to nearby health facilities, including for emergency obstetric and newborn care (EmONC).

Other access points (e.g. reception and transit centres, waystations, temporary accommodation)
The following actions should be taken to ensure appropriate health services are provided to refugees at the temporary access points:

1. **Coordination:**
   - Identify and collaborate with partners, including national authorities, UN agencies, NGOs and civil society organizations.
   - Rapidly assess the health status of the population and map existing health and nutrition services and health and nutrition supplies using the 3Ws.

2. **Plan for service delivery:**
   - Collaborate with the Ministry of Health (MoH) and partners to reinforce existing services to meet the needs of refugees and host communities.
   - Coordinate and plan with MoH and partners to set up parallel services in support of the national health system, if the national system fails to address emergency health needs during the emergency phase of the influx. Plan for transitioning to national services from the onset wherever possible.
   - Consider that not all refugees might be in transit/reception centers. If refugees are dispersed across vast areas, identify gaps in healthcare services of such refugee hosting areas and address them.

3. **Immediate Health and nutrition Interventions:**
   - Screen and identify:
     1. Identify those with severe medical conditions and refer to nearby public hospitals with emphasis on emergency obstetric and neonatal care and life saving care.
     2. Nutrition screening of the children under 5 and pregnant and lactating women for acute malnutrition and link them to nutrition assistance programs.
     3. Identify patients who need continuous medication for chronic non-communicable diseases including HIV and TB and link them to health services.
   - Deliver services:
     1. Vaccinate all children (at minimum, up to 15 years) against measles and polio and provide Vitamin A supplements and deworming if not already done at point of entry.
     2. Prioritize treatment of acute illnesses in line with local epidemiology.
     3. Prioritize access to essential primary healthcare and the access to emergency obstetric and neonatal care. This includes communicable disease control, infant and young child services, essential reproductive health services including clinical management of rape (See also **SRH** and **HIV** entry), noncommunicable diseases (NCDs) and emergency medical care.
     4. Treatment of severe **acute malnutrition** (see **nutrition** entry).
     5. Food security: Provision of high energy biscuits, hot meals (depending on the situation)
       - Support providing psychological first aid (PFA) and connect those in need to services.
       - Set up epidemiological surveillance to identify diseases with a potential for outbreaks.

4. **Sharing Information:**
   - Engage Community Health Workers from the onset of an emergency and implement health, nutrition and hygiene promotion including on communicable disease control and
timely health seeking.
- Inform refugees about available services, services locations, and access conditions.
- Ensure language translation services if there is a language barrier.

5. Financial and System Integration:
- If healthcare services are chargeable and fees are a barrier, take measures to address this such as requesting waivers for refugee fees, developing reimbursement mechanisms with health facilities through establishing contracts or cash-based interventions.
- Collaborate/coordinate with partners to establish parallel services only if the local public health system is inadequate. If the parallel services are established, ensure they have an inclusion plan to the national system from the onset.
- Newly established services with partners should be integrated into the national health system and be accessible to both refugees and host communities.

6. Data Management and Monitoring:
- Ensure that the public health situation at the access points is monitored and the stakeholders receive regular reports to enable rapid response if the situation changes.
- Implement an integrated refugee health information system (iRHIS) if existing national system does not include refugee specific data.
- HIS must include mortality data collection (ensure capture of deaths occurring both inside and outside of the health facility).
- Collect/provide key initial data in first week: Influx numbers, mortality, key morbidities, nutrition situation.
- Share data regularly with MoH and partners as well as with other sectors.

7. Special Considerations:
- Prioritize and support refugees with specific needs and vulnerabilities in accessing health services.
- Apply an Age-Gender-Diversity perspective and utilize community-based approaches in assessments and responses.

The package of services will depend on the location and the duration of stay. Identify trained health staff among refugees to support the response as health workers, including community health workers, in line with national policies.

Post emergency phase

Generally, post emergency, many refugees will have relocated or moved to settlements depending on the context. However, there can be a situation of ongoing movement across borders and new arrivals, in which case services at the first points of contact should be maintained. Seek integration with the national health system for such services as much as possible.
Health at points of entry and access points checklist

- Set up triage and health and nutrition screening at points of entry.

- Prioritize vaccination against measles and polio of children under 5 (and up to 15 years of age depending on local factors).

- Identify people with immediate health needs and provide initial care.

- Identify people with chronic conditions already on treatment (e.g., TB, HIV, NCDs) and ensure continuation of their treatments.

- Provide psychological first aid (PFA).

- Ensure a referral system and transport for emergency cases including EmONC.

- Provide essential package of primary health services including community health services at reception and transit centers.

- Ensure coordination with national authorities and partners.

- Set up surveillance and a HIS if not already in place.

4. Standards

- UNHCR has a comprehensive public health strategy (currently 2021-2025) that applies to emergency and non-emergency operations in both camp and out-of-camp settings which includes urban settings.

- UNHCR and its partners follow national standards wherever available and applicable.

- The following SPHERE standards (Sphere handbook 2018) are applicable as minimum international standards:

  Health systems standard 1.1: Health service delivery
People have access to integrated quality healthcare that is safe, effective and patient-centred.

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People have access to healthcare workers with adequate skills at all levels of healthcare. Refer to entry Primary health care staffing standard.

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Annexes

UNHCR/AI/2023/03 AI on Public Health Programming

UNHCR, Guidelines for referral health care in UNHCR country operations, 2022

UNHCR, Essential Medicines and Medical Supplies Guidance, 2023

UNHCR, Epidemic Preparedness and Response in Refugee Camp Settings, 2011

Settlement in urban areas

19 July 2019

Key points

- No one option is ideal. Settlement planning is context specific and must be adapted to the specific urban context, addressing a variety of environmental, socio-cultural and economic factors.

- A sound settlement strategy may combine several settlement options. Accommodation in collective centres, although not ideal, may be the most common in some urban areas. Camps may not be avoidable, but may be combined with other alternatives.

- Host arrangements in cities can be particularly overcrowded and prolonged shared accommodation may strain relationships with host families. Rental accommodation may be more appropriate.

- Natural resources are scarcer in urban areas; access to water, cooking and heating fuel may be limited and/or be cash based.

1. Overview

A ‘settlement’ is an environment of household shelters: it is to a community what a shelter is to a household or family. Urban settlement options support settlements in (small and large) towns and cities.

A human settlement derives from the structured landscape of a territory. It takes into consideration spatial allocation of functions while maintaining equilibrium between the needs of
the population, the availability and allocation of resources, economic dynamics, the amelioration of living conditions, the provision of services and enhancing transportation networks, as well as recreational spaces. A settlement must address the needs of the community at large and be designed with the active involvement of persons of concern, partners, and all sectors.

Settlement refers to the physical spaces and environments in which households are sheltered, and how one shelter relates to others. The term is generally used in the context of displaced populations to describe the temporary or sometimes permanent living arrangements of displaced families. In this context settlements can range from planned camps to dispersed accommodation in host villages/neighbourhoods, collective centres, spontaneous camps, rental accommodation, etc.

An urban settlement is where displaced populations settle within an urban agglomeration such as a town or city. A master plan usually divides towns or cities into zones regulated by norms based on specific sectors such as housing, hygiene, habitat, and environment. Zones are inclusive of residential areas, services and infrastructures, and spaces for administrative, commercial and industrial activities.

Land availability is limited in cities and towns; persons of concern often settle in informal areas or marginalized neighbourhoods which have inherent issues of access, availability of services, lack of sanitation, and limited space for shelters. Displaced population may blend into the urban poor which makes targeted assistance challenging, but ever more important to ensure resources reach the intended recipients.

This section looks at common urban settlement options and the development of urban settlement strategies. These require analysis that should be undertaken during the preparedness planning phase, in which settlement options are identified in collaboration with stakeholders. Responses should take account of the capacity of displaced communities, and resources offered by the city and its communities. Prior to determining suitable options, ensure that the following information is available:

- Spatial analysis that describe the availability, uses, and suitability of land
- Evaluation of the absorption capacity of hosting areas and the extent of natural resources
- Sources of water and their capacity
- Market assessments including - infrastructure, logistical resources, storage capacity, the availability of construction materials, and the feasibility of setting up supply chains into affected areas

**Collective centres**
A variety of pre-existing buildings or structures may be used as collective centres - community centres, town halls, hotels, gymnasiums, warehouses, unfinished buildings, disused factories. These facilities are seldom fit for habitation and must be rehabilitated and/or upgraded to meet the shelter needs of residents. Collective centres should be used only as short-term accommodation to gain time to provide more suitable shelter.

Considerations:
Families and communities may be able to be kept together maintaining existing support mechanisms. If the building is connected to the water and sanitation system it may only require upgrades to achieve adequate standards. If buildings are in good condition, it is very cost effective and can be easily winterized. Collective centres can get overcrowded; psychosocial problems can arise if displaced individuals remain in collective centres for too long without privacy and independence. Increased security, fire and communicable disease risk due to the concentration of people.

**Host neighbourhoods**
Displaced people may live with and amongst local households, on land or in properties that local people own. Hosts may be relatives, distant family members, friends or acquaintances, or people previously unknown to those who have been displaced.

Considerations:
- Host arrangements provide immediate shelter for persons of concern.
- Access to spontaneous community support mechanisms can encourage self-reliance, independence and a sense of belonging. Host population may have limited resources; and already living below the poverty line. Absorption capacity maybe limited and competition for resources can be fierce in urban areas.
- Long-term accommodation with host families in dense urban areas can be over-crowded, with detrimental effects to health and welfare of both host and displaced families.
- Housing may already be substandard; host families may be in need of improved shelter.

**Short-term tenancy (land, a house, an apartment, a room)**
Persons of concern may rent from the local population via formal or informal agreements. As with host neighbourhoods rental accommodation may be available immediately, and persons of concern will have greater independence and self-reliance. However, in a competitive market, refugees, IDPs, and returnees may be vulnerable to discrimination and exploitation by unscrupulous land lords; rental accommodation that is available and affordable is often substandard; the relationship between landlord and tenant may be exploitative.

**Dispersed self-settlement without legal status**
Persons of concern may settle in scattered locations across large areas, on land or buildings which they have no approval to occupy. Urban land, housing, services, and resources are all limited, and settling without permission in urban areas is extremely problematic for persons of concern; the threat of forced eviction, violent conflict with local populations, exploitation and abuse, and denial of rights is greater in dense urban areas, especially in informal settlements and slums towards which displaced populations are likely to gravitate. The local population may also need support, for example in ensuring that resources and communal service infrastructure are not overburdened. Full consultation with formal and informal authorities is necessary to avoid conflict with existing inhabitants and plans. It is important that traditional or informal land tenure is recognized and supported to ensure the best protection of the displaced.
Considerations:

- Access to livelihoods may be possible in urban areas.
- Persons of concern have some degree of choice on where to settle, and may settle within local communities that share cultural ties with them.
- Gathering data from and communicating with persons of concern will be difficult and costly.
- Persons of concern are less likely to report security or protection concerns to authorities for fear of eviction or abuse.
- Reaching formal agreements to occupy property may be more difficult if HLP legal framework is inadequate, or if the property is in informal settlements which may not have legal recognition from the state and therefore no formal property titles.

**Self-settled, unplanned camps**

Spontaneous settlements or unplanned camps occur when groups of displaced people populate areas without assistance or guidance from local government or the humanitarian community. Such settlements are located on land the displaced population does not officially have the right to occupy. This constitutes the establishment of an entirely new settlement within the boundaries of this land.

Considerations:

- Spontaneous settlements in urban areas will likely occupy undesirable land in high risk areas such as along ravines or hillside slopes, or the limited public areas such as public squares or parks.
- Access to adequate supply of water supply, sanitation and other infrastructure is unlikely.
- An assessment will be needed in order to determine if the population can and should be relocated to another settlement such as a planned camp or if arrangements can be made in host neighbourhoods.
- Some spontaneous settlements, even in urban and peri urban areas can be formalized and upgraded if the site is suitable and approval is granted by the authorities. For more information see entries on spontaneous settlement strategy considerations and on managing and supporting spontaneous settlements.

2. Main guidance

**Protection objectives**

- To provide a safe and healthy living environment for persons of concern.
- To protect persons of concern from a range of risks, including eviction, exploitation and abuse, overcrowding, poor access to services, and natural hazards.
- To support self-reliance, allowing persons of concern to live constructive and dignified lives.
Underlying principles and standards

- Settlement and shelter designs should reflect the needs of persons of concern, their cultural habits and their capacities, and should also attempt to build on existing resources and enhance access to infrastructure.
- Settlement and shelter interventions need to be planned and implemented to mitigate, to the extent possible, the impact on the natural environment and to prevent hazard risks such as landslides, floods and earthquakes, among others.
- Inclusive and meaningful participation of persons of concern in accordance with UNHCR's Age, Gender and Diversity approach, is essential to ensure that men, women, girls and boys have their voice heard, identify their needs, and have the opportunity to contribute to the search of adequate solutions.
- Accessibility to land constitutes a fundamental element of the realization of the right to adequate housing, and must also provide sustainable and non-discriminatory access to facilities essential for health, nutrition, security and comfort.
- Durable solutions are the ultimate goal, taking into consideration appropriate technology, capacity-building of both refugees and local communities, and use of local skills, materials, techniques and knowledge.
- Refugees and other persons of concern should be empowered to participate actively in decisions that concern them at all stages. An inclusive approach fosters ownership and acceptance of programmes and improves maintenance of shelters and settlements. It facilitates communication and can generate information and support that may be crucial to a programme's success and sustainability.
- International human rights law and refugee law recognize the right of every individual, including refugees, to move freely.
- Persons of concern should be supported to become self-reliant, enabling them to contribute to their host country and find long term solutions for themselves.
- Settlements policy and decisions should be driven primarily by the best interest of persons of concern.
- Persons of concern should have access to essential services in all types of settlements. These services include water, sanitation, roads and infrastructure, community spaces, shelter, health, nutrition, education, food, and livelihoods.
- Settlements should provide sufficient space for shelter and associated basic services. Though in host situations, for example, it can be difficult to ensure accommodations meet standards, interventions should aim to achieve minimum international or national standards.
- Housing Land and Property (HLP) considerations are fundamental in planning and implementing settlement activities. Mechanisms should be in place to protect persons of concern from forced eviction, exploitation or abuse derived from a lack of tenure security.

Protection Risks

- In protracted situations, deteriorating living conditions of families hosting large number of persons might lead to health and psychosocial problems, as well as risks of stigmatization, harassment, economic or sexual exploitation, and violence against the displaced families.
- In areas where refugees are not welcome, both host and displaced families might become
targets of retaliation by parties to the conflict or by surrounding communities.

- Those settled spontaneously on private or public land are often under constant threat of eviction by landlords or authorities. Monitoring and responding to harassment and threats may not be achieved in a timely manner if settlements are scattered and legal tenure has not been clarified.
- Prolonged stay in camps or collective centres can result in stress and tensions and can lead to social conflict and friction with host communities, between families, clans or ethnic groups.
- Persons of concern in collective centres are often under threat of being evicted by landlords. Those occupying schools, religious, and other public buildings are under increased pressure to leave.
- The presence of ethnically, culturally, religiously or linguistically different groups may give rise to tensions.
- A proliferation of high quality shelters in an area where housing standards are low can create tension with local communities.
- High population density significantly increases health risks.

The above protection risks are applicable to rural and urban settlements. Persons of concern will encounter a number of specific risks associated with the urban environment:

- Public areas are scarce in cities; relations with the local community might deteriorate if the persons of concern occupy already limited number of public spaces such as parks or public squares.
- Criminal groups can be prolific in urban areas; persons of concern can be targeted in dispersed or groups settlements.
- Economies in urban environment are primarily cash based; agriculture is nonexistent; water points require payment. Access to food, water, and other necessities will come at a cost, which may force persons of concern to adopt negative coping mechanisms.
- Displaced children in urban areas face great risks. Lack of access to education can be caused by lack of resources, fear of the local community, or the need for children to complement household income. Lack of parental supervision and access to schools, and the overall poverty can lead girls and boys to try and fend for themselves and exposing them to child labour, sex work and theft. For girls especially the risks of early sex, exploitative sex and sex work is greater in cities and towns.
- Persons of concern may be accused and blamed for neighbourhoods' problems such as conflict between families, criminal acts - often despite lack of evidence, thefts, etc. Verbal abuse or accusations can become physical abuse, and persons of concern may not receive protection by the authorities.
- Inadequate housing can forced families to live in overcrowded conditions, or to separate. Children may be sent to live with other neighbours exposing them to neglect and abuse.

**Other risks**

Persons of concern in urban areas tend to settle in high risk areas or hazardous environments
such as unused warehouses, factories, unfinished buildings, and the land surrounding those sites. Exposure to contaminants can be high.

The presence of displaced populations, especially in dispersed self-settlement without legal status or spontaneous settlements can become a political factor and their removal a political platform for elected city officials often resulting in forced evictions.

Key decision points

- Planned camps are less likely in urban settings; spontaneous camps can appear if no other solutions are available and residents will need similar levels of support as planned camps. At the outset of a crisis, it is advisable to consider a mix of settlement and shelter options in consultation with the host Government. Initial strategies can include the adaptation of unused public buildings, arrangements with community groups, rent support. Water and sanitation services need to be available in all cases.
- In cities and towns rental support can be a viable shelter solution. See entry on rental accommodation strategy considerations for more information.
- Ensure that all stakeholders have a voice in the decision-making process to determine the appropriate settlement solutions to support.
- In cities and towns Housing, Land and Property (HLP) issues will be more complex. Regulations can be difficult to navigate. Most cities develop rapidly and informally and land use plans and ordinances are often out of date. Built up areas of informal settlements may for example still be designated as green belts and housing in those areas have no legal recognition. Acquiring tenure security in those areas for displaced populations will be as, or more, difficult than it already is for its regular residents.
- Ensure you have the appropriate technical support to clarify HLP issues and processes. Informal agreements may be the only agreements possible during the emergency response.
- Analyse settlement patterns, the topography, and the resource base, to reduce adverse impacts on the natural environment. Make use of existing planning processes (where this is possible), and follow best practice, to minimize the risks and vulnerabilities that settlement will trigger.
- Ensure that persons of concern can safely access shelter and settlements locations and essential services.
- Non-formal coordination, decision making, and support mechanisms often exist in neighbourhoods. Make sure all stakeholders are involved, including community groups and associations, in addition to the authorities.
- In heavily centralized countries communication between national and local officials may be inadequate. Always ensure that city officials are represented when planning a response and are involved during implementation.
- Involve development partners as early as possible, notably UNICEF, UNDP, and (where appropriate) the World Bank. Consider how both relief and broader development objectives can be advanced by means of the resources that those who have been displaced will attract.
- Conduct a cost benefit analysis of different settlement options, determine resource requirements, and establish priorities, to ensure that adequate human, financial and
material resources will be available.

- Ensure that the specialized technical support required is in place and that physical planners are deployed in a timely manner.
- Seek technical support from the technical department of the host Government and ensure that local authority experts are involved in settlement planning.

**Key steps**

- Analyse demographic factors, population movement, available resources, protection concerns, and local capacity. Survey available documentation on displacement and what communities can offer, but also specific needs and hazards.
- Obtain information on rules and regulations, building codes, environmental analysis, lists of contractors and material suppliers. Obtain information from local and regional associations of engineers and architects, to help identify potential local partners.
- Determine the suitable settlement solutions for the needs of the displaced population. Determine follow up actions such as: which spontaneous settlements should be upgraded, which populations should be relocated, should host family accommodation be upgraded, etc.
- Identify the range of shelter solutions that are preferred by, and that can be made available to persons of concern.
- Develop a shelter and settlement strategy.
- Assess supply and logistical requirements and constraints; put in place arrangements to address them.
- Monitor the impact and effectiveness of programmes over time.

**Key management considerations**

- Integrate settlement strategies and potential layouts in preparedness planning processes.
- Ensure systematic deployment of senior settlement and shelter experts at the onset of emergencies.
- The physical information on cities available at planning offices is often out of date. Determine the appropriate technology needed to accurately map settlements (open street map, drones, etc) or consider low tech rapid mapping exercises if the overall picture is more important than the accuracy of the mapping (for example social mapping).
- Consider how the settlement and shelter response can boost the local economy in marginalized neighbourhoods. Try to gain an understanding of the informal economy and how persons of concern can access income generating activities.
- To reduce the risk of conflicts over land, collaborate closely from the start with local authorities' technical departments, and inform yourself of local rules and regulations on land tenure, public works and housing.
- Establish and apply quality assurance measures. These may include training on best practices to build capacity.
- Identify natural hazards (such as flooding, landslides, strong winds). If there are seismic risks, seek specialized technical advice even for the design of a simple shelter.
- Coordinate and liaise with other sectors, including water and sanitation and livelihoods, to ensure solutions are integrated.
Resources and partnerships

Numerous actors become involved following the arrival of a large number of displaced people. To achieve a well-coordinated response, it is vital to clarify and distinguish their different roles and responsibilities, and to understand the structures and procedures of the local and national authorities.

Technical experts will generally carry out specific tasks. The table below suggests appropriate experts at different stages.

<table>
<thead>
<tr>
<th>Planning stage</th>
<th>Who can help</th>
<th>What they can do</th>
</tr>
</thead>
</table>
| Needs assessment; understand the persons of concern's profile and demographics | Sociologist/ economist  
Anthropologist  
Architects/ engineers/ Protection experts | Carry out comprehensive surveys, including market surveys  
Evaluate information  
Gather background information  
Analyse traditional practices and cultural habits |
| Settlement analysis and planning        | Urban planner  
Physical planner  
Architect  
Civil Engineer  
Water/sanitation engineer  
Environmental engineer  
Geologist/hydrologist | Determine possible upgrades to urban infrastructure  
Map hazards and identify settlements which face unacceptable levels of risk  
Carry out surveys and topographic studies  
Assess the capacity of water sources  
Recommend solutions and most suitable settlement options  
Estimate costs, and resource requirements |
| Implementation                          | Physical planner  
Urban planner  
Civil engineer  
Architect  
Logisticians | Prepare the work programme and risk management plans  
Supervise implementation |
Mental health and psychosocial support

11 April 2019

Key points

- Do not consider MHPSS services and support a ‘stand alone' sector, or let them become isolated from other services: they should be integrated in general community support and programmes and systems for public health, education and protection.

- Do not describe a whole population as ‘traumatized'. The term ‘trauma' should not be used
outside clinical programmes.

- Integrate an MHPSS approach in all programmes and ensure that interventions foster the dignity and resilience of persons of concern.

- Revive and strengthen family and community support systems and promote positive coping mechanisms of affected individuals and their families: these are key psychosocial interventions in an emergency.

- Ensure that mental health care is functionally linked to, and preferably integrated in the general health system; avoid establishing parallel mental health services.

- Take steps to introduce psychotherapeutic interventions for people with prolonged distress and take measures to avoid excessive prescription of psychotropic medication.

- Facilitate intersectoral coordination through a Technical Working Group for MHPSS with actors in health, community-based protection, child protection, SGBV, education and nutrition.

1. Overview

Emergencies put significant psychological and social stress on individuals, families and communities. People not only experience atrocities prior to or during flight; their living conditions once they have reached safety also impose significant stress and hardship. Refugees and other people of concern experience and respond to loss, pain, disruption and violence in significantly different ways, influencing their mental health and psychosocial well-being and their vulnerability to mental health problems. Men and women, and boys and girls of different ages, may have different ways of experiencing and expressing distress. Their reactions to disruptive situations are often overcome with time. Most people cope with difficult experiences and may become more resilient if a supportive family and community environment is available. Some people are more vulnerable to distress, however, especially those who have lost, or been separated from, family members, or who are survivors of violence.

When mass displacement occurs, the normal and traditional community structures that often regulate community well-being, such as extended family systems and informal community networks, may break down. This can cause or exacerbate social and psychological problems; and, in response, new mechanisms and new forms of leadership can arise, which may or may not be representative of age and gender or a community's diversity. The way in which humanitarian and refugee services are provided can also increase or diminish stress in affected populations. Some persons of concern may develop negative coping mechanisms that put them at increased risk. While most people will not develop mental disorders, some will, and the symptoms of individuals who already had disorders may worsen. If persons of concern no longer have access to the usual systems for providing mental health care, or those systems have deteriorated, they may be left without adequate treatment or support.
MHPSS
The composite term ‘mental health and psychosocial support’ (MHPSS) refers to any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders. Among humanitarian agencies the term is widely used and serves as a unifying concept that can be used by professionals in various sectors. MHPSS interventions can be implemented in programmes for health & nutrition, protection (community-based protection, child protection and SGBV) or education. The term ‘MHPSS problems' may cover a wide range of issues including social problems, emotional distress, common mental disorders (such as depression and post-traumatic stress disorder), severe mental disorders (such as psychosis), alcohol and substance abuse, and intellectual or developmental disabilities.

2. Main guidance

Protection objectives

- To ensure that emergency responses are safe, dignified, participatory, community owned, and socially and culturally acceptable.
- To maintain the protection and well-being of persons of concern by strengthening community and family support.
- To ensure that persons distressed by mental health and psychosocial problems have access to appropriate care.
- To ensure that persons suffering from moderate or severe mental disorders have access to essential mental health services and to social care.

Underlying principles and standards

UNHCR, Operational guidance on mental health & psychosocial support programming for refugee operations.
A comprehensive description of a multi-sectoral MHPSS response. Provides specific guidance on MHPSS interventions in community-based protection, health and education.

Provides detailed guidance that helps humanitarian actors to plan, establish and coordinate minimum multi-sectoral responses to protect and improve mental health and psychosocial well-being in an emergency.

Sphere Handbook: Protection Principle 3: "Assist people to recover from the physical and psychological effects of threatened or actual violence, coercion or deliberate deprivation."
One of the four protection principles underpinning the Sphere Handbook. It underlines the importance of appropriate referrals, fostering community action and establishing reporting mechanisms for rights violations.

Affirms that affected persons should have access to health services that prevent or reduce mental health problems and associated impaired functioning.

UNHCR, **Global Strategy for Public Health 2014-2018, Public Health Strategic Objective 4: facilitate access to integrated prevention and control of non-communicable diseases, including mental health services.**
Sets out programmes of mental health and psychosocial support, focusing on primary health care standards and establishing multi-sectoral referral mechanisms.

**Child Protection Working Group, Minimum Standards on Child Protection in Humanitarian Action, Standard 10: Mental Health and Psychosocial Distress.**
Sets out strategies and interventions that will strengthen girls' and boys' coping mechanisms and resilience and promote access to appropriate support for severely affected children.

**Interagency Network for Education in Emergencies (INEE), Minimum Standards for Education: Access and Learning Environment Standard 2: Protection and Well-being.**
Sets out interventions that ensure learning environments are secure and safe, and promote the protection and the psychosocial well-being of learners, teachers and other education personnel.

UNHCR, **Age, Gender and Diversity (AGD) Policy, 2018.**
Builds on UNHCR's 2011 AGD Policy, lessons learned and consolidates existing commitments to accountability to affected people, and updates and expands the High Commissioner's commitments to refugee women and girls (2001) to include IDP, stateless and other persons of concern. The Policy brings together the essential components for change regarding all aspects of age, gender and diversity into six areas of engagement and ten core actions with stronger and clear accountability to all persons of concern, defined responsibilities across senior management and entities in the organization, and consistent monitoring leading to evidence-based regular reporting.

**Protection Risks**

In humanitarian settings, mental health and psychosocial well-being are closely associated with protection.

- The loss and stress experienced during humanitarian emergencies cause grief, fear, anxiety, guilt, shame and hopelessness that overtax individuals' capacity to cope. Stress can cause health problems and increase communal and interpersonal violence, including intimate partner violence.
- Humanitarian emergencies increase the risk of developing mental disorders, including depression, posttraumatic stress disorder, and alcohol and substance abuse, all of which weaken the ability of individuals to fend for themselves and care for others who depend on them.
- Significant stress over long periods harms the development of children, especially young children, increases the risk that they will have physical or mental health problems, and may contribute to educational difficulties later in life. Adolescents with mental problems
are highly vulnerable if they experience violence, abuse or exploitation.

- During emergencies, people with severe mental disorders (psychosis, bipolar disorder, severe forms of depression or posttraumatic stress), or intellectual disabilities, are at heightened risk if they experience neglect, abandonment, homelessness, sexual or domestic abuse, social stigma, or are excluded from humanitarian assistance, education, livelihood opportunities, health care, a nationality, or other services.
- Those who care for people with severe mental disorders can experience extreme distress, isolation and strain on financial and other resources.
- In urban settings and displacement sites, individuals with MHPSS concerns are at higher risk because the communities in which they live are often less cohesive and community protection mechanisms are likely to be weaker.

Other risks

- UNHCR faces reputational risks. If it fails to protect people with MHPSS problems, this will harm its credibility and moral authority and may generate negative media coverage. Increasingly, the media pay attention to psychological trauma and mental health issues in humanitarian settings.

Key decision points

It is important to build understanding of MHPSS in UNHCR and among partners in all sectors, to reduce the burden of mental illness, improve the ability of refugees to function and cope, and strengthen resilience. To this end, it is important to adopt an MHPSS approach and integrate MHPSS interventions in field operations as a priority.

- Adopting an MHPSS approach. This implies providing humanitarian assistance in ways that support the mental health and psychosocial well-being of persons of concern. MHPSS is relevant for all humanitarian actors and all forms of humanitarian action.
- Integrating MHPSS interventions. This implies focusing on activities in which the primary goal is to improve the mental health and psychosocial well-being of persons of concern. Such activities are usually implemented via projects in health, community-based protection, SGBV, child protection, and education.

MHPSS activities that are integrated in wider systems (such as general health services, education, or social services) or embedded in community support mechanisms are likely to be accessible to more people, are often more sustainable, and tend to carry less stigma.

Key steps

1. Include MHPSS elements in assessments

- Initial rapid assessments for health and protection should include some MHPSS elements,
to increase understanding of the MHPSS problems refugees face, their ability to deal with them, the resources that are available, and the kind of responses required.

- Make assessments participatory; involve persons of concern at every stage, with a particular focus on including more isolated or marginalized individuals.
- Assess MHPSS needs and MHPSS resources. Focus on problems but also on coping mechanisms and formal and informal sources of support.
- Apply a broad definition of MHPSS. Assessments that narrowly focus only on one mental disorder, such as post traumatic stress (PTSD), do not provide the data needed to design a comprehensive MHPSS programme.
- In general, do not try to estimate the prevalence of mental disorders because such an assessment is methodologically complicated, requires specific resources and, most important, is not essential to start implementing services.
- As a rule of thumb, use WHO projections of mental disorders in adult populations affected by emergencies (Box 1).

<table>
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<tr>
<th>Box 1. WHO projections of mental disorders in adult populations affected by emergencies (WHO and UNHCR, 2012)</th>
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<tbody>
<tr>
<td><strong>Before emergency 12-month prevalence</strong></td>
</tr>
<tr>
<td><strong>Severe mental disorder</strong> (Psychosis, severe depression, severely disabling forms of anxiety disorder.)</td>
</tr>
<tr>
<td><strong>Mild or moderate mental disorder</strong> (Mild or moderate forms of depression, anxiety disorders, post traumatic stress disorder.)</td>
</tr>
<tr>
<td><strong>Normal distress / other psychological reactions</strong> (No disorder.)</td>
</tr>
</tbody>
</table>

2. Conceptualize MHPSS as a multi-layered system

- Think of MHPSS programmes as a systems-based approach, which has several layers of complementary support, with referral systems between the layers. It is important to develop layers of MHPSS services, ranging from interventions that benefit all persons of concern to targeted interventions for specific groups. The model is illustrated below (intervention pyramid).
Layer 1: Apply an AGD approach to basic services and security. Ensure that security is achieved and basic needs and essential services (food, shelter, water, sanitation, basic health care, control of communicable diseases) are met in a manner that protects the dignity of all people, including those who are particularly marginalized or isolated and who may face barriers to accessing services. To avoid discrimination, stigma and further distress, consider the implications of any targeted interventions, in consultation with affected populations. Apply the same principles to advocacy. Always inform persons of concern how, where and when they can access humanitarian services, to reduce distress. The objectives of protection mainstreaming are very similar to those of layer 1 in the MHPSS intervention pyramid.

Layer 2: Strengthen community and family support. Promote activities that foster social cohesion. Support the restoration or development of community-based structures that represent the population in terms of age, gender, disability and other aspects of diversity. Promote community mechanisms that protect and support individuals using participatory approaches. Ensure that play and recreation spaces and activities are available, especially for children and youth.

Layer 3: Provide focused psychosocial support. Promote individual, family or group interventions to provide emotional and practical support to those who find it difficult to cope alone or with their own support network. Non-specialised workers in health, education, community-based protection or child protection usually deliver such support, after training and with ongoing supervision.

Layer 4: Clinical services. Make clinical mental health services available to those with severe symptoms or whose intolerable suffering renders them unable to carry out basic daily functions. The problems of such persons are usually induced by the emergency, or pre-existed it. They include (but are not limited to): psychosis, drug abuse, severe depression, or disabling anxiety symptoms; some may be at risk of harming themselves or others. Interventions are usually led by mental health professionals, but can also be led by specialists in social work.

3. Promote the adoption of an MHPSS approach in UNHCR and with partners

- Employing a participatory approach and providing services respectfully can improve the psychosocial well-being of persons of concern; but staff involved in a refugee response may not always be aware of these effects. It is important to ensure that all stakeholders in UNHCR-supported programmes are aware that MHPSS is a cross-cutting issue.
- Improving staff awareness of and information on MHPSS, including the awareness of staff in reception centres and registration desks, can be achieved by seminars or training. Relevant themes include: effective communication, dealing with strong emotions, and identifying MHPSS problems in persons of concern.
- Build inter-sectoral capacity to integrate MHPSS. For example:
  - Provide half or one day orientation seminars on psychological first aid (PFA) using the facilitator guide.
  - Integrate MHPSS in the regular training programmes for staff working on sexual and gender-based violence (SGBV), Child Protection and Community-Based Protection
  - Inform senior managers about the importance of using MHPSS approaches in all sectors. Consider holding a short briefing session for senior management.
- Ensure that groups or individuals with specific MHPSS needs can access basic services.
(including food and non-food distributions). If necessary and appropriate, arrange separate queuing systems or a ‘buddy/helper’ system; monitor the distribution of goods to groups or individuals with specific needs to ensure that distribution is safe, dignified and equitable.

4. Include MHPSS interventions in community based protection programmes

Most communities already employ protection measures to support vulnerable members. You may find you can sustain or revive strategies that refugee and IDP populations used before they became displaced. At the same time, certain coping strategies (for example measures that restrict women's freedom, or exclude religious or ethnic minorities) may harm or disadvantage vulnerable groups.

- Discuss MHPSS issues with the community, using culturally and contextually relevant terminology and concepts and accessible communication formats and channels. Minimise stigmatization of and discrimination against people with mental health conditions.
- Ensure that MHPSS support is available to men, women, girls and boys of all ages, ethnicities, backgrounds and religions, and is tailored to meet their different needs, including accessible for persons with disabilities.
- Integrate MHPSS in existing interventions such as sporting activities and computer and literacy classes that can support development of coping mechanisms in addressing and alleviating stress and trauma and support avoidance of stigma that stand-alone interventions may cause. Ensure that these are age and gender appropriate and accessible for all groups. Involve people of concern (including young people) in their design and delivery.
- Facilitate community activities, using self-help groups in the community; introduce psychosocial support projects in urban multi-purpose community centres.
- Recruit and train staff and volunteers from community groups (women's groups, youth organisations, organizations of persons with disabilities, cultural and religious associations) to support individuals with mental and psychosocial concerns.
- Promote and support activities that reduce tensions between people of concern, and between people of concern and surrounding communities.
- Take steps to integrate people with severe mental disorders (in disability programmes the term psychosocial disabilities is used for this group), intellectual and developmental disabilities and epilepsy in programmes for community-based rehabilitation; provide support to enable them to participate in mainstream programmes.

For more information, see the Entry on community-based protection.

5. Design and implement MHPSS interventions in child protection programmes

- Provide parents and caregivers with information on children's and their own emotions and behaviour in emergencies, and explain how they can help their children and themselves to recover, and access services.
- Support community-based early childhood care and development programmes, to ensure that very young children receive appropriate protection, care, stimulation and support. Where relevant, link these activities to nutrition and breast-feeding programmes.
- Establish structured recreational activities, led by community volunteers, and coordinate
these with education activities.

