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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</thead>
<tbody>
<tr>
<td><strong>Components</strong></td>
</tr>
<tr>
<td>Lifesaving NFIs that can be carried by the recipients on foot. For example, blankets, semi-collapsible jerry can and cloth for sanitary material.</td>
</tr>
<tr>
<td><strong>Appropriate contexts</strong></td>
</tr>
<tr>
<td>Cross-border.</td>
</tr>
<tr>
<td>Transit or reception centres.</td>
</tr>
<tr>
<td>Temporary communal accommodation.</td>
</tr>
<tr>
<td>Settlements, camps and urban (if there are stock shortages or funding gaps).</td>
</tr>
<tr>
<td><strong>Applicable populations</strong></td>
</tr>
<tr>
<td>All forcibly displaced and stateless persons who will not be ‘fixed’ in the location where the distribution will take place, i.e. people on the move/in transit.</td>
</tr>
<tr>
<td><strong>Complete NFI kit</strong></td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Components</strong></td>
</tr>
<tr>
<td><strong>Appropriate contexts</strong></td>
</tr>
<tr>
<td><strong>Applicable populations</strong></td>
</tr>
</tbody>
</table>

*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:**

<table>
<thead>
<tr>
<th><strong>Distribution to/via local authorities</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appropriate contexts</strong></td>
</tr>
<tr>
<td><strong>Applicable populations</strong></td>
</tr>
<tr>
<td><strong>Advantages</strong></td>
</tr>
<tr>
<td><strong>Risks</strong></td>
</tr>
</tbody>
</table>
| 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. |

| Distribution to representatives for the target population |
|---|---|
| **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.

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### 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></td>
<td>Control over the number of people assisted. May undermine abusive community-level power relations and leadership. Easy to monitor directly. Possibility for protection staff to be present and consult the target population. Useful in dealing with unstructured populations (no leaders, or social structure no longer in place).</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 prioritised 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.

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:

• Did the NFIs reach the intended final recipients?
Were NFIs used for their intended purpose?
Are the recipients still in possession of the NFIs? If not, how have they disposed of the NFIs and why?
Are any of the NFIs that were distributed being sold on the local markets?

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
The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian... Please read the connected entry "Requesting CRI from UNHCR's..."
6. Main contacts

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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>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>
<td></td>
</tr>
</tbody>
</table>
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.

**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

**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

The Sphere Project, Handbook, 2018, Health Assessment Checklist, pg 349-350
The Multi Sector Initial Rapid Assessment guidance (MIRA)
Rapid Health Assessment of Refugee or Displaced Populations (MSF 2006)
Health in camps and settlements
Nutrition needs assessment

6. Main contacts

Public Health Section, DRS: hqphn@unhcr.org

WASH in Emergencies

24 January 2024
Key points

- Joint rapid assessment of needs, current level of access, and gaps should be conducted by a team of relevant stakeholders including the users, to the extent possible
- Do not implement parallel services; to the extent possible, include and build on existing services, facilitate early inclusive delivery of assistance, collaboration and coordination mechanisms among local authorities, service providers, and users
- Prioritize age, gender and diversity (AGD) sensitive life-saving interventions, and regularly monitor and report on the WASH situation as well as key WASH indicators
- Integrate environmental considerations in the initial WASH assessment and consider climate and environmentally friendly options to the extent possible
- Seek the support of and complementarity with other agencies specialized in the area of WASH, including relevant authorities, local service providers and development actors, which can support emergency responses and beyond

1. Overview

This entry highlights key WASH underlying principles, interventions, indicators, and further references to achieve access for forcibly displaced and stateless persons to at least minimum humanitarian standard of water of sufficient quality and quantity; safe sanitation; and hygiene practices during the first six months of humanitarian emergency. This entry includes WASH at household level as well as for institutions such as hospitals, health and nutrition centres, schools, etc.

The underlying principles, key indicators, and minimum standards are relevant for different types of settlements (formal and informal settlements, collective and transit centres, in rural and urban areas). In contexts where UNHCR and partners are not directly responsible for WASH service provision, for example in urban areas or dispersed settings, focus should be on facilitating access using alternative response mechanisms such as cash-based intervention and advocacy.