- Ensure that children at risk, and separated and unaccompanied children, are identified and referred to relevant services, including best interest procedures and multi-sectoral services. Ensure that such children receive appropriate psychosocial support, including individual, family and group based interventions appropriate to their needs, and where necessary refer family members to appropriate psychosocial or mental health services.
- Ensure that psychosocial support activities link to and support safe emergency education of good quality and to child protection services, such as best interests procedures, community based child protection activities and where appropriate, family tracing and reunification services.
- Work with other sectors to ensure that they consider the protection and well-being of children. Assist them to make their services child-friendly and accessible.

For more information, see the Entry on child protection.

6. Design and implement MHPSS interventions in programmes for SGBV prevention and response

- Incorporate psychological first aid into the training package for first responders to SGBV survivors (including for medical staff trained in clinical management of rape survivors).
- Include linkages to available community-based psychosocial supports and social services for survivors based.
- Consider including brief psychological interventions [PV1] in the training for SGBV case managers.
- Facilitate referral to trained providers of evidence-based psychotherapies (which can be trained and supervised non specialists) for survivors who are not functioning well because of their symptoms of mental health conditions such as depression and stress-related disorders.
- Provide clinical care with follow-up for survivors who have developed moderate to severe mental health conditions (by mental health-care providers with appropriate training in the provision of mental health care of survivors of sexual violence).

7. Design and implement MHPSS interventions in education programmes

If education programmes are provided quickly to children and youth in an emergency situation, it has a normalizing effect and can reduce the psychosocial impact of extreme stressors and displacement and thereby protect children at risk. Education may also have a healing effect on parents and communities, by restoring a routine and normalcy and creating hope of a better future.

- Encourage the creation of parent or school associations and provide training for them; accompany them if needed.
- Train teachers to identify children who have MHPSS problems and refer them to an appropriate professional (social workers, psychiatric nurses or case managers, for example).
- Organize social and cultural events, including sports events, in schools and informal education programmes, to raise the morale of children, parents and the community.
Make sure that children feel their schools and learning environments are accessible, safe and conducive to learning. Consider structures (well-built classrooms, separate latrines for boys and girls) and the school's culture. Policies should prohibit corporal punishment, exploitation by teachers, and discrimination against minority children or children with disabilities.

For more information, see the Entry on education in emergencies.

8. Design and implement MHPSS interventions in health programmes

- Train health staff (clinical officers, medical doctors, nurses) using the mhGAP Intervention Guide (WHO, 2010). If possible, use the version for humanitarian settings (WHO and UNHCR, forthcoming).
- Arrange regular visits (at least twice a month) by a psychiatrist or another mental health professional, to provide supervision and mentoring.
- Ensure that people with severe mental disorders have access to care.
- Avoid hospitalization; if it becomes necessary, limit it to short term emergency admission (for example, because an individual with a severe mental disorder becomes a danger to themselves or others).
- Ensure that individuals with severe mental disorders, and their families, receive regular follow-ups. Visits can be made by community workers or refugee outreach volunteers.
- Health programmes should make generic medication available for selected mental, neurological and substance use disorders, using the UNHCR essential medicine list.
- Ensure that mental health data are integrated in UNHCR’s HIS system.
- Take steps to make brief psychological therapies available to people impaired by prolonged distress.

For more information, see the Entry on health responses.

9. Establish coordination mechanisms for MHPSS

At country level

- Participate in interagency MHPSS Technical Working Groups (TWG), if these are established and consider co-chairing. If a major refugee emergency does not have an MHPSS TWG, UNHCR should consider creating one.
- Ensure that a representative of the MHPSS TWG participates in coordination meetings for protection (including child protection) and health.

At local level

- Create an MHPSS working group that meets regularly to discuss services and complex cases. It should include staff from health, protection, community-based protection, and education.
- Ensure MHPSS is discussed in coordination meetings on health and protection (including in sub groups for SGBV or Child Protection), for example by making it a regular agenda item.
Key management considerations

Many humanitarian operations now consider MHPSS to be a normal area of intervention. However, approaches continue to vary widely, and conflicting approaches can lead to bad practices. Senior UNHCR managers should emphasize the important role of MHPSS in UNHCR’s protection mandate and require colleagues and partners to observe the IASC’s Guidelines on MHPSS and UNHCR's internal Operational Guidance.

It is particularly important to promote integrated approaches and foster inter-sectoral collaboration (in health, community-based protection, education, child protection, SGBV, etc.). Adequate staffing and resources should be made available to ensure that MHPSS needs can be adequately addressed. Senior managers should also ensure an MHPSS approach is adopted throughout an operation and is not considered the responsibility of a handful of specialists.

Resources and partnerships

Partners

- Partners should be aware of the Operational Guidance and be willing to apply its principles in their work.
- Partner organisations often have a background in either health or protection: for MHPSS programming an ability to work cross-sectorally is essential.
- Stand-alone programmes that focus on one aspect of MHPSS should be discouraged in favour of a more holistic approach.
- Partnerships with national services are generally preferable to new programmes that provide services exclusively to persons of concern.
- MHPSS components should be integrated into the child protection and community-based protection programmes of partner organizations.

MHPSS professionals

- A mental health professional (such as a psychiatric nurse, a psychiatric clinical officer or a psychiatrist) should be employed to assess and manage individuals with severe or complex mental disorders, and to provide guidance and support to primary health care staff.
- Supervision by psychiatrists, clinical psychologists, or psychiatric nurses should be available to support primary health care staff and build their capacity through training, consultation, mentoring and supervision.
- Social workers and community-based workers (such as trained refugee outreach volunteers or community health workers) are needed to do home-based follow up, assist individuals with MHPSS problems (including epilepsy) to access health and community services, and to encourage or support self-help and mutual support initiatives.
Annexes

UNHCR, Operational guidance on mental health & psychosocial support programming for refugee operations

Child Protection Issue Brief

Community-Based Protection & Mental Health & Psychosocial Support

Understanding Community Based Protection, Policy Paper

Manual on UNHCR Community Based Approach

WHO and UNHCR, Assessing mental health and psychosocial needs and resources, 2012

Clinical management of mental, neurological and substance use conditions in humanitarian emergencies

IASC, Guidelines on Mental Health and Psychosocial Support in Emergency Settings

Mental Health and Psychosocial Support in Humanitarian Emergencies. What Should Camp Coordination and Camp Management Actors Know

Mental Health and Psychosocial Support in Humanitarian Emergencies. What Should Protection Managers Know

Mental Health and Psychosocial Support in Humanitarian Emergencies. What should Humanitarian Health actors know

Helping Survivors of Sexual Violence in Conflict

Faith Sensitive Approach in Humanitarian Response

Mental Health for People on the Move in Europe

Operational Guidelines - Community Based Mental Support in Humanitarian Settings
3. Learning and field practices

4. Links

Psycosocial Support Network Guide on Community-based Psychosocial Support (ACT Alliance), Toolkit for the Integration of Mental Health into General Healthcare in Humanit... Mental health and psychosocial support resources (UNHCR Public Health Section)

5. Main contacts

Contact:
- DPSM, Public Health Section (mental health). At: HQPHN@unhcr.org.
- DIP, Community-Based Protection. At: hqts00@unhcr.org.
- DIP, Child Protection. At: hqchipro@unhcr.org.
- DIP, SGBV unit. At: hqsgbv@unhcr.org.

Vaccination coverage standard

09 January 2024

Key points

- Vaccination against measles and polio for children is an absolute priority and measles
vaccine coverage rates of greater than 95% are needed to prevent outbreaks

- The standard applies to all operational settings, including both camp and out of camp settings
- As you prepare a mass vaccination campaign against measles and polio, plan in parallel to restore or set up the EPI (expanded programme on immunization), in coordination with national authorities and partners

1. Overview

Emergencies may cause major disruptions in the delivery of routine health services including routine vaccination programs. Thus, many of these services need to be addressed on an emergency basis and re-established as quickly as possible.

When populations are displaced, a system needs to be established to ensure that at least 95% of new arrivals in a camp or community who are aged between 0/6 months and 15 years receive vaccination against measles and polio as guided by the epidemiological situation and in consultation with the Ministry of Health (MoH) and WHO/UNICEF.

Vitamin A should be administered under the same programme to children aged between 6 and 59 months.

2. Relevance for emergency operations

In emergency situations, people, especially children are vulnerable to communicable disease outbreaks including vaccine preventable disease (VPD) outbreaks. This may be exacerbated by co-existing malnutrition as a result of food shortages, crowded living conditions, limited access to health care, scarcity of safe water, poor sanitation and waste management.

Therefore, vaccination should be among the high priority health interventions to be implemented to limit avoidable morbidity and mortality from VPDs.

3. Main guidance

Emergency Phase

At completion of the polio and measles vaccination campaign:

- At least 95% of children aged between 6 months and 15 years have received measles vaccinations.
- At least 95% of children under 15 years have received polio vaccinations.
- At least 95% of children aged between 6 and 59 months have received an appropriate dose
of Vitamin A.

**Post emergency phase**

The above standards apply to both emergencies and long-term phases. In addition:

- Once routine immunization services (EPI) have been established, at least 90% of children aged between 0 and 12 months have received 3 doses of either (a) DPT (Diphtheria, Pertussis, Tetanus) or (b) pentavalent vaccine (depending on which of the two serves as a proxy indicator for full immunization coverage).

**Vaccination coverage standard checklist**

- Determine whether there is a need for vaccinations, and the appropriate approach for the emergency based on assessment of risk, feasibility of a campaign and context.

- Conduct a mass measles vaccination campaign for children aged six months to 15 years, regardless of measles vaccination history, when estimated measles coverage is less than 90 per cent or unknown. Include vitamin A for children aged 6 – 59 months.

- Ensure that all infants vaccinated between six and nine months receive another dose of measles vaccine at nine months.

- Consider polio vaccination campaign for children aged under 15 years in settings where polio outbreaks or threats to eradication program exist.

- Re-establish routine immunization service as soon as possible to protect children against VPDs to reduce risk of infections.

- Screen children attending healthcare facilities or mobile clinics for vaccination status and administer any needed vaccinations.

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**4. Standards**

[Sphere standards 2018](#)
Children aged six months to 15 years have immunity against disease and access to routine Expanded Programme on Immunization (EPI) services during crises.

Annexes

The Sphere Handbook, 2018

WHO, Vaccination in acute humanitarian emergencies: a framework for decision making, 2017

5. Links

The Sphere Handbook, 2018 WHO Vaccination in acute humanitarian emergencies UNHCR Integrated Refugee Health Information System (iRHIS)

6. Main contacts

UNHCR Division of Resilience and Solutions, Public Health Section: hqphn@unhcr.org

Primary health care coverage standard

09 January 2024

Key points

- Standards of primary health care coverage apply to refugee camps and to out-of-camp (including urban) situations
- Community health programmes should be initiated in consultation with local health authorities and community representatives and should strive to have balanced representation of women and men
- Programmes should provide information on major health problems, health risks, the availability and location of health services, and behaviors that protect and promote good health. They should address and discourage harmful practices
1. Overview

All refugees should have access to quality integrated curative and preventive healthcare services, that is safe, effective and patient oriented, whether they live in refugee camps or out-of-camp (including urban) situations. UNHCR will work with Ministries of Health and partners to strengthen access to primary health care facilities.

Primary health care can be delivered through a combination of community level, mobile and fixed health care facilities. The number, location and type of each will vary by context.

Distance to health facilities should be considered when health facilities are designed and constructed. At least one health facility should be within 5 km of refugee locations. Where this is not the case, an effort should be made to increase coverage.

Emergency referral systems with pre-determined, safe and protected transport mechanisms should be available.

2. Relevance for emergency operations

In emergency situations, primary health care can provide essential and integrated routine health services, identify and manage emergency cases, prevent diseases outbreaks with effective public health measures and play a key role in disease surveillance.

3. Main guidance

Emergency Phase

- The number of health facilities is sufficient to meet the essential health needs of all the disaster-affected population. In addition:
  - At least 80% of refugees have access to a health facility within one hour walk from dwellings.
  - At least one health care facility is available for every 10,000 people. (Basic health units are primary healthcare facilities that offer essential health services.)
  - In rural dispersed settings, at least one health care facility is available for every 50,000 people combined with community case management programmes and mobile clinics.
  - One district or rural hospital is available for every 250,000 people.
  - In urban areas, secondary health care facilities may be the first point of access and, therefore, cover primary health care facilities for a larger population than 10,000.
  - At least 18 inpatient beds (excluding maternity beds) are available for every 10,000 people.

Post emergency phase
The above standards apply to both emergency and post emergency phases.

**Primary health care coverage checklist**

- Prioritize primary health care activities at community and facility or at the closest operational level based on type of crisis, epidemiological context and available resources.

- Establish and strengthen triage mechanism and referral systems.

- Adapt or use standardized protocols for healthcare, case management and rational drug use.

- Provide healthcare that guarantees patients’ rights to dignity, privacy, confidentiality, safety and informed consent.

- Provide safe healthcare and prevent harm, adverse medical events or abuse.

- Use appropriate infection prevention and control (IPC) measures, including minimum WASH standards and medical waste disposal mechanisms, in all healthcare settings.

**4. Standards**

*Sphere standards, 2018*

Sphere Health systems standard 1.1: Health service delivery

People have access to integrated quality healthcare that is safe, effective and patient-centred.

**Annexes**

*The Sphere Handbook, 2018*
5. Links

Sphere Handbook 2018

6. Main contacts

UNHCR Division of Resilience and Solutions, Public Health Section: hqphn@unhcr.org

Primary health care utilisation threshold

09 January 2024

Key points

- Health care utilization rates are an important indicator of access to and acceptability of health services
- When analyzing utilization rates, consider whether you can aggregate health facility use by sex, age and (where relevant) origin, ethnic affiliation, and disability
- 'Population' includes all individuals who visit health facilities, whether they are refugees or nationals
- The standards apply to refugee camps and to out of camp (including urban) situations

1. Overview

The standards in this section address the core aspects of access to quality health care and utilization of services.

Health service utilization rate measures the rate at which new visits are made to health facilities in one year. If the rate is lower than expected, it may indicate that the population does not have adequate access to health services. This may be due to poor quality, direct or indirect cost barriers, preference for other services, overestimation of the population or other access problems. If the rate is high, it may suggest that the population is 'overusing' health services. This may be due to the presence of a specific public health problem or because the population has been underestimated or to access problems elsewhere.

The number of consultations per trained clinician per day measures the workload which is a
2. **Relevance for emergency operations**

During an emergency, health systems and the provision of health care are often disrupted or weakened. There may be barriers to accessing health facilities in addition to a lack of adequate staff. It is, therefore, important to monitor service utilization and health care workers workload.

3. **Main guidance**

**Emergency Phase**

**Emergency standard**

- Health facility utilization rate: between 1 - 4 new consultations/person/year.
- The number of consultations per trained clinician per day is less than 50.

Whenever possible, distinction between new visits and revisits during outpatient consultations should be made. However, in an emergency it may be difficult to differentiate new visits and revisits, so they are frequently combined as total visits which can be used as a proxy for calculation of health facility utilisation rate.

**Post emergency phase**

The above standards apply to emergency and post emergency phases.

**Primary health care utilization threshold checklist**

- Develop or adapt data collection tools (register and tally sheets) to track consultations and allowing distinction between new visits and revisits.

- Ensure all clinicians working in a given health facility use standard outpatient registers.

- Monitor health facility utilization rates and consultations per clinician per day.

4. **Standards**
Sphere Health systems standard 1.1: Health service delivery

People have access to integrated quality healthcare that is safe, effective and patient-centred.

UNHCR Standards and Indicators

Health facility utilization rate: between 1 - 4 new consultations/person/year

Annexes

The Sphere Handbook, 2018

UNHCR Standards and Indicators Guide, 2019

5. Links

The Sphere Handbook, 2018 UNHCR Integrated Refugee Health Information System (iRHIS)

6. Main contacts

UNHCR Division of Resilience and Solutions, Public Health Section: hqphn@unhcr.org

Medical referral care

08 January 2024

Key points

- A global UNHCR medical referral care guidance document exists and should be used to develop and implement country specific medical referral SOPs at the onset of an emergency
- Two types of referrals are made: for (a) emergencies (obstetrical, medical and surgical); and for (b) elective cases for complementary investigations or specialized treatment. During emergency situations emergency life-saving referrals are prioritized
- Use national health systems as much as possible
- The decision to make a medical referral is always to be made by a medical professional and is based on prognosis, availability of services, and cost
- It is essential to monitor referral care, including the reasons for referral, outcomes and
1. Overview

The primary health care approach is the central pillar of UNHCR's public health strategy. However, ensuring referrals to higher levels of care for patients with life and limb threatening conditions is important to save lives. Referral to secondary or tertiary level medical care should be in line with country level standard operating procedures.

Secondary and tertiary health services are often costly and UNHCR budgets are likely to be limited. Realistic limits should be set, particularly for costly specialist services.

2. Relevance for emergency operations

Access to hospital level care (secondary and tertiary) is an important component of comprehensive health care and saves lives. In emergencies, there are often increased health needs, including health emergencies due to disruption of services and the need for referrals to prevent avoidable deaths. This is especially critical for emergency obstetric care.

3. Main guidance

Emergency Phase

The Public Health Officer and partners will need to identify appropriate referral facilities including an assessment of their capacity to provide the required services; costs; and any support needed (e.g., equipment, supplies, human resources, ambulances).

In a new onset emergency, prioritization will be needed and will depend on the availability and level of referral facilities.

Typically, initial referral criteria will include:

- Comprehensive emergency obstetric and new-born care (CEmONC)
- Lifesaving medical care (e.g., treatment of severe respiratory infections, blood transfusion)
- Life and limb saving surgical care (e.g., ruptured ectopic pregnancy, appendectomy, amputation)

Public health officers should develop a country standard operating procedure to guide referral care.

This should follow a stepwise process:
1. **Conduct a situational analysis** to determine the health burden and national health policies and system, barriers and options for referral.
2. **Explore all referral health care modalities** such as availability of charitable organizations, other NGOs and visiting specialists.
3. **Define clear target groups**, typically refugees but may include asylum seekers and stateless persons.
4. **Define medical eligibility and ineligibility for assistance** which will typically prioritize emergency and lifesaving conditions.
5. **Set up a referral care committee** to support decision making on cases. This will be most relevant in larger referral care programmes with significant budgets.
6. **Explore all financing options** as UNHCR resources are always limited there may be other options such as full inclusion in the national systems, health insurance if existing and cost effective and cash-based interventions amongst others.
7. **Develop appropriate agreements with partners and service providers**. Usually, an NGO partner will manage referrals and a PPA may be needed. The partner should establish contracts if needed with the referral facilities clearly defining the expectations and financial agreements. Ambulance services should be available 24/7.
8. **Communicating with refugees**. Refugees and other key stakeholders (MoH and partners) should be made aware of referral care support available, how to access it and limitations and that their personal data is strictly confidential and treated in line with UNHCR's Data Protection framework.
9. **Monitoring**. A system should be set up to track referrals and expenditure, UNHCR has developed the medical referral database (MRD) that can perform this function.

The structure of the SOP should include at least the following chapters:

- Hospitals selected for referral care
- Types of referral care covered
- Non-referrable medical conditions
- Decision-making processes for referral care
- Mechanisms for engaging other actors in referral care
- Cost settlement
- Monitoring

**Post emergency phase**

The above standards apply both to emergencies and long-term situations.

As the situation stabilizes, a more comprehensive referral care programme can be considered including referral for elective procedures.

**Medical Referral Care checklist**

- Establish a country level medical referral SOP at the onset of an emergency.
• Identify and establish an agreement with a referral care partner if needed.

• Ensure agreements are established between the partner and referral care service providers where needed and that 24/7 ambulance transfer is available.

• Ensure a monitoring system is established to monitor referrals and costs.

4. Standards

 Sphere standards-2018

Health systems standard 1.1: health service delivery

Establish or strengthen triage mechanisms and referral systems.

○ Implement protocols for triage at healthcare facilities or field locations in conflict situations, so that those requiring immediate attention are identified and quickly treated or stabilized before being referred and transported elsewhere for further care.

○ Ensure effective referrals between levels of care and services, including protected and safe emergency transport services and between sectors such as nutrition or child protection

Annexes

 UNHCR, Guidelines for referral health care in UNHCR country operations, 2022

 UNHCR/AI/2023/03 AI on Public Health Programming

5. Links

 Health in camps and settlements Health out of camps Health at points of entry and points of access

6. Main contacts

 UNHCR, Public Health Section. Division of Resilience and Solutions: hqphn@unhcr.org
Emergency food assistance standard

07 February 2019

Key points

- WFP is UNHCR's biggest partner in ensuring refugee food needs are met. When refugee populations are larger than 5,000, UNHCR and WFP collaborate to meet their food and nutrition needs. UNHCR meets the food and other basic needs of populations smaller than 5,000.

- When designing food assistance, cash assistance should always be considered as an option, in accordance with UNHCR's cash policy and guidance and the basic needs approach. Cash assistance programmes should be designed in collaboration with other actors, in line with the Four Principles Statement and UNHCR/WFP's Cash Addendum.

- When UNHCR provides in-kind food assistance, the NutVal calculator should be used to calculate the nutritional value of rations.

- Food assistance should target those in most need, in support of UNHCR's protection and solutions strategy for refugees, and refugee self-reliance.

- When UNHCR and WFP provide basic assistance, and collaborate to target assistance, share data, make systems inter-operable, or agree joint programming in food security and nutrition, these programmes should be integrated in Operations' Joint Plans of Action.

- The Sphere Handbook should be used as a reference when designing food assistance.

1. Overview

This entry provides information on minimum standards to ensure that basic food needs are met in emergencies and protracted situations. It should be read and implemented with standards on other basic needs (see UNHCR, Basic Needs Approach), standards on the use of cash and vouchers, and standards on nutrition.

These standards set out actions and indicators to ensure that populations of concern receive high quality food and remain safe. For additional guidance refer to the Sphere project, Minimum Standards in Humanitarian Response (2018).

2. Main guidance
Emergency standard

Food security exists when all people have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences, enabling them to live an active and healthy life. In a humanitarian crisis, food security responses should aim to meet the short-term needs of affected populations and make it unnecessary for them to adopt potentially damaging coping strategies. Over time, responses should protect and restore livelihoods, stabilize or create employment opportunities, and contribute to restoring longer-term food security. They should not have a negative impact on natural resources and the environment.

Household food insecurity is one of four underlying causes of undernutrition, along with poor feeding practices, poor care practices, an unhealthy household environment, and inadequate healthcare. Responses to treat malnutrition will have a limited impact if the food needs of the general population are not met. People who recover from malnutrition but who cannot maintain an adequate food intake will deteriorate again.

To choose the most effective and efficient options, an emergency response must identify and understand the needs of refugees, household preferences, effective and cost-efficient solutions, protection risks, the situation of host communities, and seasonal factors. It should define clearly the type and quantity of food assistance (in-kind or cash) required, who should receive food assistance, and how food assistance should be distributed.

Assessing the food security and nutrition situation
A response should be based on an objective assessment of the state of nutrition and food security. UNHCR's Standardized Expanded Nutrition Survey contains modules on nutrition and food security that provide standardized questionnaires and analysis plans. Wherever possible, these should be adapted to fit the circumstances, agreed with partners, and used to assess the situation.

Many food security assessments are done by WFP in collaboration with UNHCR. Joint Assessment Missions (JAMs) should be run when an emergency starts and every two years during a protracted operation. Operations should use JAM analyses to guide the development of Joint Plans of Action.

Food security response: food assistance
A range of interventions can promote household food security. They include cash assistance and the provision of in-kind food. When refugees have access to goods and markets, cash is often the most appropriate form of assistance and UNHCR should promote cash as part of the initial emergency response where it is appropriate, in line with UNHCR's Policy on Cash-based Interventions. Adequate cash grants can enable people to meet their basic needs, including food. UNHCR's Cash feasibility and response analysis toolkit should be used to determine when cash grants are appropriate and how they should be issued. UNHCR has committed to work collaboratively with WFP, UNICEF, OCHA and other partners to target and monitor cash grants, develop transfer mechanisms, and approve financial services. See the Four Principles statement on Cash Collaboration (2018) as well as UNHCR and WFP, Cash Addendum (2017), which outlines UNHCR's commitments on cash collaboration.
Food security responses (including food in kind and cash) should be designed from the outset to support, and work through, local markets. Decisions on local, national and regional procurement should be based on a sound understanding of local markets and financial service providers. For more information, see UNHCR, *Cash feasibility and response analysis toolkit* (2017), and UNHCR, *Multi-sector Market Assessment: Companion Guide and Toolkit* (2017).

**Food security response: key actions (Sphere, 2018)**

- Based on food security assessment data, design a response to meet immediate needs, and consider measures to support, protect, promote and restore food security.
- Consider both in-kind and cash-based options for the food basket.
- Develop transition and exit strategies for all food security programmes as early as possible.
- Integrate food security programmes with the responses of other sectors.
- Ensure that people receiving assistance have access to the knowledge, skills and services they need to support their livelihoods and cope.
- Protect, preserve and restore the natural environment from further degradation.
- Consider the impact of cooking fuel on the environment.
- Promote livelihood strategies that do not contribute to deforestation or soil erosion.
- Monitor the degree to which different groups and individuals accept and have access to humanitarian food security interventions.
- Ensure that people who receive food assistance are consulted on the design of the response and that they are treated with respect and dignity.
- Establish a mechanism for providing feedback.

**UNHCR and WFP collaboration**

WFP is a long-standing partner of UNHCR and UNHCR’s populations of concern. The *2011 Global Memorandum of Understanding* between UNHCR and WFP guides cooperation between the two agencies. To assess needs and develop a Joint Plan of Action at country level, the two organizations conduct Joint Assessment Missions (JAMs) at the start of an emergency and at two year intervals thereafter. For guidance on how to conduct a JAM, see *Joint Assessment Missions: A Practical Guide to Planning and Implementation*.

Where populations of concern are larger than 5,000 individuals, WFP is responsible for ensuring their food needs are met. UNHCR meets the basic needs, including food needs, of smaller populations.

UNHCR’s collaboration with WFP has broadened over time, as both agencies and the contexts in which we work have changed. We have renewed our commitment to collaborate on cash assistance, data sharing, and targeting assistance to those in need. UNHCR has agreed to work with WFP as a partner in designing food and cash responses, with the aim of helping refugees to be self-reliant in food security and nutrition. A Joint Plan of Action guides each operation. The following documents provide information on specific areas of collaboration that should feature in Joint Plans of Action:

- Principles for Targeting Assistance to Meet Basic Food and Other Needs (2018).
- Data Sharing Addendum (2018).
In-kind food assistance
Food assistance is required when the quality and quantity of available food or access to food is not sufficient to prevent excessive mortality, morbidity or malnutrition. In-kind food assistance should be designed to meet the immediate food and nutrition needs of the population of concern while preserving and protecting assets and increasing resilience to future threats.

A wide range of tools can be used in food assistance programmes. They include:

- General food distributions (provision of food in-kind and cash assistance for food purchase).
- Blanket supplementary feeding programmes.
- Targeted supplementary feeding programmes.
- Provision of relevant services and inputs, including transfer of skills or knowledge.

General food distributions assist those who need food most. Food distributions should cease when those who receive them can produce or obtain their food by other legal means.

People who need specific nutrients may require supplementary food in addition to general rations. Those likely to need supplements include children aged 6–59 months, older people, persons with disabilities, people living with HIV, and pregnant and breastfeeding women. Supplementary programmes should comply with UNHCR’s Operational Guidance on the use of specialised Nutritional Products to reduce micronutrient deficiencies and malnutrition in refugee populations, with UNHCR’s Global Public Health Strategy, and with the Sphere standards for management of acute malnutrition, micronutrient deficiency diseases, and infant and young child feeding.

On-site feeding is undertaken only when people do not have the means to cook for themselves. It can be necessary immediately after a crisis, during population movements, or where insecurity would put recipients of take-home rations at risk.

An effective food assistance programme requires strong supply chain management, logistical capacities, and management of commodities. Management of cash delivery systems must be robust and accountable, with systematic monitoring. (See the Entry on Cash based interventions.)

Nutrition requirements for general food assistance
Individuals must have adequate access to a range of foods, including fats, proteins, carbohydrates, vitamins and minerals, that together meet their nutritional requirements. The minimum nutrient requirements for an individual are given in the table below and should be used to design and assess general rations. The table should not be used to assess the adequacy of supplementary or therapeutic care rations, or rations for specific groups (such as persons suffering from tuberculosis or living with HIV).

These minimum requirements list the average nutritional needs of all age groups and both sexes. They do not describe the specific needs of particular age or sex groups and should not be used to set the requirements of individuals.
General rations should be adjusted (up or down) based on:

- The demographic structure of the population, in particular the percentage of those under five years, and the percentage of females, older people, and adolescents.
- Mean adult weights, and actual, usual or desirable body weights.
- The rate of activity required to maintain productive life. Nutrition requirements will rise if activity levels are more than ‘light’ (1.6 x basal metabolic rate).
- Average ambient temperature, and shelter and clothing capacities. Requirements will rise if the mean ambient temperature is lower than 20°C.
- The nutritional and health status of the population. Requirements will rise if the population is malnourished or needs more nourishment to catch up on growth. The prevalence of HIV may affect the population's requirements.

Planning general food rations

To ensure that nutrition needs are met, an online nutrition calculator, [www.nutval.net](http://www.nutval.net), should be used to plan general food rations. When commodities and amounts are entered into the app., it calculates the nutritional composition of the ration. In addition, ask whether you need to add:

- Iodised salt for the majority of households (>90 per cent).
- Additional sources of niacin (e.g. pulses, nuts, dried fish) if the staple is maize or sorghum.
- Additional sources of thiamine (e.g. pulses, nuts, eggs) if the staple is polished rice.
- Additional sources of riboflavin, where people depend on a very limited diet.

**Note.** Donated or subsidized infant formula, powdered milk, liquid milk or liquid milk products should not be distributed as a separate commodity in a general food distribution. These items should also not be distributed in a take home supplementary feeding programme.

Key actions when designing food rations (from Sphere, 2018)

- Select foods that comply with the national standards of the host government and/or internationally accepted standards of quality.
- Choose appropriate food packaging and provide labels that show the date of production, country of origin, expiration or ‘best before’ date, nutritional analysis, and cooking instructions. Make sure this information is labelled clearly and in a local language, especially when the food in question is unfamiliar or is not commonly used.
- Evaluate the refugee population's access to water, fuel, stoves and food storage facilities.
- Provide access to adequate milling and processing facilities when wholegrain cereal is provided.
- Meet the milling costs of recipients using cash or vouchers. Alternatively, provide additional grain or milling equipment (these options are less desirable).
- Transport and store food in appropriate conditions.
- Measure quantities in consistent units. Avoid changing units or measuring procedures during the project.

Key actions for food targeting, distribution and delivery (from Sphere, 2018)

- In line with the UNHCR and WFP's Joint Targeting Principles, food and other basic
assistance should be targeted at those in need, based on joint analysis.

- Targeting should be clearly communicated. It should be accepted by both recipient and non-recipient populations in order to avoid creating tensions and doing harm.
- Establish food distribution methods, or cash/voucher delivery mechanisms, that are efficient, equitable, secure, safe, accessible and effective.
- Consult women and men, including adolescents and youth, when you design food delivery systems. Encourage the participation of groups that may be vulnerable or marginalized.
- Make sure that distribution and delivery points are located in places that are accessible, safe, and convenient for recipients.
- Minimize the risks to recipients when they travel to distribution points. Regularly monitor checkpoints and changes in the security situation.
- Provide recipients with advance details of the distribution plan and schedule, the quality and quantity of the food ration or the value of the cash grant or voucher, and what needs the distribution covers.

**UNHCR guidance on food donations**

- All nutritional products must be approved at global level by WHO and UNICEF as ‘safe to treat or prevent a condition’.
- In general, minimum donations for persons of concern to UNHCR must be sufficient to provide the item to all households; or, if for use by a section of population, must be sufficient to provide a three month supply.
- Acceptance or use of any special nutrition product or food must take into consideration its potential interaction with other products in use, to avoid toxicity.
- UNHCR will not accept any of the following items:
  - Products containing milk or milk products without evidence that they have been approved at global level by WHO.
  - Products that are not compatible with local cultural or religious norms.
  - Products whose expiry date falls less than one year from the date of shipment.
  - Products that do not have a clear contents label and a certificate showing that they are safe to consume.
  - Products targeted at infants or young children, including but not limited to breast milk substitutes or milk powders.
  - Non-fortified salt, oil or flour.

- All food donations should be accompanied by a cash contribution to cover the inland transport, storage and distribution costs of the donated commodity.
- UNHCR only distributes foods that meet food safety standards in both donor and recipient countries. Foods must be deemed safe for human consumption.
- Donations must adhere to the guidelines of the Codex Alimentarius Commission.

**Annexes**
3. Links


4. Main contacts

Contact the Public Health Section, Division of Programme Support and Management (DPSM), UNHCR. At: hqphn@unhcr.org.

Settlement in rural areas

19 July 2019

Key points

- Attention should be given to laws and regulations governing the use of environmental impact assessments prior to the design and planning of the settlement and shelter programme.
- No one option is ideal. Settlement planning is context specific.
- A sound settlement strategy may combine several settlement options.
- Assess available natural resources and the absorption capacity of hosting areas.
• Ensure that needs assessments evaluate the logistics infrastructure, storage capacity, the availability of construction materials, and the feasibility of setting up supply chains into affected areas.

• Environmental considerations must be integrated into physical planning and shelter programmes from the start of an emergency. The location and layout of camps, provisions for emergency shelter, and the use of local resources for construction and fuel, can have significant impacts on the environment.

1. Overview

A human settlement derives from the structured landscape of a territory. It takes into consideration spatial allocation of functions while maintaining equilibrium between the needs of the population, the availability and allocation of resources, economic dynamics, the amelioration of living conditions, the provision of services and enhancing transportation networks, as well as recreational spaces. A settlement must address the needs of the community at large and be designed with the active involvement of persons of concerns, partners, and all sectors.

Settlement refers to the physical spaces and environments in which households are sheltered, and how one shelter relates to others. The term is generally used in the context of displaced populations to describe the temporary or sometimes permanent living arrangements of displaced families. In this context settlements can range from planned camps to dispersed accommodation in host villages/neighbourhoods, collective centres, and spontaneous camps, etc.

A rural settlement is where displaced populations settle on land outside of cities and towns. The population is often dependent on agricultural and pastoral practices, and has fewer community infrastructure systems than in urban settlements. Rural contexts are defined by population thresholds that differ internationally.

This section looks at common rural settlement options and the development of settlement strategies. These require analysis that should be undertaken during the preparedness phase, in which settlement options are identified in collaboration with stakeholders.

Options should be adapted to capacity and available resources. Prior to determining suitable options, ensure that the following information is available:

- Spatial analysis that describe the availability, uses, and suitability of land.
- Evaluation of the absorption capacity of hosting areas and the extent of natural resources.
- Sources of water and their potentially sustainable yield.
- Market assessments, including infrastructure, logistical resources, storage capacity, the availability of construction materials, and the feasibility of setting up supply chains into affected areas.
The most common rural settlement options are host villages and ‘camp-like' settings.

**Host villages**
In host villages, displaced people live with and amongst local households, on land or in properties that local people own. Hosts may be relatives, distant family members, friends or acquaintances, or people previously unknown to those who have been displaced.

**Dispersed self-settlement without legal status**
Persons of concern may settle in scattered locations across large areas, on land or buildings which they have no approval to occupy. In this form of settlement the displaced population has no assistance or guidance from local Government or the aid community.

**Spontaneous settlements**
Spontaneous settlements or unplanned camps occur when groups of displaced people populate areas without assistance or guidance from local government or the humanitarian community. Such settlements are located on land the displaced population does not officially have the right to occupy. Some spontaneous settlements can be formalized and upgraded if the site is suitable and approval is granted by the authorities. For more information see entries on spontaneous settlement strategy considerations and [managing and supporting spontaneous settlements](#).

**Planned camps**
Planned camps are a form of settlement in which refugees or IDPs reside and receive centralised protection, humanitarian assistance, and other services from host governments and humanitarian actors. Planned camps are designed and developed to contain the needed infrastructure to serve its residents, and have formal recognition/approval from the authorities. For more information see entries on [camp strategy considerations](#) and [site planning for camps](#).

### 2. Main guidance

**Protection objectives**
- To provide a safe and healthy living environment for persons of concern.
- To protect persons of concern from a range of risks, including eviction, exploitation and abuse, overcrowding, poor access to services, and natural hazards.
- To support self-reliance, allowing persons of concern to live constructive and dignified lives.

**Underlying principles and standards**
- [UNHCR Master Plan Approach to Settlement Planning Guiding Principles](#) is a key reference when defining a settlement response.
- Settlement and shelter designs should reflect the needs of persons of concern, their cultural habits and their capacities, and should also attempt to build on existing resources and enhance access to infrastructure.
- Settlement and shelter interventions need to be planned and implemented to mitigate, to
the extent possible, the impact on the natural environment and to prevent hazard risks such as landslides, floods and earthquakes, among others.

- Inclusive and meaningful participation of persons of concern in accordance with UNHCR's Age, Gender and Diversity approach, is essential to ensure that men, women, girls and boys have their voice heard, identify their needs, and have the opportunity to contribute to the search of adequate solutions.
- Accessibility to land constitutes a fundamental element of the realization of the right to adequate housing, and must also provide sustainable and non-discriminatory access to facilities essential for health, nutrition, security and comfort.
- Durable solutions are the ultimate goal, taking into consideration appropriate technology, capacity-building of both refugees and local communities, and use of local skills, materials, techniques and knowledge.
- Refugees and other persons of concern should be empowered to participate actively in decisions that concern them at all stages. An inclusive approach fosters ownership and acceptance of programmes and improves maintenance of shelters and settlements. It facilitates communication and can generate information and support that may be crucial to a programme's success and sustainability.
- International human rights law and refugee law recognize the right of every individual, including refugees, to move freely.
- Persons of concern should be supported to become self-reliant, enabling them to contribute to their host country and find long term solutions for themselves.
- Settlements policy and decisions should be driven primarily by the best interest of persons of concern.
- Persons of concern should have access to essential services in all types of settlements. These services include water, sanitation, roads and infrastructure, community spaces, shelter, health, nutrition, education, food, and livelihoods.
- Settlements should provide sufficient space for shelter and associated basic services. Though in host situations, for example, it can be difficult to ensure accommodations meet standards, interventions should aim to achieve minimum international or national standards.
- Housing Land and Property (HLP) considerations are fundamental in planning and implementing settlement activities. Mechanisms should be in place to protect persons of concern from forced eviction, exploitation or abuse derived from a lack of tenure security.

### Protection Risks

- In protracted situations, deteriorating living conditions of families hosting large number of persons might lead to health and psychosocial problems, as well as risks of stigmatization, harassment, economic or sexual exploitation, and violence against the displaced families.
- In areas where refugees are not welcome, both host and displaced families might become targets of retaliation by parties to the conflict or by surrounding communities.
- In dispersed settlement and spontaneous camps persons of concern may not have adequate access to services or humanitarian assistance.
- Those settled spontaneously on private or public land are often under constant threat of eviction by landlords or authorities. Monitoring and responding to harassment and threats may not be achieved in a timely manner if settlements are scattered and legal tenure has
not been clarified.
- Prolonged stay in camps or collective centres can result in stress and tensions and can lead to social conflict and friction with host communities, between families, clans or ethnic groups.
- Persons of concern in collective centres often under threat of being evicted by landlords. Those occupying schools, religious, and other public buildings are under increased pressure to leave.
- Relations with the host community as well as within IDP groups might deteriorate over the sharing of limited resources, for example, the depletion of nearby areas for firewood, and the occupation of land by persons of concern or the requisition of land by local authorities for their benefit.
- The presence of an ethnically, culturally, religiously or linguistically different group of people may give rise to tension.
- Despite the fact that a larger group settlement may be more secure for persons for concern than dispersed and exposed shelters, a large group settlement may be easily targeted for forced recruitment and violent attacks.
- A proliferation of high quality shelters in an area where housing standards are low can create tension with local communities.
- High population density significantly increases health risks.

Other risks

- Environmental contamination may cause serious health problems for residents and those living in close proximity. Environmental damage especially related to water and sanitation is likely in the immediate vicinity of camps.
- Living in camps can encourage dependency and reduce the ability of persons of concern to manage their own lives. It is vital to ensure that persons of concern are able to play an active role in planning and developing settlement strategies as well as designing and managing governance mechanisms in their settlements. Displacement tends to last longer than expected; camps are rarely occupied for short-term. Planners should always expect that once put in place, camps are likely to exist over a long period of time, i.e. longer than one year. Service provision over that period of time is likely to stay the responsibility of humanitarian actors, and integration with local existing services will be challenging.

Key decision points

- Seldom does one settlement and shelter option fit the needs of the entire displaced population. Explore the available options and solutions persons of concern may have already found and agree the most suitable settlement options, and humanitarian assistance plan, with the host government.
- Ensure that all stakeholders have a voice in the decision-making process to determine the appropriate settlement solutions to support.
- Housing, Land and Property (HLP) regulations are often complex and difficult to navigate. Ensure you have the appropriate technical support to clarify HLP issues and processes.
- With partners, local authorities and community-based organizations, discuss the right of persons of concern to stay in local communities and agree how they may be assisted most
effectively.

- Analyse settlement patterns, the topography, and the resource base, to reduce adverse impacts on the natural environment. Make use of existing planning processes (where this is possible), and follow best practice, to minimize the risks and vulnerabilities that settlement will trigger.
- Ensure that persons of concern can safely access shelter and settlements locations and essential services.
- Involve local authorities, persons of concern and host communities (by family, or neighbourhood or village groups) in planning of temporary communal settlements.
- Involve development partners as early as possible, notably UNICEF, UNDP, and (where appropriate) the World Bank. Consider how both relief and broader development objectives can be advanced by means of the resources that those who have been displaced will attract.
- Conduct a cost benefit analysis of different settlement options, determine resource requirements, and establish priorities, to ensure that adequate human, financial and material resources will be available.
- Ensure that the specialized technical support required is in place and that physical planners are deployed in a timely manner.
- Seek technical support from the technical department of the host Government and ensure that local authority experts are involved in settlement planning.

**Key steps**

- Ensure [UNHCR Master Plan Approach to Settlement Planning Guiding Principles](https://www.unhcr.org/guidelines/73d3f0165.html) are informing the settlement response.
- Analyse demographic factors, population movement, available resources, protection concerns, and local capacity. Survey available documentation on displacement and what communities can offer, but also specific needs and hazards.
- Obtain information on rules and regulations, building codes, environmental analysis, lists of contractors and material suppliers. Obtain information from local and regional associations of engineers and architects, to help identify potential local partners.
- Determine the suitable settlement solutions for the needs of the displaced population. Determine follow up actions such as: which spontaneous settlements should be upgraded, which populations should be relocated, should planned camps be developed, should host family accommodation be upgraded, etc.
- Identify the range of [shelter solutions](https://www.unhcr.org/452960584.html) that are preferred by, and that can be made available to persons of concern.
- Develop a shelter and settlement strategy.
- Assess supply and logistical requirements and constraints; put in place arrangements to address them.
- Monitor the impact and effectiveness of programmes over time.

**Key management considerations**

- Integrate settlement strategies and potential layouts in preparedness planning processes
- Ensure systematic deployment of senior settlement and shelter experts at the onset of
emergencies.  
- If access is limited, gather essential information from local authorities, NGOs and local civil society organisations, or secondary sources and technology.  
- To reduce the risk of conflicts over land, collaborate closely from the start with local authorities' technical departments, and inform yourself of local rules and regulations on land tenure, public works and housing.  
- Establish and apply quality assurance measures. These may include training in best practices to build capacity.  
- Identify natural hazards (such as flooding, landslides, strong winds). If there are seismic risks, seek specialized technical advice even for the design of a simple shelter.  
- Coordinate and liaise with other sectors, including water and sanitation and livelihoods, to ensure solutions are integrated.

## Resources and partnerships

- Affected populations.  
- Local or central government authorities.  
- Community and religious leaders.  
- Host community.  
- National and international NGOs.  
- IFRC and ICRC.  
- Other UN and international organizations.

Technical experts will generally carry out specific tasks. The table below suggests appropriate experts at different stages.

<table>
<thead>
<tr>
<th>Planning stage</th>
<th>Who can help</th>
<th>What they can do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs assessment; understand PoC profile and demographics</td>
<td>Sociologist/economist, Anthropologist, Architects/engineers</td>
<td>Carry out comprehensive surveys, including market surveys. Evaluate information. Gather background information. Analyse traditional practices and cultural habits.</td>
</tr>
</tbody>
</table>
| Site selection | Geologist/hydrologist  
Water/sanitation engineer  
Civil Engineer  
Physical planner  
Protection  
Environment  
Logistics | Carry out surveys and topographic studies. Draw contour lines. Assess the capacity of water sources. Evaluate data and conduct risk analysis. Recommend solutions and most suitable settlement options. |
|---|---|
| Settlement layout | Physical planner  
Architect  
Civil engineer  
Water/sanitation engineer  
Protection experts  
Environmentalist  
Logisticians | Prepare layout and technical plans. Analyse infrastructure (accessibility and conditions). Estimate costs, and resource requirements. |
| Implementation | Civil engineer  
Architect  
Logisticians | Prepare the work programme and risk management plans. Supervise implementation. |

**Annexes**


Safer homes, stronger communities. a handbook for reconstructing housing and communities after natural disasters

Strategies for transitional settlement and reconstruction, Shelter Centre, Geneva

**3. Links**

UNHCR Intranet: Shelter and Settlement Global Strategy for Settlement and Shelter 2014-2018  
The Sphere Project 2018, Shelter Centre on-line library  
World Bank, Global Facility for Disaster
4. Main contacts

Shelter and Settlement Section (SSS), Division of Programme Support and Management (DPSM).
At: HQShelter@unhcr.org.

Health out of Camps

08 January 2024

Key points

- Access to national health services should be prioritized as much as possible
- Services available must include preventive health activities, surveillance and curative care with a focus on the primary care level and a referral system for emergencies
- Establish clear standard operating procedures for accessing primary and referral health care
- Ensure inclusion of refugees in national programmes (e.g., malaria control, EPI, TB and HIV)
- Monitor access to health care and address barriers

1. Overview

The provision of health services is one component of an overall public health response to emergencies. The overall aim of any public health intervention (emergency or not) is to prevent and reduce excess mortality and morbidity.

In the first phases of an emergency, the public health response focuses on identifying and addressing life-saving needs. The best outcome is to provide refugees with full access to essential health services and wherever possible to ensure access to national services. To achieve this, it is crucial to collaborate closely with and support the ministries and local authorities responsible for public health.

Public Health interventions for refugees who are not in camps, i.e., located in urban or rural areas, aim to meet their basic health needs. Similar to camps, services available must include
preventive health activities, surveillance and curative care with a focus on the primary health care level and a referral system for emergencies.

2. Relevance for Emergency Operations (most also apply to health in camps/settlements)

- The main causes of death and diseases in emergency situations are vaccine-preventable and communicable diseases. Children, especially those under-five years of age, are at most risk.
- Large-scale population movements may overburden a host area's capacity to cope.
- Reproductive health problems (in particular pregnancy and obstetric complications) are more likely during emergencies.
- Emergency situations amplify the risk of exposure to gender-based violence, especially for women and children.
- Displacement may be associated with armed conflict, resulting in casualties and injuries and affect mental health.
- Refugee populations can be stigmatized or suffer discrimination or xenophobia, for example if they are seen as taking away resources from nationals or as bringing disease.
- Barriers to accessing health care services or disparities between the quality or the cost of services, may harm relations between refugees and host populations.
- Increasingly, refugees may not be hosted in camps, but living in urban or rural areas of the host country and may be widely dispersed.

3. Main guidance

Emergency Phase

Public health Interventions save lives and address immediate survival needs. They are, therefore, operational and programme priorities.

Public health programmes should always be available to refugees living out of camps whether in urban or rural dispersed settings. UNHCR should encourage the authorities to grant refugees access to national services, where these are available and adequate. Where they are not, UNHCR should collaborate with the Ministry of Health and other relevant actors in the area to establish new services or improve those that exist, for the benefit of both refugee and host populations.

Health conditions and health risks are associated and depend on many factors, including food security, shelter, WASH and availability of non-food items. Public health interventions are, therefore, multi-sectoral in character. Programmes must be coordinated and linked.

The efficient implementation of public health measures hinges on effective health sector coordination, technical support, and management. Technical expertise is required to provide the necessary oversight.

Given that UNHCR has an overall accountability for the refugee response, UNHCR should deploy
public health staff as soon as possible to support the assessment, develop a public health and nutrition strategy and support the operational response.

Public health interventions must always be:

- **Evidence-based.** Activities should be planned and implemented, based on the findings of the initial assessment.
- **Needs-based.** Interventions should be scaled and resources should be allocated to meet the needs of the population.
- **Technically sound.** Services should be based on current scientific evidence and operational guidance and implemented by skilled staff.
- **Impact oriented.** UNHCR promotes the primary health care approach, which ensures that essential health services address the health needs of the entire population.
- **Priority-based.** Emergency public health interventions and services should be prioritized to achieve maximum impact across the population. Interventions to address immediate health risks, such as disease outbreaks and malnutrition, must be priorities.
- **Integrated.** Avoid setting up costly parallel services. Assist the national health system to extend its services to refugees.

**Key steps**

- Establish strong co-ordination with the Ministry of Health (MoH), NGOs, UNICEF, WHO, UNFPA and other relevant actors, to ensure refugees are included in available national public health services and programmes as much as possible.
- Conduct an initial health needs assessment, including 3W (Who? What? Where?). Refer to entry on Health Needs Assessment.
- Map the existing public health services.
  - Assist the MoH to strengthen existing services to ensure they cover the needs of the increased population (refugees as well as host communities). Avoid setting up parallel services.
  - Where refugees are dispersed across many urban or rural areas, gaps in health care services may need to be filled.
- If needed, identify and support local partners (civil society organizations, facilities run by NGOs).
  - The choice and form of facility will depend on the number of refugees, their geographical location, and the capacity, quality and cost of services provided. Health services in urban areas almost always cater for both refugee and host populations. Factor this into planning.
  - Assess the need for additional staff, equipment or medicines.
  - Partners must follow national norms and standards.
- Develop clear standard operational procedures (SOP) for primary and referral care support by UNHCR.
- Make sure that refugees receive information about the services available to them, where these are located, and the conditions under which they can be accessed.
- Ensure translation is available when refugees do not speak the same language as the country of asylum.
- Ensure that refugees have access to essential primary health care services and emergency
and obstetric care. The following services should be available:

1. Measles, polio vaccination, and vitamin A supplementation.
2. Screening for acute malnutrition (where indicated) and provision of nutrition support.
3. Communicable disease control, notably:
   - Prevention (including immunization, distribution of mosquito nets).
   - Surveillance.
   - Outbreak preparedness and response planning.
   - Outbreak control.
   - Monitoring of disease outbreaks.
4. Primary health care services:
   - Screening/triage.
   - Curative health care (out-patient care and limited in patient depending on contexts).
   - Immunization (EPI).
   - Non-communicable disease care.
   - Mental health and psychosocial support.
   - Reproductive health (RH) and HIV. (See entry on SRH and HIV for detail).
   - Nutrition screening and care. (See Nutrition entries)

Where RH services are not yet available

- Implement the minimum initial service package (MISP).
- Where the MISP, plus:
  - Antenatal care
  - Postnatal care
  - Family planning
  - Post-abortion care
  - Fistula detection and management
  - Adolescent sexual and reproductive health services (SRH)
  - Comprehensive GBV response
  - Comprehensive HIV services

Where the MISP or RH/HIV components already exist

- Expand to comprehensive RH services.

- 24/7 emergency obstetric and neonatal care.
- Prevention of gender-based violence (GBV) and clinical management of rape (CMR).
- High impact STI/HIV prevention and continuation of ART / EMTCT (elimination of Mother-to-Child Transmission).

Timeframe: 0-6 months.

Timeframe: >6 months.

5. Establish a referral network and mechanisms for life-saving and obstetric referrals, based on country specific standard operating procedures.
6. Explore reinforcing or establishing a community health workforce and priority community-based health prevention activities in line with national approaches.
7. Integrate refugees in national health information system ideally with access to
disaggregated data. If no HIS is in place, implement UNHCR's integrated refugee health information system (iRHIS) as soon as possible.

8. Where required, identify and select NGO partners to implement these priority actions.
   Partners should be available, have operational capacity, and possess the required technical expertise and skills.
   ○ If patients are expected to pay for health care, make arrangements to ensure that all refugees can afford access to essential primary health care services and emergency and obstetric care.
   ○ Use UNHCR's procurement and supply system to support provision of medicines and medical supplies, if insufficient through the national supply chain, in line with the UNHCR/AI/2023/03 Administrative Instruction on Public Health Programming and the UNHCR Essential Medicine and Medical Supply Guidance 2023.
   ○ Refugees with specific needs, who require assistance to access or use health services should be prioritized and supported.
   ○ Apply an Age-Gender-Diversity perspective in programming.
   ○ Ensure links to national programmes (e.g. to treat HIV, TB, malaria, etc.) and inclusion of refugees in these programmes.
   ○ Ensure linkages with partners across sectors, including health, nutrition, WASH and protection.

Post emergency phase

After the first 6 months, ensure expansion to full reproductive health services beyond the MISP if not already done.

Ensure monitoring of access and utilization of health services and address identified barriers.

Health out of camps checklist

- Set up coordination with national authorities and partners.

- Conduct and initial needs assessment.

- Map health services available and capacity.

- Develop an action plan to meet refugees’ health needs.

- Establish agreement to include refugees in national system and determine support needed to national system.
- Identify if additional services are needed and suitable partners to provide these.

- Establish SOPs for access to primary and referral care.

- Ensure communication with refugees on available services.

- Establish links with national programmes (EPI, HIV/TB, malaria).

- Ensure linkages across sectors: nutrition, WASH, shelter, protection.

- Monitor health access and trends and address barriers.

### 4. Standards

- UNHCR has a comprehensive public health strategy (currently 2021-2025) that applies to emergency and non-emergency operations in both camp and out-of-camp settings which includes urban settings.
- UNHCR and its partners follow national standards wherever available and applicable.
- The following SPHERE standards (Sphere handbook 2018) are applicable as minimum international standards:

  Health systems standard 1.1: Health service delivery
  
  People have access to integrated quality healthcare that is safe, effective and patient-centred.

  Health systems standard 1.2: Healthcare workforce
  
  People have access to healthcare workers with adequate skills at all levels of healthcare.

  Health systems standard 1.3: Essential medicines and medical devices
  
  People have access to essential medicines and medical devices that are safe, effective and of assured quality.

  Health systems standard 1.4: Health financing
  
  People have access to free priority healthcare for the duration of the crisis.

  Health systems standard 1.5: Health information management
Healthcare is guided by evidence through the collection, analysis and use of relevant public health data.

Communicable diseases standard 2.1.1: Prevention
People have access to healthcare and information to prevent communicable diseases.

Communicable diseases standard 2.1.2: Surveillance, outbreak detection and early response
Surveillance and reporting systems provide early outbreak detection and early response.

Communicable diseases standard 2.1.3: Diagnosis and case management
People have access to effective diagnosis and treatment for infectious diseases that contribute most significantly to morbidity and mortality.

Communicable diseases standard 2.1.4: Outbreak preparedness and response
Outbreaks are adequately prepared for and controlled in a timely and effective manner.

Child health standard 2.2.1: Childhood vaccine-preventable disease
Children aged six months to 15 years have immunity against disease and access to routine Expanded Programme on Immunization (EPI) services during crises.

Child health standard 2.2.2: Management of newborn and childhood illness
Children have access to priority healthcare that addresses the major causes of newborn and childhood morbidity and mortality.

Sexual and reproductive health standard 2.3.1: Reproductive, Maternal and newborn healthcare
People have access to healthcare and family planning that prevents excessive maternal and newborn morbidity and mortality.

Sexual and reproductive health standard 2.3.2: Sexual violence and clinical management of rape
People have access to healthcare that is safe and responds to the needs of survivors of sexual violence.

Sexual and reproductive health standard 2.3.3: HIV
People have access to healthcare that prevents transmission and reduces morbidity and mortality due to HIV.

Injury and trauma care standard 2.4: Injury and trauma care
People have access to safe and effective trauma care during crises to prevent avoidable mortality, morbidity, suffering and disability.
Mental health standard 2.5: Mental health care

People of all ages have access to healthcare that addresses mental health conditions and associated impaired functioning.

Non-communicable diseases standard 2.6: Care of non-communicable diseases

People have access to preventive programmes, diagnostics and essential therapies for acute complications and long-term management of non-communicable diseases.

Palliative care standard 2.7: Palliative care

People have access to palliative and end-of-life care that relieves pain and suffering, maximizes the comfort, dignity and quality of life of patients, and provides support for family members.

Annexes

UNHCR/AI/2023/03 AI on Public Health Programming

UNHCR, Guidelines for referral health care in UNHCR country operations, 2022

UNHCR Essential Medicines and Medical Supplies Guidance, 2023


5. Links

Health needs assessment Sexual and Reproductive Health Care Standards Medical referral care Mortality surveillance threshold Primary health care staffing standards Primary health care coverage standards Vaccination coverage standard Primary health care utilization standard

6. Main contacts

Public Health Section, DRS: hqphn@unhcr.org
Site planning for camps

10 July 2019

Key points

- Consider alternatives to camps whenever possible
- Consider national development plans, to ensure settlement planning is economically, socially and environmentally sustainable
- Be dynamic. Settlement plans should be adaptable and capable of responding to changes in a crisis situation
- Consult with all relevant stakeholders and Government when selecting sites. Seek appropriate technical support.
- Avoid settlements that are very large

1. Overview

This entry provides guidance on standards and basic requirements that should be considered when developing a site plan for refugee, IDP settlements or camps. UNHCR discourages the establishment of formal settlements and whenever possible prefers alternatives to camps, provided they protect and assist people of concern effectively.

Site planning is the physical organization of settlements. Camps are a form of settlement in which refugees or IDPs reside and can receive centralised protection, humanitarian assistance, and other services from host governments and other humanitarian actors. Good site planning has a positive effect on the health and wellbeing of a community. It also facilitates the equitable and efficient delivery of goods and services.

With this in mind, settlement plans should:

- Apply UNHCR Master Plan Approach to Settlement Planning Guiding Principles.
- Take into account national development plans to ensure that settlement plans are economically, socially and environmentally sustainable.
- Be people-centred, promoting self-reliance and enabling communities to develop suitable solutions themselves.
- Take into account the characteristics and identity of the area, of the environment, and of the people and their habitat.
Systematically apply an Age, Gender and Diversity (AGD) approach to ensure that all persons of concern have equal access to their rights, protection, services and resources, and are able to participate as active partners in the decisions that affect them.

Be dynamic. Settlement designs should be adaptable and capable of responding to changes in a crisis situation. They should foresee an exit strategy when persons of concern find durable solutions.

2. Main guidance

Protection objectives

- To plan and manage settlements in a manner that encourages affinities, and mitigates potential friction, between refugee and host populations.
- To locate camps at a reasonable distance from international borders and sensitive sites, such as military installations.
- To recognize, and encourage other actors to recognize, that every person, including every refugee, is entitled to move freely, in accordance with human rights and refugee law.
- To assist refugees to meet their essential needs and enjoy their economic and social rights with dignity, contributing to the country that hosts them and finding long term solutions for themselves.
- To ensure that all persons of concern enjoy their rights on equal footing and are able to participate in decisions that affect their lives. (AGD approach)
- To ensure that settlement and related policies and decisions are driven primarily by the best interests of refugees (rather than the interests of UNHCR or Government).

Underlying principles and standards

UNHCR Master Plan Approach to Settlement Planning Guiding Principles provide the framework for the definition of physical site layouts. The table below defines the guiding principles and expected outcomes.

<table>
<thead>
<tr>
<th>Guiding Principles</th>
<th>Expected Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principle 1</td>
<td></td>
</tr>
</tbody>
</table>
| National legislation, policies & plans provide a framework for settlement design. | - The spatial design of the settlement is in compliance with national and local planning regulations and emergency response minimum standards.  
- Infrastructure improvements are designed to support national/regional development plans and priorities. |
## Principle 2
Environmental considerations drive design.

- Risk of natural disaster impact (e.g. due to floods, landslides) is identified and addressed.
- Risk of endangering natural resources (e.g. deforestation which can, in turn, increase the risk of natural disaster impact) is identified and mitigated.

## Principle 3
Defining site carrying capacity.

- The capacity of the site has been defined taking into account sufficient access to water, fuel, and land for livelihoods.
- Risk of conflict between the displaced population and host community over access to natural resources is identified and mitigated.

## Principle 4
Decisions about density must be taken in context.

- Site density is in ‘harmony’ within the physical context.

## Principle 5
Supporting safe and equitable access to basic services.

- Equitable access to basic services for the displaced population and the host community is ensured.
- Development and upgrading of existing services facilities have been prioritized over the creation of new parallel services.
- Travel distance to basic services is within standards.

## Principle 6
Providing an enabling environment for livelihoods and economic inclusion.

- Site location and layout represent a positive choice in terms of impact to livelihood, economic opportunities and self-reliance of displaced population and host community.

## Principle 7
Addressing housing, land and property issues, an incremental tenure approach.

- Risk of conflict link to land tenure has been addressed and mitigated.
- Following the initial emergency response, actions are taken to increase the security of tenure for the displaced population through pathways for the incremental establishment of tenure through formal or customary means.

## Principle 8
Defining localized critical design drivers.

- Site layout is informed and respond to physical and social factors and the spatial needs over time.
- Residential areas, key services and infrastructures are not susceptible to the risk of natural hazards such as flash floods and landslides.
**Principle 9**
Follow natural contours in the design of road and drainage infrastructure.

- Site layout respond to the natural topography and drainage patterns of the site.
- An effort has been made to reduce construction and maintenance cost of road and drainage infrastructure.

**Principle 10**
Finalizing the settlement layout.

- Site layout takes into account the social organization of the displaced population under the bases of an Age, Gender, and Diversity approach.
- The physical layout considers fire risk mitigation strategies and complies with standards for the provision of basic service.

SPHERE emergency standards are the key references when designing planned settlements. The table below sets out minimum standards which should be upheld when planning camps.

<table>
<thead>
<tr>
<th>Description</th>
<th>Minimum Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered living area</td>
<td>3.5 sqm. per person minimum</td>
</tr>
<tr>
<td></td>
<td>In cold climates and urban areas more than 3.5 sqm. may be required (4.5 sqm. to 5.5 sqm. is more appropriate)</td>
</tr>
<tr>
<td></td>
<td>Minimum ceiling height of 2m at highest point</td>
</tr>
<tr>
<td>Camp settlement size</td>
<td>45 sqm. per person</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>30 m of a firebreak every 300 m</td>
</tr>
<tr>
<td></td>
<td>Minimum of 2 m between structures – ideally 2 times the height of the structure</td>
</tr>
<tr>
<td>Gradient for camp site</td>
<td>As a guide 1 to 5 %, ideally 2 to 4%</td>
</tr>
<tr>
<td>Drainage</td>
<td>Appropriate drainage needs to be put in place, especially relevant in all locations that experience a rainy season.</td>
</tr>
</tbody>
</table>
Table 1 - Minimum standard for planning camps

Refer to Entry on Camp planning standards (planned settlements) for more information on site selection and site planning standards.

Sites for planned camps should be selected in consultation with a range of sectors, including protection and supply, as well as with technical specialists such as hydrologists, surveyors, planners, engineers, and environmental engineers. Developing an inappropriate site or failing to develop a site to standards can result in further displacement causing unnecessary further loss and distress to persons of concern and may put some people/groups at further risk. The chart below lists some of the key critical factors which must be considered:

**Protection Risks**

Settlements and camps by their nature generate a number of specific risks as follows. Respect for planning standards can contribute to life with dignity in a safe and healthy environment for persons of concern.

- Prolonged stay can result in stress and tensions and can lead to social conflict and friction between families, clans or ethnic groups.
- High population density significantly increases health risks. Density is also proportionally related to increase in tensions and protection threats to vulnerable or marginalized individuals or groups.
- Environmental contamination may cause serious health problems for residents and those living in close proximity. Environmental damage especially related to water and sanitation is likely in the immediate vicinity of camps.
- High population concentrations and proximity to international borders may expose persons of concern to protection threats.
- Large camps may provide a hiding place and support base for persons other than refugees. It may be difficult to identify such people, who may continue to benefit from assistance.
- Camps can increase critical protection threats, including sexual and gender based violence (SGBV), threats to and abuse of children, and human trafficking.
- Living in camps can encourage dependency and reduce the ability of refugees to be independent and self-reliant.

**Other risks**

Camps are rarely occupied for short-term. Planners should always expect that once put in place, camps are likely to exist over a long period of time - in many cases years or even decades. Service provision over that period of time is likely to remain as the responsibility of humanitarian actors, and integration with local existing services will be challenging. Camps can also distort local economies and in the long run adversely affect development planning.
Key decision points

Settlement planning should start at the very early stages of preparedness planning. Preparedness measures in this phase should address shelter solutions and settlements, carefully taking into account of the specific context of the affected area, the host population, and adverse effects and dynamics generated by a developing crisis.

In addition to providing security, host governments are ultimately responsible for allocating land for camp and settlements. An overall site plan or map should detail the configuration of a proposed population settlement, its surroundings and characteristics, and location, and should set out principles of modular planning. The plan or map should include natural features and contain topographical information outlining the physical features of the landscape (rivers, valleys, mountains) and general planimetric information describing locations and facilities in the settlement. The plan or map should ideally have a metric scale between 1:1,000 and 1: 5,000. The plan/map should also provide social features including host communities, and the social organization of refugee populations.

Site planning should ensure that the spatial allocation of functions is such that refugees and displaced persons can reduce their dependence on aid, increase their independence, and potentially integrate fully with host communities. Whatever the circumstances, an overriding aim must be to avoid high density settlements. Ideally no camp should be larger than 20,000 people.

Coordination is a vital element of settlement planning, because it links land, shelter, services, infrastructure, livelihoods, environmental considerations, and governance. Many sectors need to cooperate to ensure that assistance gaps do not occur, and that the dignity of persons of concern is protected.

Local and International partners should be engaged whenever and soon as possible. UNHCR takes full operational responsibility only when circumstances require and it is in the interest of refugees.

Key steps

A planned camp settlement response should be implemented by means of the following steps.

- In consultation with Government identify a suitable site and carry out thorough suitability assessments.
- Form and train the team who will manage the project, ensuring continuity with the planning phase.
- Work with relevant programmes to identify implementing partners. Project partnership agreements (PPA) may be appropriate.
- Determine the need for working groups and coordination mechanisms with key stakeholders and establish them as early in the process as possible. Consider local guidelines, regulations and practices. Ensure that adequate and effective liaison arrangements are in place with local and national Government offices and other sectors.
- Develop proposals and concepts into working drawings, with specifications, bill of quantities (BoQ), tender documents, etc.
- Commission and produce environmental impact assessments and incorporate their recommendations in implementation plans.
- Conduct soil tests, hydrological surveys, detailed topographical surveys, etc.
- Draft and establish project management techniques, checklists and operating procedures.
- Work with other programmes and supply on procurement and award processes.
- Establish monitoring and evaluation frameworks for continuous monitoring.
- Establish reporting criteria and project tracking mechanisms.
- Develop and deliver completion and handover certification.
- Develop and deliver maintenance and exit plans.
- Refer to UNHCR’s Master Plan Approach Process Checklist

### Key management considerations

- Ensure that shelter and settlement programming sets safeguards in place to prevent any action from inadvertently increasing marginalization, vulnerability, exclusion and stigmatization that may put some people/groups at further risk.
- Camps can generate economies of scale relative to more dispersed settlements and services can be provided to a large population efficiently. Identification of and communication with persons of concern is easier in camps, as it is meeting immediate needs.
- Most refugee operations last longer than expected. Take this into account when selecting a site, planning the camp, and estimating resources and staffing. The footprint of early planning assumptions can endure for decades.
- Decisions on camp location should involve national and local Governments as well as host and refugee communities. Because decisions on site selection are difficult to reverse, seek and make use of technical support from the beginning.
- Adopt a ‘bottom up’ approach to planning, based on the characteristics and needs of individual families. Ensure that persons of concern have a voice in settlement planning and reflect their wishes as much as possible.
- Develop a comprehensive approach (‘master plan’) to camp layout, which promotes community ownership and maintenance of water points, latrines, showers, facilities for washing clothes, and waste management.
- An adequate supply of water throughout the year is vital. The settlement’s sanitation strategy should reflect the specific soil type at the site.
- Bear in mind that natural features of the site will reduce or affect the amount of usable space.
- Prepare an exit strategy and plans for decommissioning from the start.
- UNHCR neither rents nor purchases land for refugees.

### Resources and partnerships

Staff
A variety of (technical and non-technical) support staff may be needed depending on the scale and complexity of the settlement planned.

It is important to liaise closely with other sectors, including WASH, health, protection, and education, and with relevant programmes.

**Partners**

- Identify key partners, including Government, but also NGOs, other inter-governmental organisations and other humanitarian and private sector actors.
- Establish links with and consult representatives of the refugee community and host communities. Take steps to enable them to participate in decisions that concern them.

**Resources**

- Drawings, specifications, bill of quantities and tender documents will need to be commissioned, made accessible and filed securely.

**Annexes**

- UNHCR - Global strategy for settlement and shelter (2014-2018)
- UNHCR - Policy on alternatives to camps (UNHCR HCP 2014 9)

**3. Links**

- UNHCR Master Plan Approach to Settlement Planning Guiding Principles
- UNHCR Master Plan Approach to Settlement Planning Guiding Principles Annexes
- The Sphere Project - Humanitarian Charter and Minimum Standards in Humanitarian...
- UNHCR, emergency portals
- UNHCR, information management portal
- Camp management tool kit
- Global Shelter Cluster

**4. Main contacts**

Shelter and Settlement Section, Division of Programme Support and Management:
HQShelter@unhcr.org
Shelter solutions

Key points

- Shelter cannot be looked at in isolation; any response must consider the settlement or the context in which the households are sheltered.
- Preferred shelter solutions must be designed and engineered on the basis of context-specific structural and performance requirements.
- A shelter strategy should provide emergency shelter solutions initially (immediately after displacement) and more durable solutions over time.
- When displacement is protracted, a variety of shelter options should be considered.
- In short shelter design criteria should address hazard risks and safety, timeliness and construction speed, lifespan, size and shape, privacy, security and cultural appropriateness, ventilation and thermal comfort; environmental, considerations, cost, standards and building codes.
- Promote local construction.
- Transfer technology where required, to improve best practice and manage hazards. Seek technical support in areas of seismic risk and with strong winds.
- Involve host communities and persons of concern from an early stage.
- Favour shelter strategies that enhance integration and benefit the local economy.
- The development of an appropriate shelter response is a process and not simply the delivery of a product in this order of ideas it is important to bear this in mind to ensure social aspects and needs becomes also design drivers.

1. Overview

Refugees and others of concern to UNHCR have the right to adequate shelter - to protection from the elements, to a space in which they can live and store belongings, and to privacy, comfort and emotional security. A shelter is a habitable covered living space that provides a secure and healthy living environment with privacy and dignity in order to benefit from protection from the elements, space to live and store belongings as well as privacy, comfort and emotional support. Shelter programmes generally involve a mix of sheltering solutions such as kits, plastic sheeting, tents, and cash assistance. Shelter is likely to be one of the most important determinates 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 shelter needed, what materials and design to use, who constructs them and how long must they last will differ significantly in each situation. Where persons of concern are located will also impact the response; dense urban areas have specific characteristics and therefore the shelter solutions may differ from rural areas. 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. Shelter responses should be adapted to take account of the local context and climate, cultural practices and habits, local skills, and available construction materials.