Environmental considerations should also be made as integral part of the wider WASH analysis, including the location and rate of use of water resources, treatment facilities and distribution networks of water for drinking and domestic use, the provision of sanitation facilities, management of solid waste, among others.

As the entry aims to act as a quick refresher rather than an exhaustive guide, other relevant resources, such as the UNHCR WASH Manual referenced in this entry, should be consulted for further guidance, as necessary.
2. Relevance for emergency operations

WASH interventions in emergencies focus on:

- Saving lives, contributing to protection, safety, dignity and peaceful coexistence.
- Reducing mortality and morbidity by preventing the transmission of diseases and outbreaks.
- Providing immediate access to WASH services as a human right, which means that services shall be extended to forcibly displaced people in all settings, based on the criteria of availability, quality, acceptability, accessibility, and affordability.

Furthermore, climate change poses serious risks to the delivery of water and sanitation services for forcibly displaced and host communities: drought, heatwaves, storms, and flooding make the delivery of services more complex. Environmental and climate related considerations for WASH interventions should be mainstreamed and addressed from the onset of an emergency, and preferably beforehand during the emergency preparedness phase.

3. Main guidance

A) WASH Principles

Emergency WASH interventions should be guided by underlying principles aimed at promoting access to life-saving water, sanitation and hygiene services, in line with the overall protection, assistance and solution mandate of UNHCR for refugees, stateless people and their hosting communities. Emergency responses should adhere to the principles highlighted in the WASH, Protection and Accountability Briefing Paper, with a focus on reducing tensions that may arise by the competition over limited WASH resources. They should also be in line with the UNHCR Strategic Framework for Climate Action, with the aim of limiting environmental degradation and enhancing climate resilience.

1. Prioritize community-based age-gender-diversity approaches in needs assessment, response design and delivery of assistance.
2. Focus on life-saving needs through community-level interventions, with quick transition to family- shared and family-owned infrastructures. These will facilitate greater sense of ownership, privacy, acceptance and overall effectiveness.
3. For hosting communities where access levels do not meet UNHCR or national minimum standards, consider the allocation of WASH support to hosting communities.
4. Rather than setting up parallel systems, aim at strengthening existing services and facilities. If these are insufficient, aim at designing and implementing new inclusive (for forcibly displaced and their hosting community) WASH infrastructure and service delivery systems. Aim to leverage development and other actors in the development of these.
5. Quickly facilitate the establishment of user committees on water, sanitation, solid waste. These should include a mix of forcibly displaced and host communities and be age, gender, and diversity sensitive. Train and equip the committees and do regular check-in to
facilitate peaceful co-existence, ownership, and sustainability.

In line with the UNHCR Policy on Cash-Based Interventions, consider CBI to cover WASH needs to the extent possible. In close collaboration with CBI colleagues and stakeholders, run market assessment to confirm CBI is a viable option. Verify as well that CBI targeting and distribution timelines allow to meet WASH needs. Keep in mind that the use of CBI would allow for greater choices and more dignity for beneficiaries, especially for personal hygiene and menstrual hygiene management (MHM) items. A mixed approach of in-kind distribution could also be considered, for instance toilet construction materials would benefit from economies of scale and could be provided in-kind, while cash would facilitate access to labour.

WASH interventions should always be:

- **Evidence-driven.** Activities should be planned and implemented based on the findings of the initial assessment. The operational context should be carefully considered. Undertake a baseline survey as soon as possible, to collect household-level indicators and adjust WASH interventions and strategy.
- **Needs-driven and priority (lifesaving)-based.** Emergency WASH interventions and services should be prioritized to achieve maximum impact across the population. Interventions to address immediate WASH, health, nutrition and protection risks, such as disease outbreaks and malnutrition, should be priorities. Interventions should be scaled, and resources should be allocated to meet the needs of the most vulnerable population.
- **Technically sound.** Services should be based on scientific evidence and operational guidance and implemented by skilled staff and partners, with full participation of users in the design and provision of WASH services to reduce protection risks. The UNHCR WASH Manual can provide further technical guidance.
- **Integrated/inclusive.** Avoid setting up costly parallel services. Assist the national water authorities to extend/strengthen their services to forcibly displaced and affected hosting communities.
- **Coordinated:** Strong coordination of WASH programmes is vital to ensure that all needs are covered, and optimal coverage is ensured through complementarity of actors while avoiding duplications.