Seldom does one shelter solution fit all the needs of displaced populations. It is best practice to provide, to the extent possible a palette of options which may include cash assistance, rental support, construction materials, transitional shelter, shelter kits, plastic sheeting, tents, etc.

The table below summarizes the various settlement options with their most commonly associated shelter solutions:

<table>
<thead>
<tr>
<th>Settlement</th>
<th>Most frequently used Shelter Solutions</th>
</tr>
</thead>
</table>
| Planned and managed camps                        | • Tents  
  • Shelter kit  
  • Plastic sheeting  
  • Transitional/Temporary shelters  
  • Local construction materials                                                                 |
| Hosting villages                                 | Shared accommodation or shared property                                                                |
|                                                 | • Plastic sheeting  
  • Shelter kit  
  • Local construction (one room)  
  • Cash assistance                                                                                   |
| Dispersed self-settlement without legal status   | • Tents  
  • Plastic sheeting  
  • Shelter kit  
  • Cash assistance                                                                                   |
| Short-term land, house, apartment, or room tenant| Individual or shared accommodation                                                                     |
|                                                 | • Cash assistance  
  • Plastic sheeting  
  • Shelter kit  
  • Local construction                                                                                   |
2. Main guidance

Protection objectives

- To provide a secure and healthy living environment with privacy and dignity to persons of concern.
- To protect persons of concern from a range of risks, including eviction, exploitation and abuse, overcrowding, poor access to services, and unhygienic living conditions.
- To support self-reliance, allowing persons of concern to live constructive and dignified lives.
- To recognize, and encourage other actors to recognize, that every person, including every refugee, is entitled to move freely, in accordance with human rights and refugee law.
- To assist refugees to meet their essential needs and enjoy their economic and social rights with dignity, contributing to the country that hosts them and finding long term solutions for themselves.
- To ensure that all persons of concern enjoy their rights on equal footing and are able to participate in decisions that affect their lives. (AGD approach)
- To ensure that settlement and related policies and decisions are driven primarily by the best interests of refugees.

Underlying principles and standards

- Shelter assistance should prioritize groups with specific needs, including women (in particular female-headed households), children, older people, and persons with disabilities. Criteria have been developed to help identify those most in need of assistance.
- Displaced populations should be empowered to build their own shelters with the necessary organizational and material support and to participate in all phases of the shelter programme.
- Shelter solutions should be cost effective, use local materials to the extent possible, and adequately reflect cultural preferences and traditional lifestyle of persons of concern.
- Shelter solutions should have the least possible impact on the natural environment. Careful consideration should be given to the sourcing of local materials to prevent environmental damage. Shelters should provide covered living space that is sufficient to allow a household to carry out essential household and livelihood activities (including space to cook, sleep, and store belongings)
- Designs should take into account: climate, topography, hazards and environmental risks, national and international minimum standards, livelihoods, and the local availability of resources, including materials, skills and infrastructure.
To ensure "a life in dignity", SPHERE Standards and UNHCR Global Strategy for Settlement and Shelter 2014-2018 provide practical advice on how best to design a different types of shelters and uphold the rights of displaced persons.

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

- Minimum 3.5m² covered living space per person in tropical or warm climates, excluding cooking facilities or kitchen. (it is assumed that cooking will take place outside. Minimum height of 2m at the highest point

- Minimum 4.5m² to 5.5m² covered living space per person in cold climates including kitchen and bathing facilities, as more time will be spent inside the shelter (cooking, eating, and livelihoods). 2m ceilings to reduce the heated space

The design of shelter should, if possible, provide for modification by its occupants to suit their individual needs.

**Protection Risks**

The right to adequate housing was first recognized with Article 25 (1) of the Universal Declaration of Human Rights. The principle: ‘Everyone has the right to adequate housing’ is applicable in all stages of the displacement cycle prior to, during and after displacement, and is relevant to all people of concern, including women, girls, men, and boys. Adequacy of housing includes security of tenure, availability of services, materials, facilities and infrastructure, affordability, habitability, accessibility, location, and cultural adequacy.

- Displaced unaccompanied children, particularly child-headed households, are particularly exposed to protection risks due to a lack of appropriate shelter, including trafficking and various forms of violence, abuse or exploitation.
- Persons can be at greater risk of harassment, assault or exploitation if they live in shelters without proper walls, partitioning or the possibility to lock the shelter doors.
- Unaccompanied older persons might have difficulties constructing their own shelters or might need to share shelter with others. Unless they receive targeted support, they can find themselves in a precarious and undignified situation of dependency. Older persons heading households and/or caring for children have specific needs requiring targeted support.
- Persons with disabilities also need to receive specific attention, and shelter must be adjusted to their specific needs.
- During conflict, ethnic or religious minority groups might be unwelcomed among the host
population or within the displaced population itself and, consequently, may experience difficulty finding shelter.

Other risks

- Shelter solutions should take into consideration hazards in the area such as earthquakes, floods, landslides and other. In dispersed settlement and spontaneous camps persons of concern may find accommodation in high risk areas and informal settlements which are hazard prone.
- Conflict may arise with the host community if the presence of refugees increases strain in local services and makes access to resources such as water more difficult.

Key decision points

Shelter solutions must provide protection from the elements, privacy, emotional security and a space to live and store belongings in a dignified manner. They should be culturally and socially appropriate and familiar. Suitable local materials are best, if available, and shelters must be able to cope with changes of season. Whenever possible, persons of concern should build their own shelters, with appropriate technical, organisational and material support. This helps to ensure that dwellings meet their users' particular needs, generates a sense of ownership and self-reliance, and reduces costs and construction time.

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.

Emergency shelter needs are best met by using materials and designs that persons of concern or the local population would normally use. Emergency shelter materials should not be imported unless adequate local materials cannot be obtained quickly or in an environmentally responsible manner. The simplest structures, and labour-intensive building methods, are preferable.

The UNHCR family tent may be considered, for example, when local materials are either not available at all or are only seasonally available. The UNHCR family tents are also used to save life during the onset emergencies with high volume displacement and when local construction cannot meet immediate shelter needs. The life-span of an erected canvas tent depends on the length of storage before deployment, as well as the climate and the care given by its occupants. Where tents are used for long duration, provisions for repair materials should be considered. In general, tents are difficult to heat as walls and roof provide limited insulation and can be an expensive item if not in stock (airlifting cost). However, UNHCR has developed a winterization kits for the family tent for cold climate.

The design of shelters 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 may remain inside their shelter throughout the day, thus more space will be required. Where there are daily extremes of temperatures, lack of adequate shelter and clothing can have a major adverse effect
on protection and well-being of refugees, including health and nutritional status. It is likely that any operation will require a combination of approaches to meet the needs of the displaced population. Deciding which options to provide will be a key determinant in the quality of life persons of concern are able to achieve during their displacement. The following table provide some guidance on the advantages and disadvantages of several types of shelter solutions.

<table>
<thead>
<tr>
<th>Shelter Solution</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family tents</td>
<td>Traditional relief tent; lightweight; proven design; good headroom; can be winterised; large production capacities</td>
<td>Canvas rots; inflexible; draughty; may be unstable in high winds or heavy snow, difficult to heat. Where tents are used for long duration, provisions for repair materials should be considered.</td>
</tr>
<tr>
<td>Plastic sheeting</td>
<td>Most important shelter component in many relief operations; UV-resistant; heavy duty; lightweight, flexible; large production capacities</td>
<td>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.</td>
</tr>
<tr>
<td>Materials and tools for construction (shelter kits)</td>
<td>Suitable local materials are best, if available, and must be suitable for variance in the seasons, culturally and socially appropriate and familiar</td>
<td>Required time and training</td>
</tr>
<tr>
<td>Prefabricated shelter and containers</td>
<td>Permanent or semi-permanent structures; easy to maintain; long lasting; valuable reusable materials</td>
<td>High unit cost; long shipping time; long production time; transport challenges; assembly challenges; inflexibility; disregard cultural and social norms; difficult to cool.</td>
</tr>
<tr>
<td>Rental subsidies</td>
<td>Greater sense of independence; greater integration in a community; influx of income to host community</td>
<td>Difficult to monitor that shelter meets standards; competitive market may result in exploitation and abuse; inflation and speculation may occur; upgrades or repairs may be needed</td>
</tr>
</tbody>
</table>
**Key steps**

- An initial rapid shelter and settlement assessment should be carried out within the first three days of an emergency, to identify needs and resources. Commission a multi-sectoral teams to make sure that all issues are taken into account. Use the findings to design and organize more in depth needs assessments as needed.
- Based on the assessment prioritize life saving activities and priorities, and anticipate medium and long term shelter needs.
- Identify the range of shelter solutions that are preferred by, and that can be made available to persons of concern.
- Develop a shelter and settlement strategy.
- Assess supply and logistical requirements and constraints; put in place arrangements to address them.
- Monitor the impact and effectiveness of programmes over time.

**Key management considerations**

- Integrate settlement strategies and potential layouts in preparedness planning processes.
- Ensure shelter programmes have sectors strategies.
- Ensure systematic deployment of senior settlement and shelter experts at the onset of emergencies.
- If access is limited, gather essential information from local authorities, NGOs and local civil society organisations, or secondary sources and technology.
- Develop information strategies to increase the community's involvement in and ownership of shelter planning and maintenance.
- As you develop a shelter response plan, consult and involve local and national authorities, and persons of concern.
- To reduce the risk of conflicts over land, collaborate closely from the start with local authorities' technical departments, and inform yourself of local rules and regulations on land tenure, public works and housing.
- Establish and apply quality assurance measures. These may include training in best practices to build capacity.
- Identify natural hazards (such as flooding, landslides, strong winds). If there are seismic risks, seek specialized technical advice even for the design of a simple shelter.
- Coordinate and liaise with complementary sectors, including water and sanitation and livelihoods, to ensure solutions are integrated.

**Resources and partnerships**

- Persons of concern.
- Local or central government authorities
- Community and religious leaders
- Host community
- National and international NGOs
- IFRC and ICRC
Other UN and international organizations
National (particularly local language) and international news media

Annexes


Shelter Design Catalogue January 2016

Family Tent

New Self Standing Tent

Refugee Housing Unit Fact Sheet

Shelter Strategy Standard Format

Shelter and Settlement Preparedness and Response Checklist

Sphere Handbook (2018)

3. Links

UNHCR Intranet: Shelter and Settlement UNHCR Handbook for the Protection of Women and Girls

4. Main contacts

Shelter and Settlement Section (SSS) – Division of Programme Support and Management (DPSM) HQShelter@unhcr.org
Emergency shelter standard

30 October 2019

Key points

- Ensure minimum standards of covered living space per person are respected.
- Shelter solutions should be adapted to the geographical context, the climate, the cultural practice and habits, and the local availability of skills as well as accessibility to adequate construction materials in any given country.
- The provision of core relief items is inherently linked to the adequacy of settlement and shelter. Core relief items may include shelter-related materials, as well as other domestic items.
- Consider the life span of shelter materials as they deteriorate with time. Further to the initial distribution, replacement, reinforcement or maintenance may be required.
- Individual family shelter should always be preferred to communal accommodation as it provides the necessary privacy, psychological comfort, and emotional safety.
- Whenever possible, persons of concern should be empowered to build their own shelters, promoting a sense of ownership and self-reliance.

1. Overview

This section will provide guidance on the expected standards when providing emergency shelter. A shelter is defined as a habitable covered living space providing a secure and healthy living environment with privacy and dignity. Persons of concern to UNHCR have the right to adequate shelter in order to benefit from protection from the elements, space to live and store belongings as well as privacy, comfort and emotional security.

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.

Emergency shelter needs are best met by using the same locally available, sustainably sourced materials and construction methods as would be normally used by the refugees themselves or the local hosting 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. That said, plastic sheeting has become the most important shelter component in many humanitarian response operations often in combination with rigid materials, as they offer flexibility and can be used in a variety of ways in both urban and rural settings.

Regardless of the type of emergency shelter used the following principles generally apply:

- Shelters must provide protection from the elements, space to live and store belongings, privacy and emotional security.
- Blankets, mats, and tarpaulin must be provided as needed.
- Refugee shelter should be culturally and socially appropriate and familiar where possible. Suitable local materials are best, if available.
- Shelter must be adequate regardless of seasonal weather patterns, if not it should be adapted accordingly.
- Wherever possible, persons of concern should be empowered to build their own shelter, with the necessary 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.

Each type of emergency shelter has advantages and disadvantages depending on the context in which it is used. Consider the following points when deciding on the emergency shelter or combination of shelter types to be used in any given response:

<table>
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<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
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<td>Permanent or semi-permanent structures; long lasting.</td>
<td>High unit cost; long shipping time; long production time; transport challenges; assembly challenges; inflexibility; disregard cultural and social norms.</td>
</tr>
<tr>
<td>Rental subsidies</td>
<td>Greater sense of independence; greater integration in a community; influx of income to host community.</td>
<td>Difficult to monitor that shelter meets standards; competitive market may result in exploitation and abuse; inflation and speculation may occur; upgrades or repairs may be needed.</td>
</tr>
</tbody>
</table>

## 2. Main guidance

### Emergency standard

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

- Minimum 3.5m² covered living space per person in tropical or warm climates, excluding cooking facilities or kitchen (it is assumed that cooking will take place outside).
- Minimum height of 2m at the highest point.
- Minimum 4.5m² to 5.5m² covered living space per person in cold climates, including kitchen facilities as more time will be spent inside the shelter (cooking, eating, and livelihoods). 2m ceilings to reduce the heated space.
The design of shelter should, if possible, provide for modification by its occupants to suit their individual needs.

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

- Structural stability (to withstand snow- and wind-loads)
- Wind protection of walls, roofs, doors and windows
- Protected and heated kitchens and sanitary facilities
- Provision for heating.

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

**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.

**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.

**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 m2 in most cold areas. When the stove for heating is used for cooking as well, particular attention should be given to its stability.

**Longer-term standard**

The SPHERE standards (2018) referenced above remain the minimum internationally recognised quantifiable standards applicable throughout all operational phases. Nevertheless, it must be emphasized that these remain minimum standards and that it is imperative to consider the next stages of the sheltering process as early as possible in the response. An approach that is able to breach the division between emergency, temporary, and permanent shelter and that links relief,
rehabilitation and development should be sought.

While it may be difficult during an emergency to look beyond the provision of life saving shelter support, it is imperative to keep in mind that persons of concern should be supported to reach durable solutions. Within and beyond the emergency phase shelter solutions should be adapted and contextualized according to the following elements:

- geographical context
- climate
- cultural practice and habits
- local availability of skills
- access to adequate construction materials

Standards to be applied to temporary and/or permanent shelters will be depend on the context in which they are applied and will be commonly defined by shelter partners and in close coordination with government authorities and development partners.

Annexes

Sphere Handbook (2018)

3. Links

UNHCR Emergency Information Management Toolkit – Shelter and Settlement UNHCR,
Settlement Information Portal (SIP) UNHCR, Global strategy for settlement and shelter 2014-2018
Approach to Settlement Planning Global Shelter Cluster UNHCR, Shelter design catalogue The Sphere Project, Humanitarian Charter and Minimum Standards in Humanitarian ...

4. Main contacts

Shelter and Settlement Section (HOShelter@unhcr.org)

Spontaneous settlement strategy guidance

30 October 2019

Key points
Although they may seem chaotic, there may be some reason for why groups have settled in certain locations that may not be immediately apparent, such as division by area of origin or along ethnic lines. It is better to discuss these reasons with the concerned individuals to find a solution rather than forcing people to move.

- The location for a refugee camp and its planning significantly impacts on protection and access to assistance.

- As a priority it should be determined whether or not a spontaneous camp is the most appropriate settlement option for the displaced population

- When addressing an existing settlement, UNHCR should engage in advocacy and plan its operational response in such a way which enables phasing them out as early as possible or facilitating a transition to more integrated and sustainable settlement solution

- Spontaneous settlements should respect minimum international standards and best practice.

- Ensure phase-out, exit and camp closure is considered and planned from the start.

1. Overview

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 collective centres, or organized camps. It is of upmost importance to identify the most suitable option or combination of options for accommodating persons of concern appropriate to the context in which displacement is taking place.

Camps are a form of settlement in which refugees or IDPs reside and receive centralised protection, humanitarian assistance, and other services from host governments and humanitarian actors.

These settlements can be planned and developed on land allocated by the Government, or created spontaneously when persons of concern settle on land which has not been designated to accommodate them. Spontaneous settlements are formed by persons of concern without adequate planning and permissions in order to meet immediate needs. Aside from creating an unfriendly environment, the provision of services may become cumbersome and costly.

Spontaneous settlements occur when displaced groups of people populate areas without assistance or guidance from local government or the humanitarian community. Such settlements are located on land the displaced population does not officially have the right to occupy.

A camp's location, size, design and duration are context-specific. The location of a camp its layout and available services significantly impact on protection and access to assistance. Initial
site selection has an impact on decisions throughout the camp life-cycle. Ideally, UNHCR and partners should be involved in site selection and planning of all camps; however, in reality a large number of camps are settled spontaneously before support is available.

Generally, spontaneous camps have more disadvantages than advantages. Re-designing the camp would be necessary (where resources are available) as may be re-location as early as possible, to a well-identified site; especially if there is conflict with local community. The layout, infrastructure and shelter of a camp will have a major influence on the safety and well-being of its residents.

## 2. Main guidance

### Context characteristics and risks associated

As a priority it should be determined whether or not a camp is the most appropriate settlement option for the displaced population. Camps are a last resort, and should be established only when other solutions are not available. If some displaced persons are lodging with host families or have self-settled within local communities that share cultural ties with them for example, consider these options and determine if these alternatives are more appropriate.

Spontaneous camps are often situated on poor and possibly hazardous sites, or situated close to areas of insecurity. Immediately assess whether the camp should be supported in situ, relocated or if the population of concern should be moved to other settlements such as a planned camp or a collective centre. This process and the solution adopted generally require political and economic motivations as well as technical and social aspects.

Spontaneous camps are often very densely populated and arranged with little consideration to communal facilities and infrastructure. They generally require phased upgrading in order to meet international standards and local and international good practices, including introducing fire-breaks, surface water drainage and infrastructure such as schools, distribution centres, water supplies and recreational areas.

It is also important to determine who has the right to the land (HLP concerns) where the self-settled camp is located and to understand what arrangements, if any, have been put in place to use that land. The permission to settle on these sites is usually informal, often an ad hoc agreement with host community, and requires reconsideration or negotiation with authorities or private landowners.

### Context-specific protection objectives

- To provide a secure and healthy living environment with privacy and dignity to persons of concern
- To protect persons of concern from a range of risks, including eviction, exploitation and abuse, overcrowding, poor access to services, and unhygienic living conditions.
To support self-reliance, allowing persons of concern to live constructive and dignified lives.

Urgent consideration should be given to relocation if the site has been judged to be unsatisfactory. Relocation should be done in coordination with the local authorities and government. The difficulty in moving refugees from an unsuitable site increases markedly with time. Even if those already there cannot be moved, divert new arrivals elsewhere.

Conflict, violence and persecution continue to cause large-scale displacement in many parts of the world. To provide international protection, and ensure that the rights and dignity of persons of concern are respected, UNHCR must act in a variety of ways, which include the provision of adequate shelter and settlement. When developing an operational response, the following key protection issues should be considered:

- Ethnicity and culture. Close ethnic and cultural affinities between refugees and their host communities should be identified at an early stage. Settlement planning and responses should aim to mitigate friction and reduce potential tensions between refugee and host communities and reduce other security risks.
- Proximity to borders. To ensure security and protection of refugees, camps should be located at a reasonable distance from international borders and other sensitive areas (such as military installations).
- Freedom of movement. International human rights law and refugee law recognize the rights of every individual, including refugees, to move freely. UNHCR encourages every State to respect refugees’ freedom of movement and encourages States that have reservations to lift them.
- Self-reliance. Refugees wish to cater for their essential needs and enjoy their economic and social rights, sustainably and with dignity. UNHCR encourages States to help refugees become self-reliant, enabling them to contribute to their host country and find long term solutions for themselves.
- Best interest of refugees. Settlements policy and decisions should be driven primarily by the best interest of refugees.
- **Age, gender and diversity.** Policies and programmes systematically apply an **Age, Gender and Diversity** (AGD) approach to ensure that all persons of concern have equal access to their rights, protection, services and resources, and are able to participate as active partners in the decisions that affect them.

**Principles and policy considerations for the emergency response strategy in this context**

The particular way settlements are planned and designed can impact the community cohesion. Good settlement planning can also allow for more efficient and affordable access to basic
services, mitigate risks (such as flooding or outbreak of diseases), and enhance living environments; allowing families to enjoy a better quality of life.

Before considering the upgrading of a spontaneous settlement, determine if it is possible to pursue alternatives which can ultimately be more sustainable and cost-effective, they harness the potential of refugees, rationalize service delivery or allow for more targeted assistance to those most in need.

The layout and organization of a spontaneous settlement often reflects the priorities and preferences of persons of concern and should be taken into consideration when upgrading a site or relocating its residents.

If the refugees have spontaneously settled in a scattered manner, they should not be brought together unless there are compelling reasons for breaking their present settlement pattern.

When addressing an existing settlement, UNHCR should engage in advocacy and plan its operational response in such a way which enables phasing them out as early as possible or facilitating a transition to more integrated and sustainable settlement solution.

Spontaneous settlements should respect minimum standards. See entries on Site Planning for camps and Camp planning standards (planned settlements) of this handbook.

**Priority operational delivery mode and responses in this context**

Determine if the spontaneously settled site is viable and should be upgraded. See entry on Camp planning standards (planned settlements) of this handbook.

Determine the need to negotiate existing agreements to occupy the land. UNHCR neither rents nor purchases land for refugees.

Residents make investments to adapt the sites when they settle. Consider and be sensitive to their investment (financial or social) when discussing upgrading plans.

Residents must participate meaningfully in all decisions that affect their current and future accommodation.

Once the decision has been made to upgrade the spontaneous camp, follow the principles, standards and indicators detailed in entries on camp strategy guidance (planned settlements) and on site planning for camps.

**Priority actors and partners in this context**

- Consult with relevant authorities, implementing partners and the affected population at all
phases of camp development.
- Consult with spontaneous camp residents and host community prior to making any decisions on upgrading the settlement or arranging relocation.
- Ensure common agreements with humanitarian stakeholders, international donors.
- Establish an immediate link and collaborate with local authorities' technical departments, and study local rules and regulations about land tenure, public works and housing to reduce risk of conflict over land and to ensure compliance to local building regulations.
- Technical staff both shelter and other relevant sectors e.g. WASH

Annexes

UNHCR’s Global Shelter and Settlement Strategy, 2014-2018

UNHCR Policy on alternatives to camps

Sphere Handbook (2018)

3. Links

UNHCR Intranet: Shelter and Settlement

Shelter Cluster UNHCR’s information management portal


UNHCR, Settlement information portal (SIP) Camp management tool kit

UNHCR Emergency Portals

4. Main contacts

Shelter and settlement section, Division of Programme Support and Management. At: HQShelter@unhcr.org.

Rental accommodation strategy considerations

18 May 2020

Key points

- Ensure rented accommodation meets standards.
- Support an increase and/or upgrade of rental stock.
- Support livelihood activities that will increase persons of concern's self-reliance. Minimize
the impact of speculation on the rental market.

- Ensure that tenancy agreements protect tenants from discrimination, abuse and exploitation and forced eviction.

- Consider the protection situation in the area of displacement, including security conditions and specific needs and risks, such as child protection and SGBV.

- Consider the national and local economy and the opportunities for persons of concern to become self-reliant, build sustainable livelihoods and contribute to the community. Consider how the influx will impact the host populations' ability to access livelihoods or services.

### 1. Overview

Rental accommodation is a settlement option that is more commonly used in urban settings. It is most feasible when displaced populations have the necessary resources available (funds, in-kind, etc.), and the host community has appropriate accommodation to rent.

When possible, displaced people may seek refuge in familiar areas where friends or relatives may be established and can provide informal support. Others prioritize economic opportunity when they decide where to settle.

Enabling refugees to reside in communities lawfully, peacefully and without harassment, whether in urban or in rural areas, supports their ability to take responsibility for their lives and for their families and communities.

Humanitarian support for this settlement option usually focuses on ensuring that rented accommodation is adequate and affordable. It needs to be affordable so that more households can obtain rented shelter; it should be adequate in terms of standards and quality. Strengthened protection outreach and monitoring will be required as with any alternative to camp approach.

### 2. Main guidance

**Context characteristics and risks associated**

To rent, an affected household needs to be able to acquire a short-term lease on a rural or urban property. Rent may be paid in cash or in-kind.

Conflicts and natural disaster often reduce the availability of land, housing or apartments to rent and households that are impoverished by conflicts and natural disasters are often unable to pay rent.
In a competitive market, persons of concern may be at risk of discrimination and exploitation by unscrupulous land lords. Frequently they do not have enough money for a deposit or lack necessary references. Regulations requiring proof of residence or citizenship may restrict their access to formal tenancy arrangements. Rental agreements may not be formal or enforced, leaving persons of concern lacking security of tenure and vulnerable to abuse.

Rent inflation and speculation may occur if the demand for rented property is high. Rental accommodation that is available and affordable is often substandard. It may take a long time to reach agreement with Government, local authorities, or property owners on the use of available land or property.

**Context-specific protection objectives**

- To provide safe and healthy living environment for persons of concern.
- To protect persons of concern from a range of risks, including eviction, exploitation and abuse, overcrowding, poor access to services, and unhygienic living conditions. To support self-reliance, allowing persons of concern to live constructive and dignified lives.

**Principles and policy considerations for the emergency response strategy in this context**

It is important to understand the opportunities and constraints for host populations who accommodate displaced populations in their dwellings or on their land. Income may be generated by renting a house or land to displaced people who want to settle. If the property rights of smallholders are protected, they are more likely to invest in the land and other productive assets.

Host governments may be reluctant to support rental accommodation as an alternative to camps for security reasons or concerns that refugees will compete with nationals for limited economic opportunities and scarce resources such as water or land. Host governments may also consider that allowing refugees to settle in communities and participate in the economy makes it less likely that they will return home in the future. A thorough analysis of the national laws, policies and practices in relation to the protection of refugees, including restrictions on the exercise of rights and freedoms should be conducted.

Shelter and housing programmes should also analyse the socio economic environment of residential areas to determine affordability and availability of rental accommodation.

Adequate accommodation in sufficient numbers may not be available from the outset. Upgrades or repairs to rental units may be needed and this may not happen quickly enough to respond to shelter needs early in the response. Consult relevant authorities, partners and persons of concern in order to establish a fair and coherent level of rent and rent support that will not disrupt the local rental market.
From the start, collaborate closely with the technical offices of local authorities, and study local rules and regulations concerning land tenure, public works and housing, in order to reduce the risk of conflicts over land and ensure compliance with local building regulations.

**Priority operational delivery mode and responses in this context**

- Explore cash support options to help refugees pay for rental accommodation.
- Technically assess the quality of rental accommodation to make sure it meets minimum standards.
- Facilitate access to basic services, including water, sanitation, health and education.
- When necessary and appropriate, support the upgrades of repairs to ensure that rental accommodation meets standards.
- Analyse the [Housing, Land and Property](#) (HLP) environment, laws and their enforcement, and identify practices that may render persons of concern in a position of vulnerability to discrimination, exploitation or abuse.
- Shelter assessments can include an analysis of the rental market, especially in urban displacements. This assessment should include and analysis of available rental stock, prices, conditions and needed rehabilitation, access to basic facilities, legal and protection issues, etc.

**Priority actors and partners in this context**

- Local or central Government authorities.
- Community and religious leaders.
- Host communities.
- National and international NGOs.
- IFRC and ICRC.
- Other UN and international organizations.
- National (particularly local language) and international news media.

**Annexes**

- UNHCR, Global Strategy for Settlement and Shelter 2014-2018
- Sphere Project, the Humanitarian Charter and Minimum Standards in Disaster Response, (2011). Shelter Centre, Shelter after disaster
- UN Habitat, Rental Housing. An essential option for the urban poor in developing countries
- World Bank, Open Knowledge Repository, Safer homes, stronger communities
- UNHCR- Policy on alternatives to camps (UNHCR-HCP-2014-9)
Community based hosting arrangements

18 May 2019

Key points

- The first step towards supporting host families and persons of concern is to identify their needs and where they live. Consider both persons of concern and host families.

- Consult and coordinate closely with host communities, persons of concern, local authorities, NGOs, and relevant UN agencies.

- Assess the absorption capacity of host communities. Make sure that hosting arrangements will not cause harm to persons of concern or host communities.

- Assess vulnerability (in terms of income, security of tenure, and special needs) and set criteria of eligibility for the hosting programme.

- Prepare a comprehensive strategy; set out in detail the arrangements for the hosting programmes; update the arrangements as circumstances evolve.

1. Overview

The term ‘hosting arrangement' describes how persons of concern are sheltered in host communities. Persons of concern may settle with and amongst local households, on land or in properties that local people own. Hosts may be relatives, distant family members, friends or acquaintances, or people previously unknown to those who have been displaced. Hosting arrangements can exist in urban and rural contexts.
Hosting arrangements can be positive; persons of concern can settle with families with which they share cultural ties; increase solidarity and collaboration between refugee and local population; persons of concern have a greater say in where and with whom to live; there is a greater sense of self-reliance when persons of concern make arrangement for themselves.

As with all other settlement types hosting arrangements do not meet the needs of all the displaced population. One solution does not fit all. Hosting arrangements are rarely sustainable with overcrowding conditions and insufficient resources for all, straining the relationship between host and displaced families.

In hosting arrangements different shelter support can be provided:
Shelter materials provided to build an extension or additional structure in the host's property:

- Plastic sheeting (combined with other locally procured materials).
- Shelter kit.
- Local construction (one room)
- Cash or voucher based intervention.

Landlord-renter relationship:

- Cash based intervention
- Rental subsidies.

Whenever possible, some level of support should be provided to the host community. Both groups often have similar needs (water, food, sanitation, etc.). It is important to ensure that scarce resources available to the host community are not depleted.

2. Main guidance

Context characteristics and risks associated

Whether in urban or rural context often a combination of approaches is needed; hosting arrangement can be an appropriate temporary solution. Host population may have limited resources; often already living below the poverty line. Absorption capacity will be limited and competition for resources is often fierce in urban areas.

Risk associated with hosting arrangement are primarily driven by overcrowding, lack of privacy, limited resources, lack of trust, discrimination, tenure insecurity. Specifically:

- In protracted situations, deteriorating living conditions of families hosting large number of persons might lead to health and psychosocial problems, as well as risks of stigmatization, harassment, economic or sexual exploitation, and violence against the displaced families.
- Housing may already be substandard; host families may be in need of improved shelter.
Inadequate housing can forced families to live in overcrowded conditions, or to separate. Children may be sent to live with other neighbours, increasing the potential for exposure to neglect and abuse.

- Host families may have limited resources and basic domestic items, mattresses, mats, blankets, cooking utensils, etc. would have to be shared. A situation that can rapidly erode hospitality.
- In areas where refugees are not welcome, both host and displaced families might become targets of retaliation by parties to the conflict or by surrounding communities.
- Persons of concern may be accused and blamed for neighbourhoods' problems such as conflict between families, criminal acts – often despite lack of evidence, thefts, etc. Verbal abuse or accusations can become physical abuse, and persons of concern may not receive protection from the authorities.
- In urban environments the economy is primarily cash based; agriculture is non-existent; water points require payment. Access to food, water, and other necessities will come at a cost, which may force persons of concern to adopt negative coping mechanisms.
- Displaced children in urban areas face great risks. Lack of access to education can be caused by lack of resources, fear of the local community, or the need for children to complement household income. Lack of parental supervision and access to schools, and the overall poverty can lead girls and boys to try and fend for themselves and exposing them to child labour, sex work and theft. For girls especially the risks of early sex, exploitative sex and sex work is greater in cities and towns.
- Host families can become overburdened by the responsibility of caring for persons of concern, and eventually it may create conflict. To reduce this risk, every effort should be made to work closely with the community, local government and NGOs when programmes are designed and implemented, and to support displaced families in hosting arrangements in order to lessen the burden on the host family.

**Context-specific protection objectives**

- To provide a secure and healthy living environment with privacy and dignity to persons of concern.
- To protect persons of concern from a range of risks, including eviction, exploitation and abuse, overcrowding, and poor access to services. Threat of eviction is greater and often constant in urban areas when persons of concern settle in land and property without permission (dispersed settlement without legal status)
- To support self-reliance, allowing persons of concern to live constructive and dignified lives.
- To recognize, and encourage other actors to recognize, that every person, including every refugee, is entitled to move freely, in accordance with human rights and refugee law.
- To assist refugees to meet their essential needs and enjoy their economic and social rights with dignity, contributing to the country that hosts them and finding long term solutions for themselves.
- To ensure that all persons of concern enjoy their rights on equal footing and are able to participate in decisions that affect their lives. (AGD approach)
Principles and policy considerations for the emergency response strategy in this context

- Inclusive and meaningful participation of all persons of concern in accordance with UNHCR's Age, Gender and Diversity approach, is essential to ensure that men, women, girls and boys have their voice heard, identify their needs, and have the opportunity to contribute to the search of adequate solutions.
- Durable solutions are the ultimate goal, taking into consideration appropriate technology, capacity-building of both refugees and local communities, and use of local skills, materials, techniques and knowledge.
- Refugees and the affected population should be empowered to participate actively in decisions that concern them at all stages. An inclusive approach fosters ownership and acceptance of programmes and improves maintenance of shelters and settlements. It facilitates communication and can generate information and support that may be crucial to a programme's success and sustainability.
- Shelter solutions should be appropriate to the context in which they are provided. They should reflect the needs of the affected population, their cultural habits and their capacities, but should also attempt to build on existing resources and enhance access to infrastructure.

Priority operational delivery mode and responses in this context

Identify host communities, engage with them, and assess their absorption capacity

Identify host communities that might be able to accommodate persons of concern; assess their absorption capacity. Map the location of persons of concern and potential host communities.

Consult host communities and persons of concern; include representatives from relevant UN agencies, local Government and partner organisations.

Assess the most pressing needs of persons of concern and host communities

Itemize and assess local resources and coping mechanisms. Decide what UNHCR support is necessary to make the hosting arrangement feasible and successful. Prioritize the most in need of support people, but make clear what criteria have been used.

Establish the profiles of persons of concern and host communities. Assess the resources available to both groups (water, sanitation, health facilities, schools, livelihoods) and locally available materials that might be of value to persons of concern and hosts.

Make sure that issues of security of tenure are addressed to the satisfaction of host communities and persons of concern; cross check the arrangements with local authorities.
Agree the assistance model and implement

Drawing on your analysis (the first two steps), agree with partners the most appropriate shelter solution (shelter kits, cash, etc.). Prepare a clear plan with goals and outcomes, attribute roles and responsibilities, and set a timeline and budget.

Select program participants by applying the agreed targeting criteria. Agree who owns shelters or materials that are distributed by the programme; do so before distribution starts. If possible, arrive at a legal agreement.

Monitoring and evaluation

Put in place a monitoring mechanism and agree standards and indicators that you and other local actors will use to monitor and evaluate the programme's outcomes. Ensure they are in accordance with national and international standards (Sphere Project).

Ensure that assessments made at the start of the programme are used as a baseline.

Monitor the quantity and frequency of all material or financial distributions, the procurement of goods, and the implementation against timeline and budget.

Put in place mechanisms to ensure accountability to program participants at all stages, including communicating goals and progress, collecting, responding and adapting to feedback.

Priority actors and partners in this context

Consult relevant national authorities, operational partners (UN, NGOs, and community organizations), the host community, and the population of concern in all phases of programme development. If strategic decisions require high-level advocacy, consult partners, including UN agencies, NGOs and donor representatives, as appropriate.

From the start of a response, collaborate closely with the technical offices of local authorities, and study local rules and regulations with respect to land tenure, public works and housing. To reduce the risk of conflict over land, ensure the programme complies with local building regulations.

Annexes

UNHCR Global Strategy for Settlement and Shelter 2014-2018

UNHCR, UNHCR policy on alternatives to camps, 2014
3. Links


4. Main contacts

Contact the Shelter and Settlement Section, Division of Programme Support and Management. At: HQShelter@unhcr.org.

Collective centre strategy considerations

30 October 2019

Key points

- Provide support that enables the authorities to assume their responsibilities effectively.
- Provide necessary protection to displaced people and look after their welfare.
- In all collective centres, from set up to closure, strive to ensure that residents find durable solutions at the earliest possible opportunity.
- Ensure the participation of residents in decision making. Provide platforms for inclusive participation, build their confidence, and promote their involvement.
- Through an AGD approach, ensure the persons of concern are adequately represented and included in governance structures of collective centres.
- In both long-term and short-term collective centres, identify residents' needs and assist residents to address them.
- Ensure that residents of collective centres are informed of the services that are available to them and how to access them.
- Minimize the risk of violence, abuse and exploitation by enduring that distribution points and mechanisms are secure, safe and accessible.
- Prepare contingency plans for a variety of possible displacement scenarios.
1. Overview

Persons of concern may seek temporary accommodation and protection in pre-existing buildings or structures commonly known as collective centres. These are generally defined as planned or self-settled, depending on the circumstances in which they were established.

- They are planned when a responsible authority (for example, a State) designates them as a space to be used by displaced populations. Such buildings may or may not have been prepared for use as temporary shelters. Planned centres include pre-designated or purpose-built shelters such as cyclone, hurricane, storm and flood shelters.
- They are self-settled when displaced people occupy them at their own initiative, without formal approval or coordination with the authorities or owners.

A variety of facilities may be used as collective centres - community centres, town halls, hotels, gymnasiums, warehouses, unfinished buildings, disused factories. These facilities are seldom fit for habitation and must be rehabilitated and/or upgraded to meet the shelter needs of residents.

Collective centres can be an adequate temporary solution as long as they are appropriately serviced and maintained. The life span of collective centres varies widely and in many cases depend on when the building if due to return to its original purpose. Collective centres should generally be used only as short-term accommodation to gain time to provide more suitable shelter.

2. Main guidance

Context characteristics and risks associated

Persons of concern may be displaced for many years. It is therefore vital to ensure that settlement options within the shelter and settlement strategy are soundly planned and that the assistance they provide promotes as much self-sufficiency as possible. Persons of concern should play an active role in planning and developing settlement strategies and establishing governance and management mechanisms in their settlements.

Collective centres have certain advantages:

- They can accommodate refugees immediately without disrupting accommodation in the host area.
- Services such as water and sanitation are likely immediately available, although they may be inadequate or insufficient for the number of people using them.
- No new buildings need to be constructed specifically for persons of concern.
However, they also have disadvantages:

- They can quickly become overcrowded.
- Sanitation and other services can become overburdened.
- Equipment and structures may be damaged or in state of disrepair.
- The buildings are not used for their original purpose which may disrupt services to the host population.
- They often lack family privacy and protection risks increase.
- They lack flexibility and adaptability to changing or increasing needs of persons of concern.
- Collective centres may cause environmental problems often related to water and sanitation and solid waste management. Environmental contamination may cause serious health problems for the residents and those living in close proximity.

**Context-specific protection objectives**

Both planned and self-settled collective centres should provide a secure and healthy living environment with privacy and dignity and protect their residents from internal and external hazards. Achieving this is often challenging particularly due to overcrowding and the unsuitability of the structure for habitation. Violence, drug abuse, sexual and gender- based violence may occur regularly. External hazards can include proximity to international borders, environmental contamination, or natural hazards such as flooding.

**Principles and policy considerations for the emergency response strategy in this context**

When it responds to refugee emergencies, UNHCR and partners should adapt settlement assistance to the context, notably the situation in host areas, and should take account of environmental, socio-cultural, and economic factors.

Inclusive and meaningful participation of all residents - men, women, boys and girls, is essential to ensure that persons of concerns have their voice heard, identify their needs, and have the opportunity to contribute to the search of improvements and solutions.

Assessments must be conducted to determine the conditions of the buildings and for how long they may be used. Be aware that UNHCR never offers rent, no matter who owns a building.

Priority operational delivery mode and responses in this context

- Collective centres are categorized by type - planned or self-settled, and by lifespan - short- or long-term.
- Public buildings should only be used as short-term accommodation while more suitable shelter is arranged.
- Infrastructure and utilities should be well maintained from the onset.
- UNHCR’s and Sphere shelter standards should be applied.

Priority actors and partners in this context

- Governments and their technical departments (planning, infrastructures, public works, housing, civil protection)
- The UN system (notably UN-Habitat, IOM, UNWRA)
- Non-governmental organizations
- ICRC and IFRC
- Relevant academic institutions
- Relevant private sector organizations

Annexes

UNHCR, Handbook for the Protection of Internally Displaced Persons, Guidance Note 4

UNHCR, Global Strategy for Settlement and Shelter 2014-2018

UNHCR-IOM, Collective Centres Guidelines, 2010

Coordination and Management of camps and other collective settings- Guidance Note 12

3. Links

UNHCR Intranet: Shelter and Settlement

4. Main contacts

Shelter and Settlement Section (SSS), Division of Programme Support and Management (DPSM).
e-mail: HQShelter@unhcr.org
Livelihoods and economic inclusion

27 May 2019

Key points

- The Global Compact on Refugees (GCR) calls for enhancement of refugee resilience and self-reliance and for adoption of a whole-of-society approach, both to reach this objective and for the benefits it will bring.

- Access to livelihoods and economic inclusion contribute in vital ways to refugee resilience and self-reliance.

- UNHCR recommends that, to improve refugee inclusion in programmes and services, operations should convene and partner with organizations that specialize in livelihoods.

- You can do this by consulting a range of stakeholders. For example:

  - Financial and business development service providers.
  - Private sector organizations (companies, chambers of commerce, employment agencies, business associations).
  - Public and private training institutes.
  - Development actors, including development NGOs.
  - Governments.
  - UN agencies.
  - Academic and research institutions.

Assess whether it is viable to include refugees in programmes and services. Ask, for instance, whether specific actors:

- Provide services that are relevant to refugees.
  - Have the capacity to meet the needs of all or specific groups of refugees. Do they offer appropriate incentives? What influence do they have?
  - Possess the necessary expertise. Can they survive and compete in local markets?

UNHCR should not itself intervene to fill a gap in services except as a last resort. It should only intervene when other stakeholders:

- Lack the expertise to offer refugees appropriate opportunities.
  - Are prevented from intervening.
  - Lack the capacity to meet refugees' needs.

Where UNHCR operations do implement directly, they should apply the Minimum Economic Recovery Standards. These help to ensure that livelihood programmes are market-oriented and of high quality.
1. Overview

Refugees can be protected, and obtain long-term solutions more successfully, when they have livelihoods and participate economically. Economic inclusion implies giving all members of society, including non-citizens and vulnerable and underserved groups, access to labour markets, finance, entrepreneurial expertise, and economic opportunities. Refugees who enjoy economic inclusion are more likely to be self-reliant and resilient, to meet their needs in a safe, sustainable and dignified manner, to avoid aid-dependency and negative coping mechanisms, to contribute to their host economies, and to be prepared for the future, whether they return home, integrate in their country of asylum or resettle in a third country.

Economic inclusion starts from the moment a refugee influx begins. If humanitarian assistance and educational services are well-directed from the start, they can create better outcomes for refugees in later phases of displacement. The first short-term support provided by humanitarian assistance helps refugees to meet basic needs and obtain adequate protection. In the medium and long-term, assistance should secure the inclusion of refugees in programmes and services offered by development actors, the private sector, and governments. Participation in market systems (through wage- or self-employment, for example) depends not just on access to finance, training, access to education at all levels, coaching, job placement, and a wide range of other support services, but also on the presence of an enabling environment whose rules and regulations protect rights and security. Where refugees have limited access to the right to work and related rights, UNHCR and partners will need to advocate for an environment that encourages the economic inclusion of refugees and enhances their access to livelihoods and decent work. It is important to recognize that positive outcomes in this area require multi-year strategic planning.

2. Main guidance

Protection objectives

- To meet basic needs.
- To protect productive capital and diversify income sources.
- To prevent asset depletion and negative coping strategies.
- To protect and build human and social capital and promote decent work strategies.
- To support equal access to services and economic opportunities.

Underlying principles and standards

Key principles

- Convene internal and external stakeholders.
- Strengthen livelihood support based on socio-economic profiling.
- Assist refugees to become self-reliant and resilient, including during the emergency phase.
- Assist refugees to contribute to (and be included in) local development plans and
processes.
- Avoid the provision or creation of parallel services.

**Standards**
The Minimum Economic Recovery Standards (MERS) set out the minimum level of activities required to support the economic recovery of vulnerable populations after crises. The MERS handbook offers tools and approaches that help practitioners, multilateral stakeholders, local market actors, governments, and donors to support economic recovery using a market-based response. The standards draw on the accumulated experience of the world's leading humanitarian agencies and economic development practitioners.

The MERS is composed of six sets of standards that can be read in sequence or separately.

- The Core Standards describe approaches and activities that prevent or mitigate physical, social, economic, environmental or other harms, and promote protection in alignment with the Core Humanitarian Standards.
- Assessment and Analysis standards advise on how to design, implement and share assessment results that inform effective and context-appropriate programmatic strategies.
- Asset Distribution standards assist practitioners to apply market-aware thinking to asset distribution, support activities linked to longer term-recovery, and minimize disruption of local market systems.
- The MERS also promote livelihoods, financial inclusion, and self-reliance through standards that focus on development of enterprise and market systems, financial services, and employment.

**Protection Risks**
Risks that may need to be addressed include:

- Sexual exploitation and abuse.
- Risky coping mechanisms (including survival sex, child labour, engagement in illegal activities).
- Obstacles to access and enjoyment of assistance and other services.
- Lack of access to formal and informal markets and labour opportunities.
- Depletion of assets, leaving people vulnerable.
- Restraints on, or prevention of, freedom of movement.

**Other risks**

- Legal systems may not adequately respect, protect and fulfil rights.
- Support programmes may discriminate between refugees and host communities.
- There may be a shortage of appropriate partners, especially development partners.
- Programme models may create dependence rather than self-reliance.
- Livelihood programmes may create frustration if they have no impact or their impact is deferred.
- Local people may perceive that refugees are competing with them for jobs and work.

**Key decision points**

Assess existing and potential livelihood opportunities and services. Because they know the context and have links with the local population, NGOs and other local institutions that are perhaps not typical UNHCR partners may be equipped to support and promote livelihoods work and help refugees to become more self-reliant. Use market assessments and value chain analysis (where appropriate) to evaluate host community and in-camp markets, and cross-check the findings against ProGres data on refugee profiles, to identify skills that are needed and skills that refugees possess. Consider sustainability, how both refugees and host communities make a living, and the capacity of the area to absorb refugees. Explore alternative solutions from the beginning.

Operations should seek partners that can include refugees in their programmes and services, taking into consideration the comparative advantage of development actors, private companies, government, financial services providers, and other stakeholders. Partners can develop joint advocacy plans to improve the economic environment for refugees.

**Key steps**

- To improve refugees' inclusion in programmes and services, operations should convene and partner with organizations that specialize in livelihoods.
- You can do this by consulting a range of stakeholders. For example:
  - Financial and business development service providers.
  - Private sector organizations (companies, chambers of commerce, employment agencies, business associations).
  - Public and private training institutes.
  - Development actors, including development NGOs.
  - Governments.
  - UN agencies.
  - Academic and research institutions.

- Assess whether it is viable to include refugees in programmes and services. For instance, ask whether specific actors:
  - Provide services that are relevant to refugees.
  - Have the capacity to meet the needs of all or specific groups of refugees. Do they offer appropriate incentives? What influence do they have?
  - Possess the necessary expertise. Can they operate and compete in local markets?
UNHCR should not itself intervene to fill a gap in services except as a last resort. It should only intervene when other stakeholders:

○ Lack the expertise to offer refugees appropriate opportunities.
○ Are prevented from intervening.
○ Lack the capacity to meet refugees’ needs.

Where UNHCR operations do implement directly, they should apply the Minimum Economic Recovery Standards. These help to ensure that livelihood programmes are market-oriented and of high quality.

Key management considerations

To strengthen refugee self-reliance successfully, livelihood interventions need to be supported by a range of teams working in education, protection, programmes, solutions, community services, communications, and other disciplines. Success also depends on cooperation with development actors, the private sector, and local partners. Where local partners lack expertise or capacity, the office may need to bring in technical support to strengthen them.

Resources and partnerships

Staff
UNHCR livelihoods staff in the field.

Partners
Implementation partners who take a market-oriented approach and are familiar with refugee issues.
Operational partners with specific expertise in microfinance, vocational training, entrepreneurship, employment services, and agriculture and rural development.

3. Links


4. Main contacts

Contact the Livelihoods and Economic Inclusion Unit, UNHCR Division of Resilience and Solutions
Shelter needs assessment

24 October 2019

Key points

- Conduct an initial rapid shelter and settlement assessment within the first three days from the onset of an emergency, whenever possible within a coordinated multi-sectoral assessment.

- If possible the initial rapid shelter and settlement assessment should be coordinated and supervised by an experienced sectoral expert and jointly undertaken with shelter and settlement actors already present in the area and should involve local stakeholders.

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- If possible the initial rapid shelter and settlement assessment should be coordinated and supervised by an experienced sectoral expert and jointly undertaken with shelter and settlement actors already present in the area and should involve local stakeholders.

1. Overview

Whenever a mass displacement occurs be it in an urban or rural context, the first step is always to understand the needs of the population. An initial shelter and settlement assessment provides crucial information which will invariably inform the type of settlement most suited to a given context, the capacity, layout and services needed within a settlement, along with providing essential elements to consider when planning and designing shelters following the peak of the emergency. Whenever a mass displacement occurs be it in an urban or rural context, the first step is always to understand the needs of the population. An initial shelter and settlement assessment provides crucial information which will invariably inform the type of settlement most suited to a given context, the capacity, layout and services needed within a settlement, along with providing essential elements to consider when planning and designing shelters following the peak of the emergency.

2. Main guidance
Underlying policies, principles and/or standards

UNHCR Global Strategy for Settlement and Shelter (2014-18)


Inter-Agency Standing Committee (IASC) (2015) Multi-Cluster/Sector Initial Rapid Assessment (MIRA)

UNHCR (2018) Age, Gender and Diversity Policy

Good practice recommendations

An initial rapid shelter and settlement assessment should be carried out within the first three days of an emergency, to identify needs and resources. To plan and implement an effective response, it is vital to coordinate assessments across a range of sectors (Protection, WASH, Camp Management, Health, Nutrition, and Education). The Needs Assessments for Refugee Emergencies (NARE) checklist, a highly customisable initial multi-sectoral needs assessment is often used and contains a specific section with relevant questions to inform settlement development and shelter response.

The scale and complexity of an emergency and the available staff and resources will influence the amount and quality of information that can and should be collected during shelter and settlement needs assessments. The information collected will in turn inform how best to prioritize lifesaving needs which should be addressed immediately, versus medium term needs. The assessment should be coordinated and supervised by an experienced Shelter Officer or Site Planner.

The overall Emergency Needs Assessment should provide sufficient information to identify the immediate life-saving shelter and settlement activities and priorities, anticipate the potential future problems related to shelter and settlement, including projections and contingency planning, and identify ‘self-supported' refugees - those with adequate shelter provided from their own resources, and the strategies they are using to cope.

In situations where new arrivals are staying between camp and out of camp, self-settled or in
host families, or when an influx of new arrivals may be placing pressure on local communities, the emergency needs assessment should also identify and mitigate potential shelter and settlement-related tension(s) between new arrivals and the host community and identify the type and level of support required for families in a host community.

**Recommended methodology**

To understand the dynamics of a crisis and the contextual implications for shelter and settlement, it is essential to gather a broad set of relevant information which will inform the sector specific assessment and response. This exercise requires a pre-crisis and post-crisis secondary data analysis to determine what information is already available as well as primary data collection. Information can come from other sectors and/or organisations. Any missing information should be included in the primary data collection.

**Secondary data analysis:** Review of secondary data relevant for shelter and settlements should provide critical background information and analysis, such as:

- Climate and cultural practice information that impacts settlement planning, shelter and Core Relief Item (CRI) selection.
- Building practices of refugees in country of origin (e.g. building types, sizes, construction materials, physical architecture, etc.).
- Review of previous market surveys (availability and prices of construction materials and household items pre-crisis).
- **Housing, land and property** ownership practices and laws in the country of asylum (e.g. renting, leasing, ownership, compulsory acquisition)
- Identify which national government departments are responsible for shelter, settlement planning and public infrastructure facilities
- Determine local Government and NGO response capacity for shelter and settlement
- Identify national building standards
- If the government has allocated potential sites to host refugees, check if geological information is available for the sites in the event of a planned settlement and structural safety in the event of public building rehabilitation

Secondary data review post-influx should specifically provide:

- Existing infrastructure and services surrounding the area where the refugees are located which will influence settlement development and planning
- Traditional shelter types of both displaced population and host community (avoid disparity between refugee and host community living conditions)
- Availability of shelter materials (e.g. natural resources, nearby stockpiles, regional suppliers, etc.)
- Identification of persons with specific needs requiring shelter (re)construction assistance or specific shelter options (disability and access)
- Options to ensure safety of shelter (e.g. types of materials, "fences" around family plots, availability of locks)
- Availability of land and facilities for camps / settlements / collective centres
**Primary data collection**: The level of detail and questions asked during primary data collection will largely depend on information gaps identified during the secondary data review. Data collection can be carried out using the following methodologies:

- Community Observation
- Community Key Informants
- Focus Group Discussions
- Household Key Informant
- Infrastructure/Facilities Visits

The information collected during the initial rapid needs assessment should influence the development of a comprehensive shelter and settlement strategy which will structure and phase the sectoral response to address the needs of the persons of concern, and which will evolve over time to adapt to changing needs. Assessors should gather sufficient information in order to effectively guide the following actions:

- Identify most suitable settlement option or combination of options according to the context (host family support, collective centres, planned settlements, rental accommodation, sharing with family or relatives)
- Enable persons of concern to access and live in dignity in secure settlements that improve their social, economic and environmental quality of life as a community
- Ensure the involvement of persons of concern throughout the planning, design and implementation phases of shelter and settlement responses
- Provide appropriate emergency shelter and CRIs as needed
- Ensure minimum space of covered shelter area (3.5m² per person) is respected
- Adapt shelter to protect persons of concern from extreme weather conditions
- Ensure access to basic services
- Plan for and identify longer term or transitional shelter solutions

The following are examples of key information to be gathered through secondary and primary data collection and analysis:

<table>
<thead>
<tr>
<th>Demography</th>
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</thead>
<tbody>
<tr>
<td>How many people are affected? Who are they?</td>
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<tr>
<td>What are their nationalities?</td>
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<tr>
<td>Do they come from urban or rural enclaves?</td>
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<td>What ethnic groups do they belong to?</td>
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<td>How many men, women, boys and girls are there? What is the age breakdown?</td>
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<tr>
<td>What percentage of boys and girls (under 18) are unaccompanied?</td>
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<td>What religions do they practise?</td>
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<tr>
<td>What skills do they have?</td>
</tr>
<tr>
<td>What specific needs can be identified?</td>
</tr>
<tr>
<td>What is their physical condition (dehydration/malnutrition)?</td>
</tr>
<tr>
<td>What diseases are present?</td>
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</tbody>
</table>
### Movement
- Where are the persons of concern coming from (general trends)?
- Where are they now (approximate locations)?
- Where are they going (general trends)?
- What is the rate of arrival (number per day)?
- Is the rate of arrival likely to increase or decrease?

### Resources
- What resources do the displaced population have?
- Do they have sufficient clothing?
- Do they need blankets?
- Do they need shelter materials?
- Do they possess domestic household items and supplies?
- Do they have livestock? If so, what animals do they have?
- What other possessions do they have?

### Physical Security
- Assess the protection needs of arrivals and the social support they require.
- What problems have they experienced on their flight route (presence of armed groups, water or food, crossing the frontier, border officials, etc.)?
- Does the whole group face an external physical threat? From whom?
- Is military protection required?
- Is factional conflict taking place? Which groups are involved?
- Is counselling required?
- Is there a problem of religious intolerance? Which groups are involved?

A secondary data review should always be done in order to determine what information already exists. The critical background information collection and analysis for shelter and settlement should include:

- Climate and cultural practice information that impacts settlement planning, shelter and CRI selection
- Building practices of refugees in country of origin (e.g. building types, sizes, construction materials, physical architecture, etc.)
- Review of previous market surveys (availability and prices of construction materials and household items before the emergency)
- Clarify housing, land and property ownership trends and laws in the country of asylum (e.g. renting, leasing, ownership, compulsory acquisition)
- Determine which national government departments are responsible for shelter, settlement planning and public infrastructure facilities
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- Identify national building standards
- If the government has allocated potential sites to host refugees, check if geological information is available for the sites in the event of a planned settlement and structural safety in the event of public building rehabilitation

Information for a post-influx secondary data review should specifically look at:
Note that information can come from other sectors and/or organisations. Any missing
information should be included in the primary data collection

- Existing infrastructure and services surrounding the area where the refugees are located which will influence settlement development and planning
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- Availability of land and facilities for camps / settlements / collective centres

**Primary data collection** can be carried out using the following methodologies:

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The level of detail and questions asked for primary data collection will largely be influenced by information gaps identified during the secondary data review. Nevertheless assessors should gather sufficient information in order to address the following over-arching actions:

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- Ensure access to basic services
- Plan for and identify longer term or transitional [shelter solutions](#)

The information collected during the initial rapid needs assessment should largely influence the development of a comprehensive shelter and settlement strategy which will structure and phase the sectoral response to address the needs of the population of concern which will evolve in time. An initial rapid shelter and settlement assessment should be carried out within the first three days of an emergency, to identify needs and resources. To plan and implement an effective response, it is vital to coordinate assessments across a range of sectors (Protection, WASH, Camp Management, Health, Nutrition, and Education). The Needs Assessments for Refugee Emergencies (NARE) checklist, a highly customisable initial multi-sectoral needs
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The overall Emergency Needs Assessment should provide sufficient information to identify the immediate life-saving shelter and settlement activities and priorities, anticipate the potential future problems related to shelter and settlement, including projections and contingency planning, and identify ‘self-supported' refugees - those with adequate shelter provided from their own resources, and the strategies they are using to cope.

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The following are examples of key information to be gathered through secondary and primary data collection and analysis:

| Demography | How many people are affected? Who are they? What are their nationalities? Do they come from urban or rural enclaves? What ethnic groups do they belong to? How many men, women, boys and girls are there? What is the age breakdown? What percentage of boys and girls (under 18) are unaccompanied? What religions do they practise? What skills do they have? What specific needs can be identified? What is their physical condition (dehydration/malnutrition)? What diseases are present? |
| Movement | Where are the persons of concern coming from (general trends)? Where are they now (approximate locations)? Where are they going (general trends)? What is the rate of arrival (number per day)? Is the rate of arrival likely to increase or decrease? |
| Resources | What resources do the displaced population have? Do they have sufficient clothing? Do they need blankets? Do they need shelter materials? Do they possess domestic household items and supplies? Do they have livestock? If so, what animals do they have? What other possessions do they have? |
| Physical Security | Assess the protection needs of arrivals and the social support they require. What problems have they experienced on their flight route (presence of armed groups, water or food, crossing the frontier, border officials, etc.)? Does the whole group face an external physical threat? From whom? Is military protection required? Is factional conflict taking place? Which groups are involved? Is counselling required? Is there a problem of religious intolerance? Which groups are involved? |

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- Ensure access to basic services
- Plan for and identify longer term or transitional shelter solutions

The information collected during the initial rapid needs assessment should largely influence the development of a comprehensive shelter and settlement strategy which will structure and phase the sectoral response to address the needs of the population of concern which will evolve in time.

**Considerations for practical implementation**

The findings of an initial rapid shelter and settlement assessment should guide the level and type of intervention in any given response, and all information collected during the initial needs assessments should be shared with other relevant sectors (Protection, WASH, Food Security, Nutrition, Public Health, Environment) to ensure a coordinated response.

An initial rapid shelter and settlement assessment provides a general picture of the shelter situation detailed enough to determine what shelter and settlement problems exist, how serious they are, and what assistance strategy is appropriate. Changing needs should be reviewed periodically and subsequent actions reflected in the sectoral strategy. As the situation stabilises, the following assessments should be considered:

- Shelter Condition Assessment. These assessments describe the assistance that will be required to transform emergency shelters (most often tents or emergency shelter kits) into transitional shelters when the situation stabilises.
- Shelter Evaluations. These assess the impact of completed projects on population needs, in order to measure a shelter strategy’s relevance and success, and modify it as required.

Additional key informant questions and focus group discussion questions can be found in the Sphere Rapid Shelter Assessment and the UNHCR NARE Checklist - Draft (2014)

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Additional key informant questions and focus group discussion questions can be found in the Sphere Rapid Shelter Assessment and the UNHCR NARE Checklist - Draft (2014)

## Resources and partnerships

### Staff

- A shelter and settlement expert
- Local shelter and settlement partner organisation
- Community outreach workers

### Partners

- A variety of partners can assist with shelter and settlement assessments and responses, including international NGOs with expertise in the sector, local organisations and relevant government authorities.

### Material

- GPS
- Camera
- Rapid assessment questionnaire

### Staff

- A shelter and settlement expert
- Local shelter and settlement partner organisation
- Community outreach workers

### Partners
A variety of partners can assist with shelter and settlement assessments and responses, including international NGOs with expertise in the sector, local organisations and relevant government authorities.

Material

- GPS
- Camera
- Rapid assessment questionnaire

Annexes

Sphere Handbook (2018)


Shelter Cluster, Sphere Rapid Shelter Assessments Checklist

UNHCR, WFP - Joint Assessment Missions - a Practical Guide to Planning and Implementation (2013)

3. Links

Minimum Sectoral Data – Shelter and Settlement

4. Main contacts

UNHCR Shelter and Settlement Section, DPSM. At: HQShelter@unhcr.org

UNHCR Shelter and Settlement Section, DPSM. At: HQShelter@unhcr.org

Nutrition needs assessment

25 May 2020

Key points
• Do an initial rapid nutrition assessment as soon as possible. If possible, it should be coordinated and supervised by an experienced nutritionist.

• Ensure linkages between the rapid health and nutrition assessment. Ideally the findings are presented in the same report describing the health and nutrition status of the new arrival refugee population.

• The assessment should include secondary data on the nutrition situation, measure acute malnutrition, and assess key infant feeding practices.

• MUAC and oedema are the indicators of choice to measure acute malnutrition in the initial phases of an emergency.

• Screen breastfeeding in children younger than 6 months. This is important to identify specific additional needs.

• Where under-nutrition is a concern, continue to screen new arrivals and hold regular mass MUAC screenings in camps and the community.

• Health, nutrition and WASH are interlinked. Ensure these sectors coordinate closely at all levels.

• Initial assessments should be multi-sectoral in character and the teams should include expertise in public health, nutrition, WASH and shelter / site planning.

1. Overview

In emergencies, food and nutrition security are often severely threatened and urgent action is required to ensure that all members of the community have access to adequate food. Those who are malnourished require nutritional rehabilitation. The extent of malnutrition has important implications for an emergency response. It influences decisions on the content and transfer mechanism of food assistance (in-kind or cash based interventions) and the requirements of selective feeding programmes.

Ideally following the multi-sectoral needs assessment for refugee emergencies (NARE), a more detailed initial rapid assessment of the nutrition status of refugees should be conducted as soon as possible. The nutrition assessment is normally part of the health needs assessment. It should collect secondary data on and related to nutrition, assess acute malnutrition, and screening of key infant feeding practices. Assessments should be carried out by sectoral technical experts with appropriate qualifications and relevant experience.

A more comprehensive nutrition survey should be undertaken as soon as feasible and no later than 3-6 months after an emergency starts. This assessment should evaluate the nutrition status of the population as a whole and should follow UNHCR’s Standardised Expanded Nutrition Survey (SENS) guidelines.
2. Main guidance

Underlying policies, principles and/or standards

Sphere, Food security and nutrition assessment standard 1.2: Nutrition assessment. Nutrition assessments use accepted methods to identify the type, degree and extent of undernutrition, those most at risk and the appropriate response.

Where people are at increased risk of undernutrition, assessments are conducted using internationally accepted methods to understand the type, degree and extent of undernutrition and identify those most affected, those most at risk and the appropriate response.

UNHCR, Global Strategy for Public Health 2014-2018: Food security and nutrition objective 3. This requires an emergency response to provide up-to-date information on, and analysis of, food security and nutrition, enabling programming to be both appropriate and based on need.

Good practice recommendations

An initial rapid nutrition assessment should be carried out at the start of an emergency, to establish the nutrition status of refugees and confirm the existence or threat of a nutrition emergency. It should estimate the number of people affected, quantify immediate needs, the availability of local resources, and the need for external resources. The initial rapid assessment will then guide the need for a more in depth assessment to determine medium to longer term needs and approaches.

The assessment should be coordinated and supervised by an experienced nutritionist or public health officer. It should collect secondary data on and related to nutrition, measure acute malnutrition, and screen key infant feeding practices.

Objectives of an initial rapid nutrition assessment

- To provide information on the nutrition situation in the country of origin and country of asylum (secondary data).
- To measure the prevalence of acute malnutrition in children aged between 6 and 59 months, based on mid-upper arm circumference (MUAC) and bilateral oedema (primary data collection).
- To assess key infant feeding practices, specifically breastfeeding of infants younger than 6 months (primary data collection).
- To identify cultural habits among the refugee population that might affect their food preferences and intake, for example whether the population is vegetarian or pastoralist with high meat and/or milk intake (secondary data, key informants).
- To identify characteristics of the refugee population that might influence the effectiveness of coping strategies or early interventions, such as animal husbandry or farming skills.
(secondary data, key informants).
- To identify specific vulnerabilities, for example that women eat last (secondary data, key informants), older people etc.
- To assess national and local capacity to lead or support the response (key informants, observation).

A situational analysis will help to establish whether the nutrition situation is deteriorating or stable, whether groups in the community have specific needs, and whether community members have specific skills or resources that can help prevent deterioration of the situation. Situational analyses should review the state of nutrition before the emergency, as well as eating habits and livelihood practices.

Where nutrition is a concern, it is usual to assess the prevalence of acute malnutrition in children aged between 6 and 59 months. Acute malnutrition reflects more recent changes in dietary intake and infection and provides an indication of the nutritional status of the whole population. Acute malnutrition among children aged between 6 and 59 months is assessed on the basis of weight-for-height or weight-for-length (WFH) indices, MUAC, and signs of bilateral oedema.

It is important to identify infants younger than 6 months who are not being breastfed. If an infant is not being breastfed or is having breastfeeding difficulties, the mother or caregiver and the child should be referred immediately to a health centre for further assessment and support.

**Methodology**

Relevant secondary data is often available and can be complemented by interviewing key informants. Key sources of secondary data include:

- Statistical offices in the country of origin or country of asylum.
- UNHCR's databases and reports.
- Other UN agencies, notably UNICEF and WFP.
- NGOs that work in the area of origin or area of asylum.
- Key informants working in the refugee affected areas.
- Key informants from among the refugees, with an age, gender and diversity lens.

During the assessment, information should be collected from as many different gender, diversity and age balanced sources as possible. The information should be triangulated.

Primary data collection should be undertaken in places where nutrition situation is a concern. Acute malnutrition and infant feeding practices can be assessed by nutrition and health workers in reception centres or other first points of contact with the population.

In a rapid nutrition assessment, the indicators of choice to measure acute malnutrition are MUAC and oedema. MUAC is quick to perform and effectively predicts risk of death in children aged 6 to 59 months. Based on a single measurement, it requires no heavy equipment, is used with the same cut-off for both boys and girls, and can be undertaken by low-skilled staff given training and supervisory support.
Instructions for MUAC and oedema screening:

- All children aged between 6 and 59 months should be screened for MUAC malnutrition and bilateral oedema at the reception centre during registration or at other first points of contact.
- To assess MUAC, measure the circumference of the left upper arm at the mid-point between the elbow and shoulder, to the nearest millimetre, using a standard MUAC tape.

<table>
<thead>
<tr>
<th>MUAC measurement</th>
<th>Malnutrition status</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;125mm (yellow and red)</td>
<td>Moderate and severe</td>
</tr>
<tr>
<td>≥115mm and &lt;125 mm (yellow)</td>
<td>Moderate</td>
</tr>
<tr>
<td>&lt;115mm (red)</td>
<td>Severe</td>
</tr>
</tbody>
</table>

- To assess bilateral oedema, apply gentle thumb pressure to the tops of both feet of the child for a period of three seconds and observe the presence or absence of an indent.
- A child with bilateral oedema is always classified as having severe acute malnutrition.

Instructions for infant screening:

- Every refugee family that has an infant younger than 6 months should be screened at a reception centre during registration or at another first point of contact.
- Based on a short questionnaire on feeding practices, screening should establish whether the child is being breastfed, whether the mother is present, and (where applicable) what foods the infant receives instead of breastmilk.
- Every infant younger than six months who is not being breastfed or has breastfeeding difficulties should be referred to a health centre for further assessment and support.

Infants younger than six months may be at risk of acute malnutrition if breastfeeding has been disrupted (for example, because the child is separated from its mother, or the mother has died, or the child is only partly breastfed). Among infants younger than 6 months, acute malnutrition is assessed using visible signs of wasting and bilateral oedema. Social criteria (an absent mother, inadequate breastfeeding) can indicate a heightened nutritional risk.

Presentation of results
The findings of an initial rapid nutrition assessment should be reported using the MUAC
screening report template. Take care when presenting MUAC results. Make clear the nature of the sample, because this determines how representative it is. (Were all children measured, for example, or only those likely to be undernourished?) Make sure that MUAC results are not conflated with the prevalence of GAM (which can only be measured in terms of weight-for-height and oedema). MUAC does not provide a formal threshold for assessing the state of nutrition in the whole population. However, rapid nutrition assessments can show where immediate interventions are needed.

Considerations for practical implementation

- The findings of an initial rapid nutrition assessment should guide the level and type of nutrition support (for acute malnutrition, infant feeding, etc.) that are offered in transit centres and/or where refugees will settle.
- MUAC results will often show lower levels of under-nutrition than weight-for-height.
- An initial rapid nutrition assessment is a preliminary estimate. It should be followed by a more comprehensive nutrition survey as soon as the situation allows, and no later than 3-6 months after an emergency starts. The comprehensive survey should assess the nutrition status of the population as a whole and should always follow the UNHCR's Standardised Expanded Nutrition Survey (SENS) Guidelines.
- Rapid nutrition assessments should be continual: all arriving children should be screened for acute malnutrition and breastfeeding support. Screening activities should also continue after the first MUAC screening report has been produced. In the same manner, the comprehensive nutrition survey may be followed by simpler weekly reports on the prevalence of MUAC malnutrition.
- In situations where under-nutrition is a concern, screening for acute malnutrition on arrival should be coupled with regular mass MUAC screenings in refugee camps or communities, to monitor nutrition levels.

Resources and partnerships

Initial assessments should involve several agencies and partners and are multisectoral. It is important that UNHCR leads this process in refugee emergencies.

Staff

- A trained UNHCR public health officer.
- An experienced nutritionist from UNHCR and/or a partner organisation.
- Community outreach workers to work in camps and the community; nutrition/health assistants to staff reception centres and contact points.

Partners

- The key technical partners are: Ministry of Health, international and/or national NGO partners (international and national) (implementing, operational, potential and already on ground), UN agencies WHO, UNICEF (for child and maternal health, vaccination, and linkages to nutrition and WASH), UNFPA (reproductive health), and WFP (links to nutrition
and food security).

**Material**

- Standard MUAC tapes.
- Infant screening questionnaire.

**Annexes**

- Infant Screening Questionnaire
- MUAC Report Template
- Draft Needs Assessment for Refugee Emergencies (Checklist)

**3. Links**

- [A standardised tool for conducting nutrition surveys in refugee populations](#)
- [The Sphere Handbook](#)
- [Refugee Health Data](#)
- [Needs Assessment for Refugee Emergencies (NARE)](#)

**4. Main contacts**

UNHCR Public Health Section, Division of Programme Support and Management (DPSM). At [hqphn@unhcr.org](mailto:hqphn@unhcr.org).