**B) Protection considerations in WASH responses**

The following UNHCR WASH protection principles elaborated in the UNHCR WASH Manual should be taken into consideration:

1. Consultation, Engagement and Accountability to Affected Population (AAP), including feedback and complaint mechanism. Ensure that feedback is invited and considered. A complaints and follow-up system should be established, even if the duration of stay (such as in transit centres) is short.
2. Equitable access to WASH service for enhanced peaceful co-existence and prevention of community tensions over scarce WASH services, prioritizing those most in need.
3. Enhanced protection, safety, and privacy.

Emergency WASH interventions have positive effects in addressing important protection risks
including but not limited to:

1. Girls, children, and women are at risk of **gender-based violence (GBV)** when walking long distances to water points, or when accessing toilets and washing areas that are unlighted at night.
2. When forcibly displaced people and their hosting communities 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; unsafe burning waste, etc.).
3. Forcibly displaced people and their hosting communities who do not have safe access to sufficient water of good quality, and sanitation, may adopt risky coping mechanisms, for instance, procuring water from unreliable sources and vendors may have health and hygiene implications; resorting in open defecation which exposes people to GBV risks).
4. Security risks may drastically increase, including riots, demonstrations, and violent behaviour over scarce water resources.

C) **WASH considerations in the selection of sites for formal settlements**

When the establishment of formal settlements cannot be avoided (for instance, upon the request of the hosting government), WASH actors should work proactively and closely with a multi-sectorial team led by settlement planning officers, to help identifying the most suitable site.

1. Sites should be jointly assessed with settlement planning officers, protection staff, and local authorities to ensure that new 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 **Formal Settlements**).
2. Ensure that the selection of sites where to establish formal settlements is also based on a thorough WASH investigation. It is vital to analyse secondary data to understand water availability and related risks (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, as well as proximity to natural reserves and water bodies that may be contaminated by pollution caused by human presence as a consequence of the establishment of the formal settlement.
3. 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) which can in turn cause recurrent pollution of water sources.
4. Refer to the **multi-sectoral site assessment form** for key considerations for the selection of new sites and the extension of existing sites, and for mainstreaming environmental assessment components.
5. At the start of an emergency response, consider running a rapid environmental assessment as early as possible so that the response can take risk-informed decisions (e.g via **NEAT+**).

Please read the entries on **Shelter, Camp and Settlement**.

D) **WASH in transit centres**
WASH interventions in transit centres do not differ from the approach in other types of locations (e.g. formal settlements): they aim to meet the basic needs of newly arrived forcibly displaced people for safe access to sufficient water of good quality, safe access to emergency sanitation, and hygiene promotion. As these facilities are transitory, investment in WASH infrastructure can be limited to emergency standards, unless other considerations have to be made (e.g. long influx period, cost efficiency analysis, etc.). Close collaboration with national water authorities (and, where relevant, owners of the transit site) is required for this implementation.

E) WASH in urban and dispersed settings

1. Provision of WASH services for forcibly displaced in urban and dispersed settings can be significantly more complicated than in formal settlements as it is harder to assess WASH needs and based on the findings, provide timely WASH assistance. Moreover, monitoring is harder and evaluating the impact of the WASH response can be more complicated in view of the physical spread and mobility of the population.

2. Many problems with poor WASH service delivery in urban and dispersed settings may be chronic, existing prior to the refugee situation, or in the case of informal settlements, refugees may have self-settled in areas without service coverage. In some cases, WASH services for the resident urban poor may be worse than for the newly arrived refugee population.

3. UNHCR and other WASH actors should ensure that efforts are made to differentiate the different WASH needs of refugees that may have settled in a variety of arrangements - e.g. in rental or hosted accommodation, in informal settlements, or in collective centres. Blanket WASH interventions for both the refugee and host populations in areas that are generally heavily impacted by the newly arrived population is a fast way to reach people in need at the beginning of an emergency, while a more targeted approach needs to be carefully planned with local authorities, municipal services, CBI actors, among others. Targeting and prioritization should be based on vulnerability criteria of concerned families (both refugees and hosting).

4. Activities at community level should be carried out as much as possible in line with existing national WASH plans. Local service providers and authorities shall be closely consulted and if their capacity allows, involved in the implementation as well.