**Sexual and Reproductive Health Care Standards**

26 October 2020

**Key points**

- Gaps in the provision of Sexual and Reproductive Health Services (SRH) services to all members of a crisis-affected population will lead to increased morbidity and mortality.
- A Minimum Initial Service Package (MISP) for SRH needs to be ensured at the onset of an...
emergency and ideally within the first 48 hours, an early expansion to comprehensive care needs to be planned from the onset.

- The implementation of comprehensive SRH programming should not negatively affect the availability of MISP for SRH services; on the contrary, it should improve and expand upon them.

- SRH services must be accessible for all crisis-affected populations, including adolescents, persons with disabilities, unmarried and married women and men, the elderly, sex workers and clients, and LGBTQ individuals.

- Accurate information and counseling, including evidence-based, comprehensive sexuality education in integral part of SRH in humanitarian settings.

- SRH must be integrated into public health packages and linked to other service sectors, including when strengthening SRH supply chain management.

- When planning for comprehensive SRH services, use the six WHO health system building blocks as a framework: service delivery, health workforce, health information system, supplies and medical commodities, financing, and governance and leadership.

1. Overview

Sexual and reproductive health (SRH) is an essential component of the humanitarian response. Morbidity and mortality related to SRH is a significant global public health issue and those in humanitarian settings often face heightened risks and additional barriers to SRH services. Neglecting SRH in emergencies may lead to grave consequences including preventable maternal and newborn deaths, sexual violence and subsequent trauma, unwanted pregnancies and unsafe abortions and the spread of HIV and other sexually transmitted infections (STIs).

The Minimum Initial Service Package (MISP) for SRH is a set of priority activities to be implemented from the onset of a humanitarian crisis (ideally within 48 hours). These life-saving activities form the starting point for SRH programming and should be built upon as soon as possibly with comprehensive SRH services and sustained throughout protracted crises and recovery.

2. Main guidance

Emergency standard

- Ensure the health sector/cluster identifies an organization to lead implementation of the MISP.
- Prevent sexual violence and respond to the needs of survivors.
- Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.
Prevent excess maternal and newborn morbidity and mortality.
Prevent unintended pregnancies.
Plan the transition to comprehensive SRH, integrated into primary health care.

**Longer-term standard**

- Accurate information and counseling on SRH, including evidence-based, comprehensive sexuality education.
- Information, counseling, and care related to sexual function and satisfaction.
- Prevention, detection, and management of sexual and gender-based violence and coercion.
- A choice of safe and effective contraceptive methods.
- Safe and effective antenatal, childbirth, and postnatal care.
- Safe and effective abortion services and care, to the full extent of the law.
- Prevention, management, and treatment of infertility.
- Prevention, detection, and treatment of sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), and of reproductive tract infections.
- Prevention, detection, and treatment of reproductive cancers.

**Annexes**

Women’s Refugee Commission & IAWG, Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations - A Distance Learning Module, 2019

Save the Children, UNICEF, Newborn Health in Humanitarian Settings - Field Guide, 2018

UNHCR, Adolescent Sexual and Reproductive Health in Refugee Situations - A Practical Guide to Launching Interventions for Public Health Programmes, 2019

**3. Links**

IAWG for Reproductive Health in Crisis Situations MISP Distance Learning Module MISP Calculators UNHCR Sexual and Reproductive Health

**4. Main contacts**

Contact the Public Health Section, Division of Programme Support and Management: hqphn@unhcr.org.
HIV prevention, support, treatment standards

26 October 2020

Key points

- HIV infection prevention and the continuation of antiretroviral treatment (ART) represent essential emergency measure and directly contribute to the reduction of morbi-mortality.

- Emphasis the importance of standard precautions (frequent hand washing, wearing gloves and protective clothing, safe handling of sharp objects, disposal of waste materials, instrument processing, and cleaning up spills).

- Ensure safe blood supply and rational use to prevent the transmission of HIV and other transfusion-transmissible infections, such as hepatitis B and C and syphilis.

- Antiretrovirals should be continued for people who were enrolled in a program prior to the emergency, including women who were enrolled in PMTCT of HIV and syphilis programs.

- PEP should be provided to survivors of sexual violence and occupational exposure. An HIV test is not required (neither for the source patient or the health worker) before prescribing PEP, and no one should be forcibly tested.

- Lubricated male condoms and, where applicable, female condoms should be available in accessible and private areas in health facilities and the community and promoted from the earliest days of a humanitarian response.

1. Overview

Although a significant proportion of people affected by humanitarian emergencies are people at risk of or living with HIV, access to HIV prevention, treatment, and care is often not prioritized during emergencies. HIV transmission in humanitarian settings is complex and is dependent on the dynamic interaction of a variety of factors. This includes HIV prevalence and vulnerability of some groups within the population in the region of origin and that of the host population, the level of interaction between displaced and surrounding populations, the duration of displacement, and the location and extent of isolation of the displaced population (e.g., urban versus camp-based refugees).

The Minimum Initial Service Package (MISP) components related to HIV interventions at the onset of a humanitarian response focus on prevention of HIV transmission and reduction in morbidity and mortality due to HIV and other STIs. Once the conditions allow, scaling up should occur from the initial minimum HIV package to comprehensive HIV prevention, treatment and care services.
for people at risk of acquiring HIV and people living with HIV and their families.

2. Main guidance

Emergency standard

- Establish safe and rational use of blood transfusion.
- Ensure application of standard precautions.
- Guarantee the availability of free, lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms.
- Support the provision of antiretrovirals to continue treatment for people who were enrolled in an antiretroviral therapy program prior to the emergency, including women who were enrolled in prevention of mother-to-child transmission (PMTCT) programs.
- Provide post exposure-prophylaxis (PEP) to survivors of sexual violence as appropriate and for occupational exposure.
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV.
- Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs.

Longer-term standard

- Conduct needs assessment: SRH coordinators and programme managers collect or estimate relevant information regarding population characteristics, health services characteristics, national legislation and policies, and HIV epidemic characteristics.
- Expand public information campaigns: Raise community awareness about how HIV is and is not transmitted and promote the rights of people living with HIV, the benefits of knowing one's HIV status, and the availability of services for HIV prevention, testing, care, and support.
- Ensure HIV prevention: Tailor combination HIV prevention programs by including different interventions depending on local HIV geographic population vulnerabilities.
- HIV counselling and testing:
  1. Voluntary counselling and testing (VCT)
  2. Provider initiative counselling and testing
     - Prevention of mother-to-child transmission (PMTCT)
     - The use of antiretroviral (ARV) for prevention and treatment purposes
     - Care for persons living with HIV
     - Management of opportunistic infections, STIs and tuberculosis
- Coordinate and make linkages: Work with other sectors and stakeholders to integrate HIV services.

Annexes

IASC, Guidelines for addressing HIV in humanitarian settings, 2010

UNHCR, WHO, UNAIDS, Updated policy Statement on HIV Testing and Counselling for Refugees
and other persons of concern to UNHCR

WHO, Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2016

UNHCR, Inter-agency Guidelines for the Delivery of Antiretroviral Therapy (ART) to Migrants and Crisis-Affected Persons in Sub-Saharan Africa, 2014

3. Links

UNHCR  WHO  IAWG MISP

4. Main contacts

Contact the Public Health Section, Division of Programme Support and Management. At: hqphn@unhcr.org.

Energy and environment - camps

27 October 2020

Key points

- Ensure potential environmental risks and energy challenges are addressed during preparedness planning.

- Ensure that funding proposals and refugee response plans address energy poverty and environmental issues.

- Monitor energy use, energy poverty, natural resource management, and environmental impacts. This information is vital for the improvement of programming.

- Do not locate camps close to environmentally sensitive areas.

- Make sure that adequate political commitment and human resources are devoted to energy issues and environmental protection.

- Seek the support of standby partners that have environmental specialists. Many agencies have rosters of environmental and energy specialists, who are often under-used.

- Seek technical advice and support on energy and the environment through the Energy and
1. Overview

Meeting the energy needs of refugees, and protecting the environment they depend on, are critical cross-cutting issues for UNHCR. Emergency responses often harm natural resources, largely due to lack of foresight during preparedness planning. Environmental degradation seriously increases risks of flooding and landslides that affected communities face after disasters. Key recurring issues are firewood collection, deforestation (due to the construction of temporary shelters and cooking), erosion and landslides, pollution of rivers and streams, overgrazing, pollution of air and soils, and unsafe waste management.

Once the environment has been damaged, its rehabilitation and the repair of long-term negative consequences are difficult and expensive, so precautionary measures to avoid damage are critical. Environment and energy should both be considered cross-cutting sectoral concerns and should be addressed from the onset of an emergency, and preferably beforehand by preparedness planning. The emergency phase is a critical moment, when energy poverty can be addressed, enhancing safety and self-reliance, and environmental degradation avoided or managed.

2. Main guidance

Protection objectives

- To provide safe, timely and reliable access to energy during refugee emergency operations.
- To protect refugees from risks, such as sexual and gender-based violence (SGBV), that often occur at night in unlighted areas (latrines, washing zones, playgrounds, workshops) or while refugees search for firewood.
- To protect refugees from physical risks such as landslides, floods, and exposure to hazardous wastes and toxins in the air, soil or water.
- To reduce tension between refugee and local populations over scarce natural resources.
- To encourage refugee self-reliance by reducing energy poverty and promoting sustainable natural resource use.

Underlying principles and standards

- Prevention measures are the best way to tackle irreversible environmental impacts. Prevention is also more cost effective than mitigation of environmental damage.
- At the onset, involve refugees and host communities in the design and implementation of energy and environment programmes.
Seek technical advice from local, regional, and national institutions, private organizations, and academic institutions.

Ensure that a stockpile of high-quality energy products is accessible to avoid prolonged energy poverty and poor service delivery.

Protect the environment, which is a source of livelihoods for both host and refugee communities.

Commitment 9 of the Core Humanitarian Standard on quality and accountability recognizes that the environmental impacts of all sectoral activities should be assessed and mitigated. Communities and people affected by crisis are entitled to expect the organizations that assist them to manage resources effectively, efficiently and ethically.

Sphere Standard 7 on shelter and settlement (environmental sustainability) states that shelter and settlement assistance should minimize any negative impacts of programmes on the natural environment.

**Protection Risks**

- Where locations are unlit at night, refugees face specific forms of insecurity, notably assault and SGBV.
- In some instances, women, men, boys and girls travel long distances to fetch firewood, thereby putting themselves at risk of SGBV.
- If they lack fuel or access to energy, refugees may adopt unsafe or harmful coping strategies. (For example, they may sell part of their food ration to purchase cooking fuel, increasing the risk of malnutrition; or burn plastics or other waste as fuel or a fire starter, exposing them to toxic chemicals.)
- Erosion following the removal of vegetation often creates large gullies that may cause deadly and damaging landslides.
- Run-off into streams and rivers may be toxic, putting at risk refugees and host communities who use it for drinking, cooking or agriculture. Toxins that accumulate in the food chain can cause chronic health risks.
- Unsafe waste disposal exposes refugees and host communities to toxic chemicals in soils and the air as well as to disease vectors.

**Other risks**

- Refugees may acquire pneumonia, cardiovascular diseases, or lung cancer, or put their health at risk in other ways, by cooking in inappropriate conditions or with bad fuels or equipment.
- Poor waste management practices also generate health risks: if safe locations for waste disposal are not planned, refugees may adopt dangerous solutions, such as burning waste.
- Failure to consider environmental issues at an early stage has been shown to jeopardize the asylum space.
- Searching for firewood takes time that could be used for educational or livelihood activities.
- In the absence of light and electricity, students cannot study at night and livelihood activities can only be undertaken during the day.
- Pollution of soils and natural waterways jeopardizes the livelihoods and development opportunities of refugees and host communities.
Unsustainable use of natural resources (wood, land, water) causes biodiversity loss and desertification.
Degradation and depletion of natural resources causes conflicts within refugee population and between refugees and host communities.
Greenhouse gas emissions contribute to global warming and climate change.

**Key decision points**

At the start of an emergency response, commission a rapid environmental assessment as early as possible so that the response can take informed decisions. Undertake an energy feasibility study to identify energy needs, the best energy strategy, and technologies that are locally available. Emergency response kits should include emergency stoves, fuel for at least 4-6 months, and a solar light.

When planning shelter and settlement, including distribution of non-food items (NFI), conduct a market survey to determine what materials and capacities are locally available. The survey should assess the degree to which supplies can be obtained for the duration of the project and make sure that the proposed operation will not interfere with the local economy. Where it may be decided to procure goods internationally (plastic sheeting, tents, NFI and other core relief items [CRI]), compare the supply chain and its environmental implications with solutions that are available locally; choose the best option.

Assess the area and its carrying capacity to determine what plot size is required and how many people it can support. Base your calculation on the needs assessment but also on environmental considerations.

If shelters or other facilities have been built using environmentally unfriendly materials (plastic sheeting, other polymer-based materials), draft a clear plan for their safe and environmentally sound disposal, or repurpose the materials at the end of their lifespan or at decommission.

Environmental protection measures should be put in place. Mark trees in and outside the camp that should not be cut or cut down. Establish a 5 metre buffer zone around all surface waters (streams, rivers, lakes...) within which vegetation should be left intact. By means of education and monitoring, prevent all dumping and discharge into surface waters. If surface waters are used as a water supply, monitor them to prevent overuse and downstream impacts. Limit vegetation clearance to avoid erosion wherever possible; prioritize hand clearance over mechanical clearance to reduce soil disturbance and limit erosion. Map potential locations for surface flooding and ensure drainage is adequate. Do not use fire or burning to clear sites or dispose of cleared vegetation. Establish refuse collection points that separate organic and inorganic waste. Where possible, compost organics and make the compost available for livelihood activities. Never burn plastic. Prepare and run an environmental awareness campaign, using a variety of appropriate forms of communication.
Key steps

1. Set up an energy and environmental task force; involve relevant stakeholders.
2. Undertake a rapid environmental assessment.
3. Develop a response plan in association with Government counterparts, selected partners and technical services.
4. By means of a needs assessment, consult both the refugee and host communities on habits and traditions that might increase the burden on the environment. Consider cooking, shelter, commonly used construction materials, use of space, and livelihoods (especially pastoral and livestock activities).
5. Identify affordable products and services that beneficiaries can access easily, with the aim of improving local provision, market development, and job opportunities.
6. Take steps to ensure that, as far as possible, all domestic and institutional energy needs are immediately met in a sustainable manner. Review the situation after 4 to 6 months. Wherever feasible, the aim should be to meet energy needs from renewable sources.
7. Take steps immediately to prevent pollution of soils or surface waters by adopting appropriate waste management and erosion controls.
8. When planning shelter and settlement, take action to mitigate the risks of soil erosion, surface water runoff and landslides. These objectives can be achieved by designing an appropriate settlement layout (roads, paths, plots); establishing an appropriate drainage system; integrating green buffer zones in the settlement design, which will also help to recharge local aquifers; and defining and planning the site’s carrying capacity. Define the optimal size of the site in terms of plots and the number of persons of concern it supports; the site should not compromise the environmental quality of the area in the short or long term.
9. Work with WASH and health colleagues on medical waste management.
10. Draw up and implement awareness-raising campaigns on energy use and environmental management. These should benefit host as well as refugee communities.
11. Test and establish a preliminary monitoring system.
12. Provide trainings for partners and community mobilizers that build their capacity to manage energy and the environment.

Key management considerations

Senior management should ensure that all sectors address energy and environmental concerns from the outset of an emergency. A dedicated budget for environment and energy should be allocated. The budget should be used to enhance protection and self-reliance, prevent degradation, implement identified mitigation measures, and train staff and partners.

An energy or environmental specialist should be included in emergency teams. S/he should coordinate a rapid environmental assessment. Camp designs and planning should take account of its findings. Where no specialist has been assigned to a team, the team should appoint one of its members to be the energy/environment focal point.
Resources and partnerships

- Government ministries (energy, environment, natural resources).
- Development actors, persons of concern, and host communities.
- National, regional and global private sector organisations with relevant expertise (energy, the environment).
- National, regional and global academic institutions with relevant expertise.
- Local NGOs with relevant expertise.
- Standby partners.

Annexes

UNHCR, Environmental Guidelines, 2005

UNHCR, Frame Toolkit. Framework for Assessing, Monitoring and Evaluating the environment in refugee-related operations, 2005

UNHCR, Refugee Operations and Environmental Management. Selected Lessons Learned, 1998

Norwegian Refugee Council, Camp Management Toolkit, 2014

UNHCR Global Strategy for Sustainable Energy, 2019-2024

3. Links

UNHCR, Note on climate change EHA Connect The Sphere Project, Reducing environmental impact in humanitarian response WFP portal

4. Main contacts

Contact the Energy and Environment Unit, Division of Resilience and Solutions (DRS, www.ecop.unhcr.org) at: hqenviro@unhcr.org

Safe Sites

03 December 2020
Key points

- Only settle PoCs in safe and secure locations.
- Work with multi-functional teams, consult members of communities, especially women and girls, and ensure their active participation in decisions that concern them.
- Comply with local building code and safety standards. Consult members of the community, especially women and girls, on locks, lights and gender segregation.
- Mitigate GBV risks and promote child protection from the start of an emergency; monitor these issues through all phases of programming.
- Prevent or mitigate negative environmental impacts, which significantly increase the vulnerability of PoCs.

1. Overview

In an emergency context, it is imperative that all sites in which refugees and internally displaced persons (IDPs) settle are safe and secure. In a number of settlement scenarios [see ‘Description of settlement scenarios’ in Appendix 2 of the Sphere Handbook (2018)], persons of concern to UNHCR (PoCs) face a range of security and safety threats and hazards, including fire, natural hazards such as floods or strong winds, physical injury, crime, and gender-based violence (GBV). To prevent, mitigate and reduce exposure to such protection risks, it is essential to establish ‘safe sites' from the start of an emergency.

When making sites safe, staff should make sure they respect minimum standards of settlement and shelter and follow best practices for the provision of safe and secure living conditions for PoCs. These goals cannot be achieved in isolation and require the engagement of a multi-functional team (from Shelter and Settlement, WASH, Energy and Environment, Protection, CCCM, Health, etc.), as well as consultation with local authorities.

Action should be taken from the start to make sure that PoCs - particularly those who face higher physical and information barriers - can meaningfully participate in the planning, implementation, monitoring and evaluation of sites. Their involvement is critical to ensuring that the priorities and needs they identify are addressed. In addition, PoC participation enables UNHCR staff to better understand the community's structure, as well as cultural and social factors that may be associated with protection risks. A specific effort should be made to understand and address barriers to participation that women and girls face.

Applying accessibility standards and adopting universal design principles will make sites more accessible but also safer for everyone. Whenever you establish a new site to accommodate PoCs, consult and involve appropriate technical experts.

2. Main guidance
Underlying policies, principles and/or standards

- Respect the minimum requirements for ensuring safe and secure living conditions. These should take account of the operational context, including: the operational setting; the profile of the PoCs who will be accommodated; logistical and budgetary factors; and local and national laws. Minimum construction standards should be based on local building and safety codes (where these exist) or international best practice.
- In the Sphere Handbook (2018) safety is clearly referenced across all shelter and settlement standards. These cover planning, location, living space, household items, technical assistance, security of tenure, and environmental sustainability.
- When developing a safe site, observe the following elements of protection mainstreaming: prioritize safety and dignity; avoid causing harm; ensure inclusive and meaningful access; establish accountability; and promote participation and empowerment.
- Mitigate the risk of GBV during all stages of programming in accordance with the IASC Guidelines for Integrating GBV in Humanitarian Action.

Promote child protection at every stage of programming in accordance with the relevant Sphere standard on child protection. [See Alliance for Child Protection in Humanitarian Action, Minimum Standards for Child protection in Humanitarian Action (2019), Standard 27, Shelter and Settlement and Child Protection.]

Good practice recommendations

**Essential**
GBV survivors should not be sought out or targeted as a group during assessments. Always conduct specific GBV assessments (to investigate GBV incidents, interview survivors about their experiences, or conduct research on the incidence of GBV) in collaboration with GBV specialists or partners or agencies that specialize in GBV.

**Key multi-sector actions.** Plan settlement actions in collaboration with relevant technical sections to ensure that the operational plan and strategy are comprehensive and aligned. When designing settlements, adopt an integrated multi-sectoral approach that incorporates best practices and standards and meets national or international building regulations.

**Participatory assessments.** If data are not available already, collect disaggregated data and information from a spread of community members to help inform planning. It is particularly important to consult women and girls in order to obtain their recommendations on how to enhance safety and security, remove barriers, and mitigate the risk of GBV. Use the UNHCR registration process as well as community-based outreach activities to identify marginalized groups and make sure that people with specific needs are consulted. Consult the community to obtain information on the natural, cultural, religious and historical importance of potential settlement locations. Assess available resources, including those in the community, and agree a management plan with stakeholders. Conduct a needs assessment for refugee emergencies (NARE) to obtain basic information on needs and resources, such as water and energy. Detailed sectoral assessments may require more sector specific analysis; you can find tools for sector
specific analysis in: the four Annexes of the Master Plan Approach (MPA) to Settlement Planning; Shelter Needs Assessments; Energy Assessments; and Natural Disaster Risk Assessment.

**Planning.** Building on information from participatory assessments, use an age, gender and diversity (AGD) and community-based protection (CBP) approach to involve a range of PoCs in designing facilities and services. Comply with national laws and regulations, including national standards on accessibility; in their absence, apply international standards. Plan land use with stakeholders, taking account of restraints on land use and time, to ensure that issues relating to housing, land and property (HLP) are highlighted and addressed early on. Where possible, promote action planning by the community and assist communities to meet their needs using their own capacities.

**Implementation.** Where it is possible to do so, build on the resources, skills and capacities of PoCs. Enable them to construct their own household facilities and encourage community members to support each other, especially persons with specific needs. Promote income generation and skills development as appropriate.

**Maintenance.** Where possible, make sure that PoCs carry out routine maintenance of their own facilities. Provide the materials, tools and training they need to do this. Encourage members of the community to support and show solidarity with people who have specific needs.

**Monitoring.** To strengthen accountability to affected people, establish community-based systems to provide feedback and monitoring. Make sure that these mechanisms include a clear referral and response pathway, so that community members receive responses to their complaints or questions. Make sure the information that such systems collect is applied to improve programming.

Monitor programmes continuously to identify any harmful unintended effects. Act quickly to prevent or mitigate these. To monitor, hold frequent feedback sessions with community members, particularly women and girls. Make sure that all groups are aware of feedback mechanisms and can access them.

Taking account of potential natural hazards and in coordination with local authorities, set up early warning mechanisms in settlements. Make sure that communities are informed of local policies and rules concerning the use of resources.

**Environmental considerations.** Negative environmental impacts can significantly increase the vulnerability of both PoCs and host communities. They also make emergencies more complex and complicate future recovery efforts. As a first step, identify environmental impacts by conducting a Nexus Environmental Assessment Tool (NEAT+) assessment. Depending on the results, you may need to undertake a formal environmental impact assessment (EIA). Be alert to the fact that protection risks may be associated with resource depletion; for example, substituting alternative sustainable sources of energy for wood fuel can reduce the incidence of GBV.
Considerations for practical implementation

Essential
Technical sectors should appoint a specific GBV focal point in the sector to facilitate coordination and follow up agreed actions and the recommendations of GBV safety audits. It is recommended that all staff in all sectors are trained in the GBV Guiding Principles, GBV risk mitigation, how to safely handle a disclosure, and how to make a referral in their location. This training should be supported by GBV specialists.

I. Settlement planning

- Ensure that sites are located at least 50 km from national borders, to protect against potential security threats.
- Ensure the site and its surrounding areas are free of all landmines and unexploded ordnance (UXO).
- Ensure the site is an appropriate distance from military installations and other potentially dangerous locations.
- Seek the maximum achievable security of tenure for sites and for all PoCs. Take into consideration that land related disputes may occur between PoCs and host communities.
- Avoid areas that are subject to landslides, flooding, animal crossings, etc. Ensure that sound civil engineering mitigates impacts that cannot be avoided.
- Wherever possible, design settlements in a manner that serves the needs of both displaced and host communities, to minimize protection risks, reduce potential conflicts, and encourage peaceful coexistence.
- Define useable land area and allocate individual plots to PoCs, taking the context and cultural aspects into account. Avoid congestion and make sure the population does not exceed the site's absorption capacity. Where necessary, request more land.
- The settlement should remain reliably accessible during the rainy season. This is important in case a fast response is necessary in order to deal with an emergency. Align roads, drainage and plots with contour lines.
- Reduce erosion risks by retaining as much vegetation cover as possible. Avoid heavy earth moving equipment where possible. During construction, install an adequate drainage system.
- Establish 50m buffer zones around surface waters. Within these zones, vegetation should be left intact, to prevent drowning and water pollution.
- Place sites at least 15 km from ecologically sensitive or protected areas.
- Consult the community, in particular women and girls, on the proposed layout, and configure sites in a way that will reduce exposure to GBV. Factors to consider include: plot sizes; shelter arrangements; the location and design of shared facilities, especially washing and sanitary facilities; access to and distance from public spaces and institutions such as schools, police stations, distribution centres, etc.
- In association with GBV specialists, plan regular GBV safety audits and monitor and adjust programmes accordingly.
- Mitigate hazards due to construction work. For instance, cover or fill in borrow pits caused by road construction or brickmaking to avoid accidents, and ensure that stagnant water does not cause health risks in mosquito-breeding areas.
Fence off power generation systems and limit access to authorised persons. If solar photovoltaic systems are employed, ensure that fences do not shade the panels.

All electrical installations and distribution networks should be undertaken by qualified personnel and regularly certified for safety.

II. Shelter

Prioritise the rapid provision of individual family shelters. Reduce the length of time PoCs spend in collective accommodation. (As far as possible, this period should not be longer than 72 hours.)

Consult women and girls as soon as possible and ensure their recommendations are factored into design and planning. Consult more broadly with other community members to understand cultural, familial and societal structures. Where it is possible and safe to do so, consult other groups in the community who could be directly or markedly affected by shelter planning. When allocating shelters or making shelter arrangements, consider the specific needs of individuals and families. For example, consider persons in same-sex partnerships, and transgender and gender non-conforming people. Liaise with protection staff and explain to members of the community the risks and challenges associated with all types of programming, especially risks and challenges that might compromise family unity, safety, etc.

All the proposed design features of the site should be discussed with the community to ensure they are acceptable.

To reduce the risk of GBV and to facilitate safe management of menstrual hygiene, make sure that women and girls have adequate privacy.

UNHCR recommends that you should install locks, making it possible to lock shelters internally and externally. This should increase privacy and security. (As with other safety features, the provision of locks should be discussed with the community and the agreed arrangements monitored so that any unintended harmful consequences can be identified and repaired.)

Windows should include safety guards to prevent break-ins and intrusions.

Where possible, shelters should be lit internally and externally to increase safety and reduce the risk of GBV. If lighting options are limited, communities should set their priorities. The incidence of GBV may be higher in partly-lit areas and this should be considered carefully.

Shelters should be appropriate for the PoCs who will live in them. They should be culturally acceptable and reflect their living habits. Make sure shelters provide sufficient privacy, have at least one internal partition and non-translucent walls. Consider the size and composition of families as well as their privacy and dignity.

Collective and individual shelters should be accessible to persons with disabilities and persons with temporary impairments.

Consult POCs before setting up cooking areas. Kitchens may be communal, grouped or individual. Communal or household cooking areas should be located at a safe distance from shelters and flammable materials.

The roofing and walls of shelters should be fully sealed to prevent leaks and maximize thermal comfort. Roof drainage should be fitted on the outside of shelters to direct rainwater away from the shelters to a drainage system.

Where high winds are common, the foundations, roof and walls of shelters should be
sufficiently robust. Where possible, collective accommodation must be partitioned to accommodate individual families and allow gender separation.

- Structures should not be composed of materials or material treatments (such as asbestos) that are hazardous to health.
- In cold climates, shelters should be sealed from draughts to reduce heat loss during winter. When stoves are used for heating, ventilation should be sufficient to evacuate fumes. In hot climates, shelters should allow air to circulate. To achieve adequate ventilation, the area of the openings (windows and vents) should amount to at least 5% of the total floor area.
- To provide adequate natural lighting, openings should amount to at least 10% of the total floor area.
- Cooking solutions should be determined in consultation with the host community and PoCs, and an assessment of what fuels and cooking technologies are locally available. To minimize the risk of GBV, consult PoCs and the host community on cooking habits and culture.
- It is recommended that emergency response kits should include a clean cooking stove, appropriate clean fuel, and a solar light with mobile charger.
- Working with GBV specialists, plan regular GBV safety audits to monitor and adjust programmes as required.
- Ensure shelters are designed to protect from snakes, insect disease vectors, and similar threats.

III. Communal areas

- Consult communities to understand how cultural and societal structures or habits impact the use of communal areas.
- Ensure that communal areas, roads and pathways are well lit by street lighting and laid out to provide good visibility. Discuss the placement of lights with members of the community, especially those who face particular risks from GBV or other threats to their safety.
- Provide a sufficient number of child friendly spaces, and spaces for women. Make provision for schools, police stations, health centres, etc.
- Consider the specific needs as well as the safety of PoCs when distributing non-food items. For example, set up a fast lane or community arrangements to meet the needs of older people, pregnant women, people with disabilities, etc.
- After construction has been completed, clear the site of all dangerous waste such as nails and leftover iron sheets.
- At the end of their lives, structures should be appropriately decommissioned. Steps should be taken to reduce the risk of injury (from uneven terrain, open latrine pits, etc.).
- Make sure that public facilities, including health posts, are connected to a reliable source of energy. Where possible, energy should be renewable.
- Light latrines and bathing units appropriately. Consider how lighting could be deployed to lower the risk of GBV. In addition, plan to provide at least one solar lamp per family.
- Communal latrines/ bathing facilities should always be segregated by gender. Signage should be clear and agreed/proposed by the community. To reduce barriers to access, consider the particular needs of transgender and gender non-conforming people. Work with Protection to explain to the community the risks and challenges associated with all types of programming. Pay particular attention to matters that might compromise access and
safety.
- Community spaces should be accessible to persons with disabilities and persons with temporary impairments.
- Facilities should be designed to safely include transgender and gender non-conforming persons and other groups who might have accessibility challenges. On this aspect of access, it is critical to consult all members of the community who might use such facilities to forestall or mitigate any risk or stigma that could be created unintentionally.
- Together with GBV specialists, plan regular GBV safety audits; monitor programmes and adjust them as necessary.

IV. Fire risk mitigation

- The settlement layout should establish a 30-metre firebreak every 300 metres between built-up areas. A minimum distance of twice the height of the shelters (to the ridge) should be left open between structures.
- Collective accommodations must include an emergency exit route to enable quick evacuation.
- It is recommended that sliding latch locks are used for internal locks, and that padlocks are avoided, to facilitate rapid evacuation in the event of fire.
- As soon as feasible, distribute information on fire safety and fire risk education throughout the community. Adopt a range of formats to ensure that all groups can obtain the information, including people who are illiterate, housebound, blind, have difficulty communicating, etc. Make a specific effort to reach marginalized members of the community who might not be reached through obvious channels.
- Establish fire points at every firebreak. These should be equipped with basic firefighting tools (shovels, sand buckets, etc.).

V. WASH

- Prioritize household washing and sanitary facilities wherever possible. Where it is not, instal facilities that a maximum of two to three families share. Where it is culturally appropriate, WASH facilities can be constructed inside homes.
- Consult women and girls as early as possible and ensure that design and planning take account of their recommendations. Consult a range of community members to obtain information on cultural, familial and societal structures. Wherever it is possible and safe to do so, consult groups in the community who may be especially affected by WASH planning. To reduce barriers to access, consider the particular needs of transgender and gender non-conforming people. Work with Protection to explain to the community the risks and challenges associated with all types of programming. Pay particular attention to matters that might compromise access and safety.
- Discuss all proposed design features with the community to ensure they are acceptable.
- Provide internal locks on the doors of all latrine and bathing units (whether these are communal, shared or household). Doors and walls should be solid; where walls are made of cloth, it should not be easy to poke holes through them. Communal facilities should be segregated by gender.
- Ensure WASH facilities are in safe areas. Consult members of the community to understand the perceived safety of different areas.
Use an age, gender and diversity approach to design the WASH response. Where possible, prioritize cash-based arrangements for non-food items (potties, scoops, re-usable cloth nappies, etc.). When planning cash based programmes, consider GBV risk mitigation measures.

Take steps to reduce the risk of injuries, from slipping, sharp objects or hazardous waste. Ensure that emergency latrine slabs are stable. The decay of wooden logs is a common problem in emergency latrines that can cause people to fall into latrine pits.

Ensure that the design of emergency latrines provides sufficient ventilation. Install screening nets on vent pipes to deter flies and other insects that spread disease. Check that drainage channels from water points move excess water efficiently into the main drainage system, avoiding stagnant pools (a major factor in diseases such as malaria).

Ensure that emergency pit latrines are not dug in areas with a high water table, and are a safe distance from water points (taking account of the topography).

Provide adequate waste collection areas in the settlement. These should separate organic from inorganic waste, be sustainably managed, and exclude rodents. Prevent the dumping and discharge of refuse into surface waters. Sites should be at least 1 km from standard dumpsites and at least 5 km from dump sites that contain hazardous waste.

Give thought to providing facilities that promote and support menstrual hygiene. Provide information on menstrual hygiene in shelters and latrines as well as public facilities such as schools, hospitals and other frequently user locations.

Together with GBV specialists, plan regular safety audits; monitor programmes and adjust them as necessary.

Resources and partnerships

As early as possible, recruit an experienced settlement planner to lead or participate actively in the site's selection and design.

Where possible, set up a technical task force with relevant expertise. It might include the WASH officer, energy officer, environment officer, shelter officer and settlement planner. Include representatives from government technical units, and implementing partners if they are available.

Annexes

UNHCR WASH Manual - 7th Edition_2020

IFRC All-under-one-roof Disability-inclusive shelter and settlements in emergencies_2015

UNHCR Environmental Guidelines_2005

UNHCR Global Strategy for Sustainable Energy_2019-2024
3. Links

UNHCR Settlement Information Portal (SIP) UNHCR WASH Page UNHCR, Energy and Environment Portal and Internet Page UNHCR, Need to Know Guidance: Working with LGBTI Persons in Forced Displacement UNHCR, Gender Equality Toolkit Global Shelter Cluster, Site Planning - Guidance to reduce the risk of GBV Global Shelter Cluster, Distribution: Shelter materials, NFI & Cash - Guidance ... The Nexus Environmental Assessment Tool (NEAT+)

4. Main contacts

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Disease surveillance thresholds

03 January 2024

Key points

- In an emergency, surveillance systems may be underperforming, disrupted or non-existent which may delay the detection of and response to outbreaks
- Displacement, overcrowding, poor sanitation, lack of access to clean water and disruption of health services increase the risk of diseases transmissions in an emergency
- A disease outbreak occurs when the number of cases of disease exceeds what would normally be expected in a given community, geographical area, or season
- Establish a functioning surveillance system to rapidly detect and respond to epidemics and other public health emergencies
1. Overview

Effective disease control relies on an effective facility and community-based surveillance system which is an important epidemiological tool for early warning, alert and response (EWAR) to acute public health events with particular attention to nationally prioritized diseases/conditions.

All diseases of outbreak potential should be assigned a corresponding alert threshold, which defines the basis upon which an outbreak should be reported.

A disease’s potential to cause an outbreak determines whether it should be under surveillance. An outbreak occurs when an infectious disease spreads rapidly to many people. An ‘alert threshold’ (or ‘epidemic threshold’) indicates the level of incidence above which a disease requires an urgent response. Every disease or condition under surveillance must have an associated case definition and a specific threshold that depends on its infectiousness, other determinants of transmission, the degree to which it is locally endemic and control strategies.

Disease control measures must be specifically developed to halt transmission of the disease agent that causes the outbreak. Often, knowledge of the agent is already available to guide the design of appropriate control measures. In general, response activities include controlling the source or preventing exposure (for example, by improving water outlets to prevent cholera); interrupting transmission or preventing infection (by mass vaccination to prevent measles, or use of Long-Lasting Insecticidal Nets to prevent malaria); or modifying host defences (by prompt diagnosis and treatment, or chemoprophylaxis).

The below standards apply to refugee camps and to out-of-camp (including urban) situations.

2. Relevance for emergency operations

Humanitarian emergencies often increase the risk of transmission of communicable diseases, resulting in increased morbidity and mortality, particularly from epidemic-prone diseases.

Therefore, one of the most urgent priorities in an emergency is to establish a functioning surveillance system to rapidly detect and respond to epidemics and other public health emergencies.

3. Main guidance

Emergency Phase

- Diseases for which a single case may indicate an outbreak e.g. cholera, measles, acute flaccid paralysis/polio, yellow fever, viral haemorrhagic fevers. This list is not exhaustive and other diseases may need to be under surveillance according to the context.
Confirmed malaria: 1.5 times the baseline (average number of cases seen in the previous 3 weeks).
Watery diarrhoea: 1.5 times the baseline (average number of cases seen in the previous 3 weeks).
Bloody diarrhoea: 5 cases in one location in one day.
Bacterial meningitis: 1 case in an overcrowded camp setting or 2 suspected cases per week in a population of less than 30,000 or 3 suspected cases per week in a population of 30,000 or more.

Post emergency phase

The above standards apply to both emergency and post emergency phases.

Disease surveillance and thresholds checklist

- Decide which priority diseases and conditions to include based on the epidemiological risk profile and context of the emergency.

- Strengthen or establish a context specific disease EWAR system with partners and agree on reporting units, data flow, reporting tools, case definitions and frequency of reporting.

- Define alert thresholds specific to each disease or condition under surveillance.

- Train healthcare staff and community health workers with emphasis on priority diseases, case definitions, alert, detection and response to potential outbreaks.

- Provide refugees and host populations with simple information on the symptoms of epidemic-prone diseases; inform them where they can go for help.

- Prepare an outbreak preparedness and response plan and ensure actions are triggered rapidly when an alert is generated, and samples can be tested by rapid diagnostic tests or laboratories to confirm an outbreak.
4. Standards

UNHCR Case Definitions 2019

Sphere standards 2018


UNHCR, iRHIS (Integrated Refugee Health Information System)

Annexes

UNHCR, Health information system case definitions, 2019

The Sphere Handbook, 2018

WHO, Early warning alert and response in emergencies: an operational guide, 2022

5. Links

UNHCR case definitions Spere Handbook 2018 WHO Early warning alert and response in emergencies: an operational guide

6. Main contacts

UNHCR Division of Resilience and Solutions, Public Health Section: hqphn@unhcr.org

Primary health care staffing standard

09 January 2024

Key points

- The standards for healthcare staffing apply to health facilities supported by UNHCR. However, national Ministry of Health guidelines if existing should take precedence
- Health workers should have the training, skills and supervisory support they require for their
level of responsibility

- Agencies have an obligation to train and supervise staff to ensure that their knowledge is up to date and appropriate to provide good quality of care
- Mainstreaming capacity-building is a priority, especially when staff have not received regular training or new protocols have been introduced
- As far as possible, training programmes should be standardized. Prioritize training that addresses key health needs and competence gaps identified during supervision

1. Overview

The primary health care workforce is all people engaged in the systems and services specific to primary health care. This includes all occupations engaged in the continuum of health promotion, disease prevention, treatment, rehabilitation and palliative care.

The health workforce is composed of a wide range of health professionals, including medical doctors, nurses, midwives, clinical officers or physician assistants, laboratory technicians, pharmacists, community health workers (CHWs) plus management and support staff.

Though the optimal number of different types of health workers varies from context to context, there is nevertheless a correlation between the availability of health workers and provision of health services. For essential primary health care services, the staffing levels below have been defined as the minimum required to attain and maintain primary health care services of acceptable quality.

Gender and diversity need to be considered. Imbalances in staffing should be addressed by redeploying health workers to areas that experience critical gaps in relation to health needs, or by recruiting new staff.

2. Relevance for emergency operations

Health systems can only function with a health workforce; and the availability, accessibility, acceptability, and quality of a health workforce arguably represent key prerequisites for improving health service coverage and realizing the right to the enjoyment of the highest attainable standard of health.

During an emergency, health systems and the provision of health care are often weakened, even before demand increases. For instance, insufficient or lack of skilled health care workers can result in excessive workload and unsafe health care. It is therefore important to ensure that people have access to health care workers with adequate skills at all levels of health care.
3. Main guidance

Emergency Phase

The table below provides indicative recommendations that may need to be adapted according to the context and any existing national standards. Any Sphere staffing standards are indicated (Sphere).

<table>
<thead>
<tr>
<th>Health Centres (ratio of health staff to population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Doctor 1 : &lt; 25,000</td>
</tr>
<tr>
<td>Clinical officer (out-patient services) 1 : &lt; 10,000</td>
</tr>
<tr>
<td>Nurses (out-patient services) 1 : &lt; 10,000</td>
</tr>
<tr>
<td>Nutrition Supervisor 1 : &lt; 10,000</td>
</tr>
<tr>
<td>Psychiatric Nurse/Clinical Officer trained in Mental Health 1 : &lt; 25,000</td>
</tr>
<tr>
<td>Qualified Pharmacist(diploma) 1 : &gt; 50,000 -100,000 or for a cluster of smaller camps</td>
</tr>
</tbody>
</table>

Community Health Care
| Community Health Workers (Sphere) | 1-2 : 1,000 | Nutrition Outreach Workers | 1-2 : 1,000 persons in refugee camps where GAM is above 10% |

**Post emergency phase**

The above standards apply to post emergency phase as well.

**Primary health care staffing standard checklist**

- Review existing staffing levels and distribution against national classification to determine gaps and under-served areas.

- Train staff in clinical protocols and case management and for their roles according to national standards or international guidelines.

- Support healthcare workers to operate in a safe working environment.

- Develop incentive and salary strategies that minimize pay differences and inequitable distribution of healthcare workers between MoH and other healthcare providers.

- Share healthcare workforce data and readiness information with MoH and other relevant bodies locally and nationally.

**4. Standards**

Sphere Healthcare systems standard 1.2: Healthcare workforce

People have access to healthcare workers with adequate skills at all levels of healthcare

- Number of community health workers per 1,000 people
  - Minimum 1-2 community health workers
- Number of skilled birth attendant personnel (doctors, nurses, midwives) per 10,000 people
  - minimum 23 per 10,000 people
- All health staff performing clinical work have received training in clinical protocols and case management

**Annexes**

[The Sphere Handbook, 2018](#)

### 5. Links

[The Sphere Handbook, 2018](#)

### 6. Main contacts

UNHCR Division of Resilience and Solutions, Public Health Section: [hqphn@unhcr.org](mailto:hqphn@unhcr.org)

**Mortality surveillance threshold**

09 January 2024

**Key points**

- Substantial elevations in mortality (two- to ten-fold the baseline) are common, particularly during the acute phase of an emergency
- Accurate population estimates (denominator) are required to measure mortality rates. This may be difficult to calculate in urban and rural settings. Other methods of mortality estimates may be applied
- It is essential to obtain good mortality data (numerator) using different methods from multiples sources including from health facilities and community (deaths at home, grave counting etc.)
- Collect and analyze data on health problems and risks in order to target the major causes of excess mortality and morbidity
- Prioritize health services that effectively reduce excess morbidity and mortality
1. Overview

Humanitarian emergencies have significant impacts on the health and well-being of forcibly displaced populations, often leading to high numbers of deaths from both preventable and treatable causes. Forcibly displaced populations are at an elevated risk of death in the period immediately before, during, and after displacement, including as they settle in refugee camps, informal settlements, or in host community settings. This elevated mortality risk can be a result of either direct causes (i.e., injury and death due to violence from the crisis), or indirect causes (i.e., deterioration of living conditions, food insecurity, lack of potable water, poor shelter, hygiene and sanitation, and disruption to health care services). Moreover, in humanitarian emergencies, the health system may be overwhelmed and/or fragmented and its ability to respond may be limited, which exacerbates the potential for excessive loss of life.

2. Relevance for emergency operations

- Population mortality is an essential public health metric of a crisis’ impact, and, by implication, of the need for humanitarian public health services.
- UNHCR is committed to supporting timely and effective public health interventions, to improve emergency response capacity, and save lives.
- The primary goal of public health interventions, and every emergency response, is to prevent excess morbidity and mortality.
- The two main public health risks that cause excess mortality are disease outbreaks and malnutrition.

3. Main guidance

Emergency Phase

The most useful indicators to monitor and evaluate the severity of a crisis are the crude mortality rate (CMR) and the more sensitive under-five mortality rate (U5MR). A doubling or more of the baseline CMR or U5MR indicates a significant public health emergency and requires an immediate response.

Baseline mortality and emergency thresholds are context specific. Where available, national or regional mortality rates from country of origin of refugees should be used as baseline reference. In any case, the most recent and reliable source of data including surveys should be used.

Historically, a crude mortality rate (CMR) of 1/10,000/day or an under-five mortality rate (U5MR) of 2/10,000/day was used as a standard emergency mortality threshold. But because baseline mortality rates have fallen considerably since that standard was established in 1985, this threshold may be too high to be applied to assess the adequacy of a humanitarian response. The current 1 death/10,000/day threshold currently corresponds to four times the average mortality rate in Sub-Saharan Africa.

The key factors to consider are how elevated the mortality rate is (i.e., the excess death rate
compared to a plausible baseline), **how long this elevation lasts for**, and **how many people experience this elevation**. These three parameters multiply to yield the excess death toll.

**A doubling or more of the known or estimated pre-emergency baseline CMR or U5MR, or the crossing of a certain context specific, pre-established threshold, is considered to indicate an acute emergency.**

Where available, national mortality rates from countries of origin or asylum should be used as the baseline reference.

Mortality rates can be expressed by calculation deaths per time-period. The unit used in the acute emergency phase when mortality rates are changing rapidly, is generally deaths/10,000/day and deaths are reported on daily or weekly.

**Post emergency phase**

In the post emergency phase, baseline estimates could be taken from the host country of refugees or displaced population.

The unit used in the post emergency phase is deaths/1,000/month, when deaths are reported on monthly basis.

**Mortality Surveillance checklist**

- Establish a general framework for planning, implementation and adaptation of a mortality surveillance system.

- Coordinate planned activities with the surveillance coordination team or committee.

- Develop or adapt data collection tools for both facility and community-based surveillance.

- Identify, train and install the cadre of workers (health staff, community health workers/volunteers, etc.) who will collect mortality information.

- Conduct introductory focus group discussion to sensitize the community to mortality surveillance activities.
• Map the camp/settlement and its health facilities for planning and implementation of facility-based mortality surveillance.

• Conduct baseline household census if there are no other sources of reliable population data.

4. Standards

UNHCR Guidelines for mortality surveillance 2023

UNHCR, Operational guidance: community health in refugee-settings 2022

Sphere standards, 2018

Estimation of population mortality in crisis-affected populations - 2018

UNHCR Integrated Refugee Health Information System (iRHIS)

Annexes

UNHCR Operational Guidance: Community health in refugee settings, 2022

The Sphere Handbook, 2018

Francesco Checchi, Estimation of population mortality in crisis-affected populations - Guidance for humanitarian coordination mechanisms, 2018

UNHCR Standards and Indicators Guide, 2019


5. Links

UNHCR Guidelines for Mortality Surveillance UNHCR Operational Guidance: Community Health in Refugee Settings 2022 The Sphere Handbook, 2018 Health Cluster Estimation of population denominators for the humanitarian healt... UNHCR Integrated Refugee Health Information System (iRHIS)
Infant and young child feeding threshold

28 October 2014

Key points

- Infant and young child feeding (IYCF) should be assessed by regular nutrition surveys following SENS guidelines.
- Key IYCF information should be gathered at reception centres or other entry points.

1. Overview

Infant and young child feeding indicators are employed to monitor the feeding practices of infants and young children aged between 0 and 23 months. Protection and promotion of appropriate infant and young child feeding (IYCF) in emergencies helps to save the lives of the most vulnerable infants and young children, and plays a key role in preventing malnutrition and micronutrient deficiencies.

If adequate feeding and caring practices for infants and young children aged less than 24 months are not protected, promoted and supported, and if infant-mother pairs who are having difficulty breastfeeding are not identified and supported, infants and young children may be fed inadequately, increasing the risk of malnutrition and death. Non-breastfed infants younger than 6 months must be identified and given support quickly. Key elements of adequate IYCF practices are:

- Timely initiation of breastfeeding.
- Exclusive breastfeeding for six months.
- Continued breastfeeding to 24 months and beyond.
- Introduction to safe, adequate and appropriate complementary foods at 6 months.

UNHCR recommends use of seven standardised IYCF indicators, through Standardised Expanded Nutrition Surveys (SENS). In emergency situations, the two most essential are ‘timely initiation of breastfeeding' and ‘exclusive breastfeeding under 6 months'.
2. Main guidance

Emergency standard

The standard below is applied to both emergencies and longer-term situations.

Key infant and young child feeding indicator thresholds in refugee settings

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit</th>
<th>Emergency standard</th>
<th>Post-emergency standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely initiation of breastfeeding</td>
<td>Proportion of children between 0 and 23 months who were put to breast within one hour of birth</td>
<td>≥70%*</td>
<td>≥80%*</td>
</tr>
<tr>
<td>Exclusive breastfeeding under 6 months</td>
<td>Proportion of infants between 0 and 5 months who received only breastmilk during the previous day</td>
<td>≥70%*</td>
<td>≥70%*</td>
</tr>
</tbody>
</table>

* Because no standard threshold exists for these indicators, thresholds are based on technical consultations and a review of current refugee populations. They may be adjusted as more evidence is gathered.

Annexes

UNHCR’s policy related to the acceptance, distribution and use of milk products in refugee settings

UNHCR, IYCF screening questionnaire

3. Links

UNHCR, Global Strategy for Public Health UNHCR SENS
4. Main contacts
UNHCR Public Health Section, Division of Programme Support and Management. At:
hqphn@unhcr.org.

Education in emergencies - Camps

05 May 2021

Key points

- Build strong relationships with the Ministry of Education and local education officials.
- Work towards inclusion in national education systems from the start of an emergency.
- Identify barriers to girls' participation in education during assessments and design interventions to support enrolment and retention
- Foster complementarity between the early phase of the education response and child protection
- Consider the educational needs of children and youth of all ages. Include secondary school-aged children and university-aged youth in the education response.

1. Overview

Access to education is a basic right that is also applicable in emergency settings. The Global Compact on Refugees (para. 68) aims to see children and youth return to learning within three months of displacement. One of the first services requested by refugees and IDPs once their basic needs have been met is for children and youth to have the opportunity to continue their education.

Education provides knowledge and skills that support community resilience, facilitate living with dignity and lay the foundation for future access to meaningful work. Going to school also offers emotional and psychological benefits. In emergencies education activities offer opportunities for refugees to receive information about their rights, available services, disease prevention, safety and physical security (including mine risk awareness) and have access to psychological support services (PSS). This entry explains some of the key steps that should be taken at the start of an emergency to ensure that children and youth have long-term access to education.
2. Main guidance

Protection objectives

- Education provides a protective environment where children and young people acquire knowledge and skills, socialize and have access to wrap-around support services (including health screening, nutrition and counselling)
- Education provides a foundation for future economic activity, meaningful work and addressing generational poverty
- Education supports psycho-social wellbeing by offering hope and a focus on the future
- Girls in education are less likely to marry and have children early
- Children and young people in education are less likely to be engaged in child labour or be at risk of recruitment into armed groups

Underlying principles and standards

Terminology:
Non-formal education (NFE) programs are often designed for specific groups of learners such as those who are too old for their grade, whose education has been disrupted or who require additional support to adapt to learning in a new country. Examples include language learning support, catch up classes, and initial literacy and numeracy programs. NFE programs for youth and adults also exist.

Formal education usually makes use of a standard curriculum and typically takes place over 8-12 years. Schools and education institutions are regulated by policies of the Ministry of Education.

Principles:

- Work towards inclusion of displaced children in the national education system from the start of an emergency. This requires close collaboration with and, sometimes, intensive advocacy with national authorities to agree on how best refugee children can receive education that is certified, of high quality and allows refugees to progress from one level of education to the next.
- Support children and youth to return to learning as quickly as possible.
- Consider the educational needs of all age groups, including secondary school age youth and those above 18
- School infrastructure should be safe and accessible to those with disabilities.
- School environments should be free of violence – including gender-based violence – and any attacks on education documented and reported.
- Sex-segregated WASH facilities should be established in schools and be accessible to children with disabilities.
- Support programs (including language learning) that promote enrolment and retention in formal education are an important element of an education in emergencies (EIE) response
- Integrate psychosocial support (PSS) activities in education programs
- Non-formal education programs should be limited in duration and help children and youth
to transition to the formal system or prepare for livelihoods-focused skills programs. Accredited accelerated education programs may be of longer duration and operate alongside formal education opportunities.

- Specific barriers to education experienced by girls, adolescent girls and boys and those with disabilities should be explicitly addressed

**Standards:**

- Where possible the standards for education delivery set by the host government should be applied. However, in emergencies, this may not be possible or practical, particularly in relation to school infrastructure. The Inter-Agency Network for Education in Emergencies (INEE) Minimum Standards for Education in Emergencies provides useful guidelines for the establishment of safe, accessible temporary learning spaces and age-appropriate WASH facilities.
- UNHCR Emergency Handbook entries [Energy and Environment - Camps](#), [Wash in Camps](#), [Safe Sites](#) and [Camp site planning minimum standards](#) (planned settlements) are also applicable.

**Protection Risks**

Lack of access to relevant, quality education opportunities can result in:

- Loss of peer support networks, social isolation, increased need for [mental health and psychosocial support](#) (MHPSS) services
- Increased likelihood of early marriage and pregnancy
- Increased risk of child labour and economic exploitation
- Forced recruitment into armed groups
- Exploitative sexual relationships, transactional/survival sex and GBV
- Irregular onward movement and trafficking
- Long-term social and economic exclusion of the refugee community and heightened rates of poverty

**Other risks**

- The absence of education services may lead to large numbers of children and youth being idle which can increase security risks in camps associated with gang membership, GVB and criminality.
- UNHCR may experience reputation risks if it does not ensure that the right to education is realized.

**Key decision points**

The decisions taken in the early phase of a response can have long-term implications for the
quality and nature of education provided. Education interventions should be informed by a clear strategy for ensuring **sustained access** to education. Issues such as language of instruction, curriculum, materials, certification and accreditation need to be considered early in a response.

An **education needs assessment** will help to understand the previous education experience of children, the length of disruption to their education, the capacity of local education infrastructure and teacher availability in the refugee community. The Education Cluster's Joint Education Needs Assessment tool can be adapted to refugee contexts. Ensure the education part of the **Needs Assessment for Refugee Emergency (NARE)** checklist is included in the multi-sector assessment.

**Advocacy with government** may be necessary if administrative barriers to education must be addressed or significant policy changes are needed.

**Key steps**

1. Familiarize yourself with the **education policy context** in the country of asylum. The **Preparedness Package for Refugee Emergencies** (PPRE) includes a Preparedness Action Plan-checklist, which provides questions to help understand the policy framework applicable to refugees and the education context of the country of origin. At the same time, learn about the educational context in the country or region from which people have been displaced.

2. Establish a **coordination** structure for the education response. In refugee settings, where possible, UNHCR should lead or co-lead this group. Familiarise yourself with the **potential education partners** in country who can support the response - UNICEF and the Education Cluster, where activated, may be able to provide useful information on education actors.

3. Ensure that the education response is well planned, budgeted and **included in inter-agency appeals**.

4. **Meet with district or local education officials** to discuss the response with them and ensure that they are informed about and supportive of efforts to support education access.

5. Work with site planners to **identify locations** where temporary learning spaces can be established.
   a. Invest in improving host community infrastructure if refugee children are able to attend host community schools close to camps.
   b. Allocate sufficient space in camps to allow for the building of more permanent structures that meet the infrastructure standards of the Ministry of Education and include gender-segregated, age-appropriate WASH facilities.

6. Establish **temporary learning spaces** where literacy, numeracy, psychosocial/ recreational
activities can take place.

7. Determine whether there are **existing programs** (such as accelerated education programs) or **materials** (books, language learning materials) approved by the national authorities that can be used in the response.

8. Work in close coordination with **child protection** actors to ensure that referral pathways exist between education and protection services. In the initial phase of a response similar activities may be carried out by **child protection** and education actors - it is important to ensure that any activities supporting learning contribute to the eventual inclusion in national services.

9. Ensure that the **community remains well informed** about education services and decisions regarding curricula and inclusion in the national system. Consult community members and respond to any concerns that they express.

10. Where refugees will be involved in the delivery of education activities, establish a **common framework** for the identification, recruitment, remuneration, conditions of service and **code of conduct** for **volunteer teachers and education personnel**.

11. Identify **key indicators** against which all education actors will report. Data on education participation should be disaggregated by age, gender, level of education and disability.

**Specific considerations for IDP responses**

- In IDP responses the coordination of the education response is usually led by the Education Cluster, where activated.
- Education programs and services established during an emergency should form part of the national education system. As far as is practical, host community schools should be supported to include displaced children and youth, with an emphasis on the continuity of learning.
- Protection monitoring and education assessments should identify any administrative or legal barriers limiting access to education.
- If IDPs speak a different language to that used in local schools, additional language support programs may be needed.

**Key management considerations**

UNHCR should play a lead role in establishing the strategic framework for the education response that is aligned with the overall **protection and solutions strategy**. Core elements of the strategy should be agreed with key actors ahead of an influx or as early as possible in the response. The strategy should also be informed by the work of development actors in the education sector and national priorities. The Regional Bureau and HQ Education team can provide guidance and
support as needed.

Once the response is underway, the diversification of education services – including supporting access to higher education – should take place.

**Resources and partnerships**

**Staff**

- Emergency Response Teams should include an Education Officer responsible for coordination, liaison with the Ministry of Education and organisations supporting the education response, engagement with other sectors (e.g., child protection, WASH, site planning) and strategy development.
- Appoint an Education Officer as soon as possible within the response staffing to ensure continuity of the education function.

**Partnerships**

- Identify focal points in the Ministry of Education at national and local levels.
- Build strong relationships with UNICEF and establish mechanisms for sharing information on response priorities and joint advocacy.
- Be aware of and identify possible synergies with development-focused initiatives in the education sector and key donors to education, including the World Bank and the Global Partnership for Education.

**Financial resources**

- Ensure that education needs are reflected in inter-agency appeals.
- Education Cannot Wait, the global fund for education in emergencies, is an important donor partner.

**Annexes**

- [UNHCR Refugee Education 2030, A Strategy for Refugee Education](#)
- [UNHCR COVID-19 Refugee Return to Schooling Guidelines, 2020](#)
- [ISEEC Report on Improving Coordination, 2020](#)
- [UNHCR Cash for Education, Direction and Key Considerations](#)
3. Links

UNHCR Education Pages Accelerated Education Working Group Inter-agency Network for Education in Emergencies (INEE) Global Education Cluster Education Cannot Wait

4. Main contacts

Contact Senior Education Officers in Regional Bureaus or the Headquarters Education Section (hqeduc@unhcr.org) in the Division of Resilience and Solutions (DRS).

Camp site planning minimum standards

19 July 2019

Key points

- UNHCR discourages the establishment of formal settlements and (whenever possible) prefers alternatives to camps, provided they protect and assist people of concern effectively.

- Shelter should be adapted according to the geographical context, the climate, the cultural practice and habits, the local availability of skills as well as accessibility to adequate construction materials in any given country.

- Due considerations should be given to the operational phase. What may be deemed adequate during an emergency in terms of shelter (for example plastic sheeting, tents) and average camp area per person cannot be regarded as adequate in a protracted displacement situation.

1. Overview

This entry provides key information on minimum standards and best practice which should be referenced and consulted when developing planned settlements / camps as part of a refugee emergency response.

Generally, a sector specialist covers shelter and settlement needs assessment, analysis and site planning during the first phase of an emergency response.
Often a reception or transit centre is necessary for temporary accommodation at the beginning of a refugee crisis. Refer to entry on Transit Center standards for more information on these standards.

These guidance notes outline the minimum standards required to ensure planned settlements enable refugee communities to live with security and dignity in a healthy environment which improves their quality of life.

UNHCR Master Plan Approach to Settlement Planning Guiding Principles is a key reference when defining a settlement response. The choice of settlement location is a critical decision which will have significant impact on the protection and well-being of displaced people, as well as broader local development. While a well-positioned settlement can have multiple protective benefits and contribute to local development, a settlement in the wrong geographical location can threaten the protection and assistance of displaced persons and have negative consequences for local development and the peaceful coexistence of communities.

2. **Main guidance**

**Emergency standard**

There are several indicators determining the adequacy of shelter for refugees and displaced persons. (See links below for additional information).

**2.1 Indicator**

Average camp area per person: The size of a camp and area per capita is critical in the planning of camps as crowded conditions lead to increased morbidity and stress. The provision of adequate space, both outside and inside shelters is an essential requirement.

The ‘average camp area per person (Sqm.)’ indicator measures the average living space to which a person has access in a camp. This space should accommodate all services while promoting dignified living:

<table>
<thead>
<tr>
<th>Indicator: Average camp area per person (Sqm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How should this indicator be measured:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard: 45 sq. m</th>
<th>Acceptable Range: ≥ 35 sq. m</th>
<th>Unacceptable Range: 34 - 30 sq. m</th>
<th>Critical Range: ≤ 29 sq. m</th>
</tr>
</thead>
</table>

A minimum surface area of 45 Sqm per person including household gardening space should be allocated. 30 Sqm per person will be necessary for roads, foot paths, educational facilities, sanitation,
security, firebreaks, administration, water storage, distribution points, markets, storage of relief items and, of course, plots for shelter. It excludes however, any land for significant agricultural activities or livestock. The remaining 15 Sqm per person is allocated to household gardens attached to the family plot which should be included in the site plan from the outset.

2.2 Emergency standard
The design of planned settlements follow SPHERE emergency standards. The table below defined the minimum standards to be applied.

<table>
<thead>
<tr>
<th>Description</th>
<th>Minimum Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered living area</td>
<td>3.5 sqm. Per person minimum</td>
</tr>
<tr>
<td></td>
<td>In cold climates and urban areas more than 3.5 sqm. may be required(4.5 sqm. to 5.5 sqm. is more appropriate)</td>
</tr>
<tr>
<td></td>
<td>Minimum ceiling height of 2m at highest point</td>
</tr>
<tr>
<td>Camp settlement size</td>
<td>45 sqm. per person (incl. kitchen and vegetable garden)</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>30 m firebreak every 300 m</td>
</tr>
<tr>
<td></td>
<td>Minimum 2 m between structures – use 2 times the height of the structure as an appropriate distance.</td>
</tr>
<tr>
<td>Gradient for camp site</td>
<td>1 to 5 %, ideally 2 to 4%</td>
</tr>
<tr>
<td>Drainage</td>
<td>Appropriate drainage needs to be put in place, especially relevant in locations that experience a rainy season or flash floods.</td>
</tr>
</tbody>
</table>

Table 1 - Minimum standards for planning camps

Site planning should begin from the scale of the individual refugee family, addressing needs at household level, such as their distance to water, access to communal services, recreation facilities, access to showers and latrines, waste management, etc.

It is advisable to consider the social structures and relations within persons of concern, including clan, tribes and extended family arrangements, as well as their traditional settlement layouts and shelter preferences. This consideration will yield a greater degree of satisfaction, and sense of ownership.

The following table uses the family unit as the smallest planning 'module' and builds up to larger units:
<table>
<thead>
<tr>
<th>Module</th>
<th>Structure</th>
<th>Approximate number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>1 x family</td>
<td>4 - 6 persons</td>
</tr>
<tr>
<td>Community</td>
<td>16 x families</td>
<td>80 persons</td>
</tr>
<tr>
<td>Block</td>
<td>16 x communities</td>
<td>1,250 persons</td>
</tr>
<tr>
<td>Sector</td>
<td>4 x blocks</td>
<td>5,000 persons</td>
</tr>
<tr>
<td>Settlement</td>
<td>4 x sectors</td>
<td>20,000 persons</td>
</tr>
</tbody>
</table>

**Table 2 - Indicative modular planning units**

The following are recommended site planning standards for services and infrastructure and should be referred to when preparing the camp layout:

<table>
<thead>
<tr>
<th>Description</th>
<th>Standard</th>
<th>Further consideration</th>
</tr>
</thead>
</table>
| Communal latrine| 1 per 20 persons - emergency phase            | Separate latrine areas for men and women  
For long-term accommodation use one household latrine per family |
<p>| Latrine distance| Not more than 50m from shelter and not closer than 6m | Latrines must be close enough to encourage their use but far enough to prevent problems with smells and pests |
| Shower          | 1 per 50 persons                              | Separate, well drained, shower areas for men and women                                  |
| Water supply    | 20 litres per person per day                  |                                                                                        |
| Water tap stand | 1 per 80 persons                              | 1 per community                                                                        |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Quantity/Location</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water distance</td>
<td>Max. 200m from household</td>
<td>No dwelling should be further than a few minutes' walk from a water distribution point</td>
</tr>
<tr>
<td>Rubbish container of 100 litres</td>
<td>1 per 50 persons</td>
<td>1 per 10 families</td>
</tr>
<tr>
<td>Refuse pit - 2mx5mx2m</td>
<td>1 per 500 persons</td>
<td>1 per 100 families</td>
</tr>
<tr>
<td>Health centre</td>
<td>1 per 20,000 persons</td>
<td>1 per settlement Include water and sanitation facilities</td>
</tr>
<tr>
<td>Referral hospital</td>
<td>1 per 200,000 persons</td>
<td>1 per 10 settlements</td>
</tr>
<tr>
<td>School</td>
<td>1 per 5,000 persons</td>
<td>1 per sector 3 classrooms, 50 Sqm.</td>
</tr>
<tr>
<td>Distribution centre</td>
<td>1 per 5,000 persons</td>
<td>1 per sector</td>
</tr>
<tr>
<td>Market place</td>
<td>1 per 20,000 persons</td>
<td>1 per settlement</td>
</tr>
<tr>
<td>Feeding centre</td>
<td>1 per 20,000 persons</td>
<td>1 per settlement</td>
</tr>
<tr>
<td>Storage area</td>
<td>15 to 20 Sqm. per 100 persons</td>
<td>Refugee storage</td>
</tr>
<tr>
<td>Lighting</td>
<td>As appropriate</td>
<td>Consider priority locations such as latrine, wash areas, public service areas</td>
</tr>
<tr>
<td>Registration area</td>
<td>As appropriate</td>
<td>May include arrivals area, medical clearance, distribution, parking</td>
</tr>
<tr>
<td>Administration / office</td>
<td>As appropriate</td>
<td></td>
</tr>
<tr>
<td>Security post</td>
<td>As appropriate</td>
<td></td>
</tr>
<tr>
<td>Security fencing</td>
<td>Depending on the circumstances</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------</td>
<td></td>
</tr>
</tbody>
</table>

Table 3 – Site planning standards for services and infrastructure

2.3 Site selection criteria:
Sites for planned camps should be selected in consultation with a range of sectors, including WASH, protection and supply, as well as with technical specialists such as hydrologists, surveyors, planners, engineers, and environmental engineers. Developing an inappropriate site or failing to develop a site to standards can result in further displacement causing unnecessary further loss and distress to persons of concern and may put some people/groups at further risk. Refer to the UNHCR Master Plan Assessment Template, which includes the Site Assessment Form to help you define suitability of a given site.

The operational context will determine site selection criteria. In general, however, the following factors need to be considered when selecting sites for refugee settlement:

| Topography, drainage, soil conditions | ☟ The topography of the land should permit easy drainage and the site should be located above flood level. Rocky, impermeable soil should be avoided. Land covered with grass will prevent dust. Wherever possible, steep slopes, narrow valleys, and ravines should be avoided.  
➤ Ideally, a site should have a slope of 2%-4% for good drainage, and not more than 10% to avoid erosion and the need for expensive earth-moving for roads and building construction.  
➤ Avoid areas likely to become marshy or waterlogged during the rainy season. Consult national meteorological data and host communities before making a decision.  
➤ Soils that absorb surface water swiftly facilitate the construction and effectiveness of pit latrines.  
➤ Subsoil should permit good infiltration (permit soil to absorb water and retain solid waste in latrines). Very sandy soils may have good infiltration; but latrine pits may be less stable.  
➤ Pit latrines should not penetrate into the ground water. The groundwater table should be at least 3m.below the surface of the site.  
➤ 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 vegetable gardens or small-scale cultivation. |
| **Water resources** | Choose locations that are reasonably close to an adequate source of good water, and ideally near high ground that has good surface water run-off and drainage. Once located, water sources should be protected. Ideally, no individual should have to walk for more than a few minutes. There should be at least one water point for every 250 people.  
Ideally, hydrological surveys will provide information on the presence of water. A site should not be selected on the assumption that water will be found by drilling. Trucking water over long distances should be avoided if possible. |
| **Land Rights** | UNHCR neither purchases nor rents land for refugee settlements.  
Refugees should enjoy exclusive use of the site in which they live, by agreement with national and local authorities.  
Governments often make public land available.  
Private or communal land (including unclosed pastoral land) may only be used if the Government has agreed a formal legal arrangement with the owner(s), in accordance with the laws of the country.  
The status of land occupied for sites should be clarified in writing by the Government.  
In association with the Government and host community, agree and clarify the entitlement of refugees to carry out given activities (forage for food, collect firewood, collect timber and other shelter materials such as grass or mud, gather fodder and graze animals). |
| **Accessibility** | Ensure the site has an adequate road infrastructure; access to it should be reliable, including during the rainy season.  
Assess the site's proximity to national services, including health facilities, markets and towns. Access to mainstream services is encouraged wherever possible and avoids the need to develop parallel services for the camp population.  
Liaise with development agencies, including UNDP and related Government ministries, to secure improvement of access routes.  
UNHCR should fund the cost of building short access roads connecting the site to the main road. |
| **Security** | The site should be located a sufficient distance from international borders (50km), conflict zones, and other potentially sensitive areas (such as military installations). Avoid locations that experience extreme climatic conditions, or present evident health (malaria), environmental or other risks.  
High winds can damage temporary shelters and increase fire risks.  
Evaluate seasonal variations. Sites that are ideal in the dry season may be uninhabitable in the rainy season.  
Avoid locating refugees in places whose climate differs greatly from that to which they are accustomed. |
Environment and Vegetation

- Ensure the site has sufficient ground cover (grass, bushes and trees). Vegetation provides shade, protects from wind, and reduces erosion and dust.
- Avoid sites where dust clouds are common; these cause respiratory disease.
- Avoid sites within 1 day's walk of an environmentally protected area (such as a wildlife reserve).
- Take steps to ensure access to a supply of firewood, in collaboration with local forestry authorities, and in negotiation with the host community.

Table 4 - Site selection factors of importance

Annexes

UNHCR - Global strategy for settlement and shelter (2014-2018)

UNHCR - Policy on alternatives to camps

Sphere Handbook (2018)

Settlement Folio

3. Links

UNHCR Intranet: Shelter and Settlement UNHCR Master Plan Approach to Settlement Planning Guiding Principles Sphere Handbook 2018 Shelter and settlement impact indicators Camp management tool kit UNHCR, IFRC, UN-HABITAT - Shelter Projects

4. Main contacts

Shelter and settlement section, Division of Programme Support and Management. At: HQShelter@unhcr.org
Camp Strategy considerations

Key points

- A defining characteristic of camps is that they often limit the rights and freedoms of refugees such as their ability to move freely, choose where to live, work or open a business, cultivate land or access protection and services and their ability to make meaningful choices about their lives.

- Pursuing alternatives to camps means working to remove such restrictions so that refugees have the possibility to live with greater dignity, independence and normality as members of the community, either from the beginning of displacement or as soon as possible thereafter.

- Programme design, including advocacy priorities, will be determined by the particular circumstances of each operation. Wherever possible, work to find alternatives to camps and toward the removal of obstacles for persons of concern to the exercise of rights and achieving self-reliance.

- Site selection for planned camps is a critical factor in the ability to provide a safe and healthy environment for persons of concern. Developing an inappropriate site or failing to develop a site to standards can result in further displacement causing unnecessary further loss and distress to refugees and may put some people/groups at further risk.

- Camps require significant investments in infrastructure and systems for the delivery of basic services. The running costs for maintaining and operating these dedicated facilities and systems are also considerable and often must be sustained for many years or even decades.

1. Overview

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 collective centres, or organized camps. It is of utmost importance to identify the most suitable option or combination of options for accommodating persons of concern appropriate to the context in which displacement is taking place.

UNHCR has developed the Master Plan Approach to settlement planning which provides a framework for the spatial design of humanitarian settlements. It establishes a unique response vision aligned to national, sub-national and local development plans and facilitates efforts to link
humanitarian responses with long-term development efforts.

Through effective settlement design, the Master Plan Approach seeks to:

- Facilitate the achievement of long-term, area-based, development priorities through the development of humanitarian settlement plans which are in alignment with national development plans and policies;
- Provide an enabling environment for the sustainable integration of displaced populations within host communities through improved, equitable and safe access to basic services, including comprehensive health, education, and economic opportunities; and
- Mitigate risks to the protection of displaced people, peaceful coexistence of communities and sustainable local development.

Camps are a form of settlement in which refugees or IDPs reside and receive centralised protection, humanitarian assistance, and other services from host governments and humanitarian actors. These settlements can be planned and developed on land allocated by the Government, or created spontaneously when persons of concern settle on land which has not been designated to accommodate them.

The layout, infrastructure and shelter of a camp will have a major influence on the safety and well-being of its residents. 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.

Initial decisions on the location of the camp should involve the Government as well as local authorities and communities. Likewise, layout should involve its residents. This approach is necessary to avoid long-term protection issues such as conflict with local communities and to ensure a safe environment for persons of concern and the delivery of humanitarian assistance. (See entry on Site planning for camps for more general information on camps and camp standards.)

2. Main guidance

Context characteristics and risks associated

When a refugee emergency occurs, the first question to ask is whether or not a camp is the most appropriate settlement option for the displaced population. All other options should be considered as they may be more appropriate to the nature of the displacement. If displaced groups are lodging with host families or have self-settled within local communities that share cultural ties with them for example, consider these options and determine if these alternatives are more appropriate. Some of these alternatives to camps can promote self-reliance within the uprooted community; however such measures require the willingness and consent of the host government and the host communities themselves.
Camps should normally be considered as the last option. If accommodation in camps is necessary, avoid large settlements and high population density in settlements and in shelters and seek technical support as initial decisions on site selection and camp planning are very difficult to reverse. 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.

Camps are often established for security reasons and to ensure that humanitarian agencies can easily monitor the situation and deliver humanitarian assistance. However, camps may not always offer better protection to refugees and the internally displaced. The closed environment of camps is particularly conducive to exploitative and manipulative activities by people who seek to gain from the vulnerable nature of the residents – especially during an emergency.

The specific nature of threats to the security of refugees and the internally displaced in camps may take a number of forms such as theft, assault, domestic violence, forced marriage, cattle rustling, vandalism and civil disputes; child abuse, rape and other sexual forms of sexual and gender-based violence, robbery (armed and otherwise); arson, fraud, forgery, aggravated assault, murder, forced prostitution, kidnapping, human trafficking, smuggling of people and arms, forcible recruitment into armed forces, extortion, enslavement, torture, war crimes, and withholding humanitarian assistance.

The size and the design of camps can contribute to the maintenance of a peaceful environment and the security for refugees and local residents.

The design of camp layouts should be comprehensive and aspects defined in a master plan. The size and growth of planned camps should be contained and no camp should be larger than 20,000 people, to minimize their environmental impact, facilitate camp management, and create a better social environment for camp residents. Camps must have adequate fire prevention strategies and firefighting capacity in place. Communal areas and/or central points should be provided with night lighting and shelters and/or layout designed with the participation of women, men, girls and boys.

**Context-specific protection objectives**

Conflict, violence and persecution continue to cause large-scale displacement in many parts of the world. To provide international protection, and ensure that the rights and dignity of persons of concern are respected, UNHCR must act in a variety of ways, which include the provision of adequate shelter and settlement. When developing an operational response, the following key protection issues should be considered:

- To provide a secure and healthy living environment with privacy and dignity to persons of concern.
- To protect persons of concern from a range of risks, including eviction, exploitation and abuse, overcrowding, and poor access to services. Close ethnic and cultural affinities between refugees and their host communities should be identified at an early stage. Settlement planning and responses should aim to mitigate friction and reduce potential tensions between refugee and host communities and reduce other security risks.
To support self-reliance, allowing persons of concern to live constructive and dignified lives.

To recognize, and encourage other actors to recognize, that every person, including every refugee, is entitled to move freely, in accordance with human rights and refugee law.

To assist refugees to meet their essential needs and enjoy their economic and social rights with dignity, contributing to the country that hosts them and finding long term solutions for themselves.

To ensure that all persons of concern enjoy their rights on equal footing and are able to participate in decisions that affect their lives. (AGD approach)

To ensure security and protection of refugees. Camps should be located at a reasonable distance from international borders and other sensitive areas (such as military installations).

Principles and policy considerations for the emergency response strategy in this context

Camp development consists of three main phases: set-up, care and maintenance, and camp closure. Each phase requires considerable input from site planners, technical staff, national authorities, the camp population and the host community.

The camp's location, size, design and duration are context specific. The location and plan of a camp can significantly impact the protection of residents and their access to assistance, and can also affect decisions about camp closure and phase out. Settlement planning is not a merely technical process. It can promote community cohesion, and efficient and affordable access to services, mitigate disaster risks (flooding and disease), and enhance living environments, allowing families to enjoy a better quality of life.

Consider the following principles:

- Decisions on camp location should involve national and local government as well as host and refugee communities.
- Because decisions on site selection are difficult to reverse, seek and make use of technical support from the beginning.
- Most refugee operations last longer than expected. Take this into account when selecting a site, planning the camp, and estimating resources and staffing. The footprint of early planning assumptions may endure for decades.
- Prepare a plan for camp decommissioning from the start.
- Locate camps at a reasonable distance (at least 50 km or one day's travel) from national borders and from other potentially sensitive areas such as military bases.
- Avoid very large settlements. (No camp should be larger than 20,000 people.)
- Site planning should take into account topography, land use, climate, soils, geology, hydrology, vegetation, infrastructure and key natural and cultural resources.
- An adequate supply of water throughout the year is vital. The settlement's sanitation strategy should reflect the specific soil type at the site.
- Bear in mind that natural features of the site will reduce or affect the amount of usable
Adopt a ‘bottom up' approach to planning, beginning with the smallest social units, preserving traditional social arrangements and structures as far as possible. Reflect the wishes of the community as much 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.

UNHCR neither rents nor purchases land for refugees.

Policies and programmes must systematically apply an **Age, Gender and Diversity (AGD)** approach to ensure that all persons of concern have equal access to their rights, protection, services and resources, and are able to participate as active partners in the decisions that affect them.

### Priority operational delivery mode and responses in this context

The table below outlines some operational priorities in each phase of the camp life-cycle:

<table>
<thead>
<tr>
<th>Phase</th>
<th>Operational response consideration</th>
</tr>
</thead>
</table>
| 1 Set-up | Consider consultations with multiple stakeholders such as:  
- National authorities.  
- Camp Management Agency.  
- Diverse representatives of the refugee and host population, including men, women, boys and girls.  
- Representatives from other sectors (health, WASH, shelter, security, logistics, education, livelihoods, protection) and from appropriate government ministries, UN agencies, or NGOs.  
- Technical experts (surveyors, Geographic Information System (GIS) experts, hydrologists, public health engineers, land tenure or customary land tenure experts).  
- Analyse and document the advantages and disadvantages of different site options. Consider protection risks, safety and security, social and cultural factors, location and condition of the land (size, access, distance from border, available resources  
- Consider whether sites could be extended in the future; and whether phased development is an option  
- Consider how **housing, land and property** rights (HLP) affect site use, including access to water and pastoral and agricultural activities. |
<table>
<thead>
<tr>
<th>2 Care and maintenance</th>
<th>○ Put in place a monitoring system for the camp's general and technical operations; make sure monitoring is always on-going.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>○ Convene meetings regularly with all stakeholders to identify gaps and problems and resolve them.</td>
</tr>
<tr>
<td></td>
<td>○ Ensure that residents are consistently involved in decisions regarding care and maintenance.</td>
</tr>
<tr>
<td></td>
<td>○ Make sure that shelters, infrastructure and facilities are regularly maintained, and upgraded when required, in consultation with the camp population.</td>
</tr>
</tbody>
</table>
Effective camp governance and community participation / mobilization mechanisms should be in place. These mechanisms will provide maintenance of camp infra-structure, data collection and sharing, monitoring of service delivery with the participation of the community and of other providers in accordance with agreed standards, in order to avoid the duplication of activities and emergence of protection and assistance gaps, and will ensure community complaints mechanisms are established and known to all. For further and specific information refer to Camp coordination, camp management (CCCM).

3 Closure

- Plans to phase out, close and decommission camps should be prepared from the start.

- Ensure that residents have accurate, objective and up-to-date information on the situation, logistics and other procedures.

- Support and protect persons and groups who are most at risk throughout the process.

- Introduce administrative procedures that ensure that all documents are returned to residents before they leave, or held by (sector/cluster/protection) lead agencies or NGOs, or destroyed.

- Develop a monitoring process that ensures that returning refugees do so safely, in security and with dignity.

- Ensure service contracts and agreements are modified or terminated appropriately (including and lease agreements with respect to housing, land and property assets).

- Develop a plan for fair and transparent disposal, distribution or handover of assets or infrastructure. Hand responsibility for care and maintenance of infrastructure to national authorities or others (as appropriate).
Figure 2 - Priority operational responses.

**Priority actors and partners in this context**

- Consult relevant authorities, operational partners (UN, NGOs, and community organisations) and the affected population at all phases of camp development.
- For strategic decisions which require high-level advocacy, consult with concerned partners, including UN agencies, NGOs and donor representatives, as appropriate.
- From the start, collaborate closely with the technical offices of local authorities, and study local rules and regulations concerning land tenure, public works and housing, in order to reduce the risk of conflicts over land and ensure compliance with local building regulations.
- Develop and train site development and camp management committees.

**Annexes**

UNHCR - Global strategy for settlement and shelter (2014-2018)

UNHCR - Policy on alternatives to camps (UNHCR HCP 2014 9)

**3. Links**

UNHCR Master Plan Approach to Settlement Planning Guiding Principles The SPHERE Handbook 2018 UNHCR, IFRC, UN-HABITAT - Shelter Projects Camp management toolkit UNHCR’s information management portal Shelter Cluster UNHCR Emergency Portals

**4. Main contacts**
Key points

- Complete and retain all relevant documents during the adaptation of a building into a collective centre. These include: The scope or works (Statement of works).
- A master plan containing survey and construction details.
- An implementation plan, including a bill of quantities (BoQ), detailed technical working drawings, and specifications of what materials will be used and their quality.
- Local or national permits and owner agreements.
- Local or international building codes and standards.
- Communications with local authorities, the local community, contractors, implementing partners or other organisations, and donors.
- Procurement and contractual documentation (tendering, accepted bids, payment arrangements, etc.).
- A quality assurance plan (including safety measures with respect to the building site, specifying responsibilities in case of accidents).
- Prepare the site (levelling, vegetation clearance, marking out, water and utilities connections, storage of topsoil, etc.).
- Monitor progress and prepare an evaluation plan, including a site book and photographs.
- Make arrangements for completion and handover by the contractor.

1. Overview

Collective centres are pre-existing buildings and structures where large group of displaced people find shelter for a short time while durable solutions are pursued. A variety of facilities may be used as collective centres - community centres, town halls, hotels, gymnasiums, warehouses, unfinished buildings, disused factories.
A thorough assessment must be conducted to determine the conditions of the building and for how long it may be used.

In all cases – regardless of the services, and utilities they offer, collective centres should be rehabilitated and/or upgraded to meet the shelter needs of their residents, including facilitating the provision of basic services. They should be managed and maintained from the onset and throughout the period persons of concern live in them.

An exit strategy is essential. Determine whether after they cease to be collective centres buildings will return to their original function or use.

2. Main guidance

Protection objectives

- To provide a safe environment with dignity to persons of concern while durable solutions are pursued
- To safeguard social rights such as adequate shelter, water and sanitation
- To provide mechanisms to access services for persons with specific needs

Underlying principles and standards

Collective centres host persons of concern in buildings that are not designed for accommodation. Although the physical space may appear adequate, the living conditions they offer often fail to meet minimum standards and do not ensure a life of dignity. Individuals may stay in collective centres for an undetermined period of time and vulnerable groups tend to settle in them and can become isolated from mainstream society.

Collective centres should be rehabilitated and upgraded to meet the shelter needs of their inhabitants, including access to basic services. They should be managed and maintained throughout the period refugees live in them.

They should provide privacy - personal spaces should be lockable to increase personal safety, independence, and adequate accommodation. It is important to ensure that smoke from stoves or open fires does not pose a health and disease risk.

For practical advice on how to set up, coordinate and manage collective centres in a manner that will satisfy minimum standards and uphold the rights of displaced people, see the section on Tools, Documents and References below.

Protection Risks

Collective centres should not be considered for longer-term accommodation. Due to the high concentration of persons of concern in collective centres, safety and security become important
issues. Violence, drug abuse, sexual and gender-based violence may occur regularly. Long term residence in a collective centre is likely to cause stress and tension, possibly leading to depression, social conflict, friction between or within families, conflicts between clans or ethnic groups, and other individual or psychosocial problems.

Long term collective centres can increase their residents' vulnerability to attack, especially for older and single people and other vulnerable groups.

The supporting infrastructure of the building (water, electricity, sanitation) can deteriorate quickly from concentrated use, to the extent that living conditions can become dangerously unhealthy.

**Other risks**

Collective centres may cause serious and often long-lasting problems, especially those related to water and sanitation and solid waste management, for residents and those living in close proximity.

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. Their prolonged use may also cause tensions with the host community as the occupation of these facilities may limit the delivery of public services.

**Key decision points**

The ruling principle when setting up collective centres should be ‘a fit structure on a suitable site’. With this in mind, managers and staff should ensure that collective centres are safe for occupation, can be upgraded to meet standards, are secure, and that their location minimizes exposure to threats to its residents.

Existing public buildings or facilities that can become collective centres provide a short-term shelter option, especially when the weather is cold or very rapid action is required. Short-term becomes the key characteristic. A fast deteriorating infrastructure and building decay due to continued use will pose serious risks to the health of the residents. It is vital to maintain collective centres and their services adequately to protect the health of the residents, reduce the economic risks they generate for the host government, and limit their impact on local society and the environment.

Local and national governments may be reluctant to license or adapt public buildings for use as humanitarian mass shelters. Even after approval is given, durable solutions should be sought quickly because approval may always be revoked if the building must return to its original use.
Key steps

Setting up collective centres should be implemented by means of the following steps.

- Consult the Government to identify suitable buildings. Involve representatives of persons of concern, and host communities, in order to avoid unrealistic expectations.
- Conduct a thorough assessment of the site and structure including safety, access, facilities, location, proximity to hazards, etc. Avoid using buildings that contain asbestos.
- Calculate the cost of rehabilitation work that will be required to provide an appropriate level of comfort and privacy. (To enable residents to store their belongings safely, for example, and avoid fire hazards, etc.). Ensure that local building codes are met.
- Identify the owners of collective centres and sign an agreement (or a protocol of understanding), indicating maximum occupancy, arrangements in case of emergency, and the condition in which the building will be left after its use as a collective centre.
- Ensure that infrastructure, a water supply and facilities are available in the collective centre; or that adequate facilities are available externally, with the permission of the host community.
- Establish contingency plans for possible displacement scenarios.
- Make arrangements to upgrade the building as required (scope of works, design documents, tendering, pre-selection of local contractors, etc.), as well as manage it (pre-selection of organisations or staff to run and maintain the facility, etc.).
- Work with relevant programmes to identify and appoint implementing partners. Project partnership agreements (PPA) may be appropriate.
- Develop and deliver maintenance and exit plans.
- Provide timely support, monitor service delivery, and prepare and disseminate effective advocacy messages.

Key management considerations

- Evaluate the composition and compatibility of ethnic and religious groups in the collective centre.
- In the selection of collective centres consider: security, accessibility, environmental factors, available infrastructure, access to livelihoods, and access to basic services.
- Sphere standards should be followed when upgrading, and facilities should meet the needs of residents. Be mindful of the cost, appropriateness and maintenance needed by the upgraded infrastructure. For example, do not install an expensive heating system if funds will not be available to fuel or maintain it.
- Lighting, and heating (in cold climates), must be sufficient and safe to avoid fire. This may be expensive to install or rehabilitate, and electrical and fuel charges may also be expensive for residents.
- Buildings should be fit to resist climatic and environmental hazards and structurally sound to accommodate the proposed number of displaced people.
- Buildings used as collective centres will deteriorate. Maintenance and rehabilitation costs can be high. Always agree early with the building's owner how the building should be returned after its use.
Resources and partnerships

- Local or Central Government authorities (including military officials).
- Community and religious leaders.
- Host communities.
- National and international NGOs.
- IFRC and ICRC.
- Other UN and international organizations.
- National (particularly local language) and international news media.

Annexes

UNHCR, Handbook for the Protection of Internally Displaced Persons, Guidance Note 12, Coordination and Management of camps and other collective settings

UNHCR-IOM, Collective Centres Guidelines, 2010

UNHCR, Global Strategy for Settlement and Shelter 2014-2018


Guidelines on emergency sheltering for refugees in Germany

3. Links

The Sphere Handbook 2018 UNHCR Share Point Settlement Information Portal (SIP) / Guidelines
UNHCR Guidance Note 12, Coordination and management of camps and other collective settings

4. Main contacts

Shelter and Settlement Section (SSS) – Division of Programme Support and Management (DPSM). At: HQShelter@unhcr.org.

Education in Emergencies - Urban

05 May 2021
Key points

- Build strong relationships with the Ministry of Education and local education officials.
- Work towards inclusion in national education systems from the start of an emergency.
- Identify barriers to girls' participation in education during assessments and design interventions to support enrolment and retention
- Foster complementarity between the early phase of the education response and child protection
- Consider the educational needs of children and youth of all ages. Include secondary school-aged children and university-aged youth in the education response.

1. Overview

Access to education is a basic right that is also applicable in emergency settings. The Global Compact on Refugees (para. 68) aims to see children and youth return to learning within three months of displacement. One of the first services requested by refugees and IDPs once their basic needs have been met is for children and youth to have the opportunity to continue their education.

Education provides knowledge and skills that support community resilience, facilitate living with dignity and lay the foundation for future access to meaningful work. Going to school also offers emotional and psychological benefits. In emergencies education activities offer opportunities for refugees to receive information about their rights, available services, disease prevention, safety and physical security (including mine risk awareness) and have access to psychological support services (PSS). This entry explains some of the key steps that should be taken at the start of an emergency to ensure that children and youth have long-term access to education.

2. Main guidance

Protection objectives

- Education provides a protective environment where children and young people acquire knowledge and skills, socialize and have access to wrap-around support services (including health screening, nutrition and counselling)
- Education provides a foundation for future economic activity, meaningful work and addressing generational poverty
- Education supports psycho-social wellbeing by offering hope and a focus on the future
- Girls in education are less likely to marry and have children early
Children and young people in education are less likely to be engaged in child labour or be at risk of recruitment into armed groups

Underlying principles and standards

**Terminology:**

**Non-formal education (NFE) programs** are often designed for specific groups of learners such as those who are too old for their grade, whose education has been disrupted or who require additional support to adapt to learning in a new country. Examples include language learning support, catch up classes, and initial literacy and numeracy programs. NFE programs for youth and adults also exist.

**Formal education** usually makes use of a standard curriculum and typically takes place over 8-12 years. Schools and education institutions are regulated by policies of the Ministry of Education.

**Principles:**

- Work towards inclusion of displaced children in the national education system from the start of an emergency. This requires close collaboration with and, sometimes, intensive advocacy with national authorities to agree on how best refugee children can receive education that is certified, of high quality and allows refugees to progress from one level of education to the next.
- Support children and youth to return to learning as quickly as possible.
- Consider the educational needs of all age groups, including secondary school age youth and those above 18
- Enhance host community school infrastructure to promote accessibility to those with disabilities
- Ensure there are age-appropriate, sex-segregated WASH facilities, also accessible to children with disabilities
- Support programs (including language learning) that promote enrolment and retention in formal education are an important element of an education in emergencies (EIE) response
- Integrate psychosocial support (PSS) activities in education support programs
- Non-formal education programs should be limited in duration and help children and youth to transition to the formal system or prepare for livelihoods-focused skills programs. Accredited accelerated education programs may be of longer duration and operate alongside formal education opportunities.
- Specific barriers to education experienced by girls, adolescent girls and boys and those with disabilities should be explicitly addressed

**Standards:**

- Outside of camps education will most likely be delivered through host community schools. Improvements to existing school infrastructure or new school construction should conform with standards set by the Ministry of Education.
- Centers where non-formal education programs are offered should – as far as possible – conform with guidance on the establishment of safe, accessible temporary learning spaces and age-appropriate WASH facilities as set out in the INEE Minimum Standards for
Education in Emergencies.

**Protection Risks**

Lack of access to relevant, quality education opportunities can result in:

- Loss of peer support networks, social isolation, increased need for [mental health and psychosocial support](#) (MHPSS) services
- Increased likelihood of early marriage and pregnancy
- Increased risk of child labour and economic exploitation
- Forced recruitment into armed groups
- Exploitative sexual relationships, transactional/ survival sex and GBV
- Irregular onward movement and trafficking
- Long-term social and economic exclusion of the refugee community and heightened rates of poverty

**Other risks**

- The absence of education services may lead to large numbers of children and youth being idle which can increase security risks in camps associated with gang membership, GVB and criminality.
- UNHCR may experience reputation risks if it does not ensure that the right to education is realized.

**Key decision points**

The decisions taken in the early phase of a response can have [long-term implications](#) for the quality and nature of education provided. Education interventions should be informed by a clear strategy for ensuring [sustained access](#) to education. Issues such as language of instruction, curriculum, materials, certification and accreditation need to be considered early in a response.

An [education needs assessment](#) will help to understand the previous education experience of children, the length of disruption to their education, the capacity of local education infrastructure and teacher availability in the refugee community. The Education Cluster's Joint Education Needs Assessment tool can be adapted to refugee contexts. Ensure the education part of the [Needs Assessment for Refugee Emergency (NARE)](#) checklist is included in the multi-sector assessment.

Advocacy with government may be necessary if administrative barriers to education must be addressed or significant policy changes are needed.
Key steps

1. Familiarize yourself with the education policy context in the country of asylum. The Minimum Preparedness Actions tool provides questions to help understand the policy framework applicable to refugees and the education context of the country of origin. At the same time, learn about the educational context in the country or region from which people have been displaced.

2. Establish a coordination structure for the education response. In refugee settings, where possible UNHCR should lead or co-lead this group. Familiarize yourself with the potential education partners in country who can support the response - UNICEF and the Education Cluster, where activated, may be able to provide useful information on education actors.

3. Ensure that the education response is well planned, budgeted and included in inter-agency appeals.

4. Meet with district or local education officials to discuss the response with them and ensure that they are informed about and supportive of efforts to support education access.

5. An education response in urban areas may include (i.) facilitating access to host community schools and (ii.) delivering non-formal education programs that support transition to or retention in host community schools.

6. Improving school infrastructure (adding classrooms, improving WASH facilities or providing furniture) can support social cohesion

7. Support teachers with practical advice on working with refugee students

8. Distributions of materials (e.g. school kits) should also include host community children and not single out displaced students

9. If children cannot immediately be accommodated in host community schools, establish support programs that focus on teaching the language of instruction used in schools or programs that focus on catching up lost learning time and strengthening core skills. Integrate psychosocial/recreational activities in these programs.

10. Determine whether there are existing programs (such as accelerated education programs) or materials (books, language learning materials) approved by the national authorities that can be used in the response.
11. Work in close coordination with child protection actors to ensure that referral pathways exist between education and protection services. In the initial phase of a response similar activities may be carried out by child protection and education actors - it is important to ensure that any activities supporting learning contribute to the eventual inclusion in national services.

12. Ensure that refugee and host communities community are well informed about education services and decisions regarding curricula and inclusion in the national system. Consult community members and respond to any concerns that they express.

13. Establish a common framework for the recruitment, remuneration, conditions of service and code of conduct for those working in non-formal education programs.

14. Identify key indicators against which all education actors will report. Data on education participation should be disaggregated by age, gender, level of education and disability.

Specific considerations for IDP responses

- In IDP responses the coordination of the education response is usually led by the Education Cluster, where activated.
- Education programs and services established during an emergency should form part of the national education system. As far as is practical, host community schools should be supported to include displaced children and youth, with an emphasis on the continuity of learning.
- Protection monitoring and education assessments should identify any administrative or legal barriers limiting access to education.
- If IDPs speak a different language to that used in local schools, additional language support programs may be needed.

Key management considerations

UNHCR should play a lead role in establishing the strategic framework for the education response that is aligned with the overall protection and solutions strategy. Core elements of the strategy should be agreed with key actors ahead of an influx or as early as possible in the response. The strategy should also be informed by the work of development actors in the education sector and national priorities. The Regional Bureau and HQ Education team can provide guidance and support as needed.

Once the response is underway, the diversification of education services - including supporting access to higher education - should take place.
Resources and partnerships

Staff

- Emergency Response Teams should include an Education Officer responsible for coordination, liaison with the Ministry of Education and organisations supporting the education response, engagement with other sectors (e.g. child protection, WASH, site planning) and strategy development.
- Appoint an Education Officer as soon as possible within the response staffing to ensure continuity of the education function.

Partnerships

- Identify focal points in the Ministry of Education at national and local levels.
- Build strong relationships with UNICEF and establish mechanisms for sharing information on response priorities and joint advocacy.
- Be aware of and identify possible synergies with development-focused initiatives in the education sector and key donors to education, including the World Bank and the Global Partnership for Education.

Financial resources

- Ensure that education needs are reflected in inter-agency appeals.
- Education Cannot Wait, the global fund for education in emergencies, is an important donor partner.

Annexes

UNHCR Refugee Education 2030, A Strategy for Refugee Education

ISEEC Report on Improving Coordination, 2020

UNHCR Cash for Education, Direction and Key Considerations

UNHCR COVID-19 Refugee Return to Schooling Guidelines, 2020

3. Links

UNHCR Education Pages Accelerated Education Working Group Inter-agency Network for Education in Emergencies (INEE) Global Education Cluster Education Cannot Wait
4. Main contacts

Contact Senior Education Officers in Regional Bureaus or the Headquarters Education Section (hqeduc@unhcr.org) in the Division of Resilience and Solutions (DRS).

Managing construction and rehabilitation projects (commercial contractors)

11 August 2019

Key points

- Set clear project goals, and define the project's size, value, and timeline. Map out possible constraints and make explicit the technical complexity of the works involved.
- Demonstrate how the proposed activities align with UNHCR's goals and objectives in the specific emergency operation.
- Examine Government regulations and complete a stakeholder analysis.
- Examine and take into account Government policies.
- Estimate the costs and assess sources of funding.
- Evaluate climatic conditions and environmental factors.
- Assess the local market and available capacity and expertise.
- Study UNHCR's management and control procedures.
- Develop a Quality Control and Quality Assurance Plan.
- Evaluate the socio-economic context (territorial issues, demography, socio-cultural factors, economic and institutional issues).
- Complete a risk analysis and consider how risks may be mitigated.
- Develop an operation and maintenance plan for the lifetime of the project.
- Establish the project's timetable.
- Identify and consider other parameters identified by the feasibility study.
1. Overview

In emergencies that displace a large number of refugees, settlements (in or out of camps) often lack infrastructure and facilities, which can compromise refugees' quality of life and create protection risks. To resolve these problems, comprehensive construction or rehabilitation plans are established, in coordination with stakeholders, to repair and improve access to roads, drainage networks, schools, health centres, community centres and public spaces.

Successful construction and rehabilitation projects require good planning and project management, which in turn depend on knowledge of the local context, technical expertise, and sound assessment of resource requirements and risks. Failure to address such issues can lead to poor quality outcomes, cost overruns and delay. Therefore, before committing to rehabilitation and construction projects, UNHCR field operations should:

- Identify the need for the rehabilitation or construction of infrastructure.
- Demonstrate how the proposed activities align with UNHCR's goals and objectives.
- Commission a feasibility study. Assess environmental, economic, political and social impacts and deem the level of risk acceptable.
- Have access to and allocate the funds required.
- Agree that the UNHCR programme unit that supports the works will take responsibility for integrating specific tasks, including liaison with local authorities and coordination with Government, refugees, and the host community.
- Determine that the works and budget maximize return and achieve best value for money.
- Identify the parties who will be responsible for taking over the facilities, and for operating them (if required), and maintaining them.

2. Main guidance

Underlying policies, principles and/or standards

Resource scarcity, rising energy costs, durability and sustainability, and environmentally responsible practices are all issues of great concern to UNHCR and cannot be ignored when planning and designing civil works. Sustainable development must meet human needs while preserving the natural environment for present and future generations. The keystone of sustainable design is providing buildings that are energy efficient, healthy, comfortable to occupy, low in maintenance, flexible in use, specified with environmentally responsible materials, and designed for long life.

Any rehabilitation or construction of infrastructure project must aim to develop facilities that are socially, economically and environmentally sustainable after completion, and are in accordance with UNHCR principles and international standards. This objective will be achieved by:

- Cooperating with local and national government authorities, United Nations agencies, non-governmental organizations and other partners.
Consulting with refugees and host communities during the planning and design phases.
Consulting environmental experts and ensuring compliance with all statutory environmental regulations applicable to the area of operation.
Promoting environmentally sustainable construction materials.
Ensuring that design and construction minimize maintenance requirements over the life cycle of the facility.

**Good practice recommendations**

Good practices ensure that the most common pitfalls of rehabilitation and construction works are being avoided, such as:

- Lack of comprehensive procurement planning and control mechanisms.
- Lax application of procurement processes (for tendering, selection criteria, evaluation, contract signature)
- Rushed application of procurement processes. Procurement in accordance with good practice needs time and planning. It should contain the adequate level of detail to avoid additional costs or change orders. Procurement and programme staff do not communicate clearly and sufficiently and thus lack mutual understanding of the requirements of implementation. Similarly the complexity of building works and the resources needed to implement them are not fully understood.
- The scope of the project and its technical specifications are not defined in enough detail.
- Unclear or incomplete Bills of Quantity, incorrect cost estimates and unrealistic timelines.
- Insufficient expertise in managing, supervising and monitoring rehabilitation or construction works.
- Lack of financial and time contingency. Cost and time may increase with unforeseen circumstances such as administrative delays, for example in receiving local authority authorizations, or permission to access the site.

**SUMMARY APPRAISAL REPORT**

1. Purpose of the Civil Works
2. Eligibility
3. Scope of Works, Drawings, BoQ, specifications and Components
4. Budget, Financing and Cost Estimate
5. Site Investigation and Technical Feasibility Study
6. Implementation
   a) Implementation Plan and Schedule
   b) Design and Construction Works Supervision Mechanism
   c) Consulting Services (if applicable)
   d) Operations and Maintenance (if necessary)
   e) Monitoring and Quality Control
7. Procurement Methodology
8. Environment and Social Impacts
9. Risk and Mitigation Measures
11. Stakeholder Consultations and persons of concern Participation (if applicable)
To avoid delays, increased costs, and contractual breaches consider the following:

- Act only when you have completed planning. The design stage itself can be sub-divided into as many steps as necessary to resolve all design problems before construction begins.
- Consider the services of external firms or consultants with appropriate technical background to prepare complex designs. Technical expertise may exist in implementing partners or within UNHCR.
- In cases where design, scope of works (SOW) and Bill of Quantities (BoQ) come from the government. These documents should be reviewed and if needed modified, developed or completed. Aim for as much detail as possible, within time constraints, on SOW, BoQ, and specifications.
- Consult carefully with stakeholders at all stages, to avoid misunderstandings that can be costly.
- Work closely with government and local authorities and take account of their policies.
- Make sure projects meet the expectations of persons of concern, host communities, and authorities.
- The procuring goods processes shall be used for "Prefabricated Buildings" by a direct acquisition of buildings and according to the UNHCR Procurement.
- The civil works items in the Bill of Quantities can allow a variation of ±10% of actual quantities.
- The budget contingency for supervising and monitoring of civil works includes unforeseeable cost requirements typically range between 12% and 20% of the total civil works cost.
- In most cases, design services are contracted separately from construction contracts. Turnkey contracts, in which the contractor is responsible for both the design and construction, can be difficult when the performance of the contractor is unknown or when the extent of the external risks is uncertain (e.g. time required for allocation of sites, approval of drawings and specifications by the government, etc).
- Purchasing of goods for the facilities, such as generators, audio-visual equipment, IT equipment, furniture, etc should be completed separately by supply/procurement colleagues. Modular design can be considered to reduce the need for multiple designs for units of similar functionality. This can reduce cost and time during the design stage. (Modular design is an approach that subdivides a design into smaller parts (modules) that can be independently constructed and then used in different sites).
- The site condition (soil, access, boundaries, etc) is an important factor in the design and can affect cost and duration of the building, particularly for sites in remote areas. Therefore, site variances should be included in all the design elements (SOW, BoQ, cost estimation, etc) if similar civil work activities are to occur on multiple sites.
- On the other hand, when modular design is being implemented on multiple sites, an individual pricing should be included per site. This makes the site-specific variation to be included in the procurement and tender evaluation and not result in a series of variation orders.
- The key stakeholders (e.g. UNHCR, government, implementing partner, etc) shall endorse the complete set of design documents, drawings and specifications before tendering and procurement activities commence. This endorsed set of documents becomes the technical reference documentation for the civil and construction project.
- Ideally, no changes should be made to the final design documents once they have been
finalized and approved. Modification of design drawings comes at high cost. Modifications once construction has started are more costly and require change orders.

- Should significant changes occur to the design documents during the development of detailed design, drawings and specifications, the detailed implementation plan should be amended to include and reflect the new requirements.
- The final design shall meet the government norms, standards and specifications, and the local building regulations where applicable. It should also take into account the local climatic conditions and the risk of natural disasters.
- A comprehensive set of drawings, SOW and BoQ increases the probability of receiving strong, detailed offers. It also help to facilitate the evaluation process, contract management, and are more likely to results in fulfilment of contract and expectations of UNHCR and other stakeholders.
- Civil works need a clear SOW so that detailed work plans can be developed. Work plans milestones can be tied to BoQ to facilitate monitoring and payment procedures.

## Considerations for practical implementation

A project to construct or rehabilitate infrastructure is successful when it meets the expectation of the country programme and other stakeholders, matches the project's scope, meets specified quality standards, is delivered on time, and follows the budget. Commercial contracts are governed by the regular procurement procedures or the exceptional procedures for procurement during emergencies, as requested by the office and approved by the Headquarters Committee on Contract. For procurement by partners funded by UNHCR, the UNHCR Policy and Procedures on Procurement by Partners with UNHCR Funds apply (UNHCR/HCP/2014/11).

Most construction projects will follow similar steps. Adjustments will be made if the scope of the project so requires. The table below outlines the common stages of construction management:

### Roles and Responsibilities of Rehabilitation or/and Construction Works

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<td>Implementation plan</td>
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<td>Design Documents (drawing, scope of works, etc)</td>
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* Management: the relevant project manager or coordinator

### Resources and partnerships

- Local or central government authorities.
- Community and religious leaders.
- The host community.
- National and international NGOs.
- IFRC and ICRC.
- Other UN and international organizations.
- Academic institutions
- Private sector

### Annexes

- [UNHCR, Global Strategy for Settlement and Shelter 2014-2018](#)
- [UNHCR Policy and Procedures on Procurement by Partners with UNHCR Funds](#)
- [Sphere Handbook (2018)](#)
- [UNHCR, Handbook for the Protection of Women and Girls](#)
- [Risk Management _ Fraud Prevention _ Toolkit](#)
3. Links

UNHCR, Coordination of camps and other collective settings UNHCR/OG/2016/1 Operational Guidelines on UNHCR Technical Specialists for Public... Fraud Prevention UNHCR, Procurement Management and Contracting Services UNHCR/HCP/2014/11 UNHCR Policy and Procedures on Procurement by Partners with U...

4. Main contacts

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