The table below provides a summary of types of WASH Interventions in urban settings, as described in the Urban WASH Planning Guidance Note.

<table>
<thead>
<tr>
<th>WASH assistance for refugee families settled in collective centres (public or private buildings), or in informal settlements</th>
<th>WASH assistance for families in rented accommodation or in hosting arrangements</th>
<th>WASH assistance to both the refugee and host population where influx overwhelms the local population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
○ Supplementary water points/extension of water networks to the concerned locations.
○ Water dispensers (or bottled water, if unavoidable).
○ Refilling taps connected to municipal water supply.
○ Clean up campaigns (against open defecation, waste, and for ditches)
○ Reinforcing sanitation and solid waste collection services.
○ Provision of hygiene kits, water filters/household level treatment, also via CBI.
○ Construction of temporary toilet and bathing facilities.

○ Provision of hygiene kits, water filters/household level treatment, also via CBI.

○ Supplementary public water points and/or extension/reinforcement of water networks to the concerned locations.
○ Rehabilitation of existing public WASH infrastructure.
○ Clean up campaigns (against open defecation, waste, and for ditches).
○ Reinforcing sanitation and solid waste collection and treatment services.
○ Provision of hygiene kits, water filters/household level treatment, also via CBI.
○ WASH related community driven Quick Impact Projects (QIPs).

F) WASH responses in public health outbreaks

It is critical to coordinate with the Health Sector before and during water-borne disease outbreaks. Key interventions during outbreaks include:

○ Increased chlorination at water storage and distribution points, targeting 0.5 mg/litre if pH \(\leq 8\) or, 1 mg/litre if pH > 8 of FRC at the water collection point;
○ Increase the sanitation coverage for safe excreta disposal;
○ Increase hygiene promotion activities and their reach in close coordination with health sector to avoid duplications and ensure maximum coverage.

Refer to Section 4 for key hygiene considerations during public health outbreaks. Refer also to the MSF Cholera Guidelines and the UNICEF Cholera Toolkit for more information.

G) Exit strategy

Ensure that a clear exit strategy exists from the start of the emergency phase. It should consider the operation, maintenance, transition and eventual decommissioning of water, toilet, wastewater and solid waste infrastructures. Where appropriate, WASH facilities should be handed over to the national Authorities or national actors.
H) The UNHCR WASH Response Programme Framework

The WASH response should be guided by the **UNHCR WASH Response Programme Framework**, as in the table below. The emergency phase is during the initial population influx, during which WASH systems are being established to rapidly provide life-saving services. Once the population has stabilized, or life-saving needs have been met, the response should transition to longer-term WASH systems as below. Basic services are aligned to the **Joint Monitoring Programme for Water Supply, Sanitation and Hygiene** (JMP).

Below indications are only indicative and should be tailored based on the context (cultural preferences, existing infrastructures, urban settings, etc).

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Emergency Response - Short Term</th>
<th>Transition toward longer term solutions</th>
<th>Basic - Longer Term</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Water supply</strong></td>
<td>• Bottled water at border crossing points <strong>if unavoidable</strong>&lt;br&gt;• Water trucking <strong>only if unavoidable</strong>&lt;br&gt;• Hydrogeological campaign to drill new boreholes (if needed)&lt;br&gt;• Surface source and treatment&lt;br&gt;• Tubewells&lt;br&gt;• Emergency bladders and/or elevated tank&lt;br&gt;• Emergency tapstand&lt;br&gt;• Temporary piped water networks with flexible lay flat hose&lt;br&gt;• Aquatabs/PUR/HTH chlorine&lt;br&gt;• Distribution of jerrycan 20L rigid&lt;br&gt;• Distribution of bucket with lid/tap&lt;br&gt;• Water dispensers (urban)&lt;br&gt;• CBI</td>
<td>• Extension/upgrades of emergency water network, including upgrades in materials, such as PE pipes&lt;br&gt;• Accommodation plumbing upgrades&lt;br&gt;• Handpumps&lt;br&gt;• Elevated water storage tower&lt;br&gt;• Creation of main water pipe system for future more reticulated systems&lt;br&gt;• CBI to cover water items (jerrycans, water filters, etc.), water bills</td>
<td>• Pipe network (reinforcements or extensions)&lt;br&gt;• Community level water treatment&lt;br&gt;• Elevated water storage tower&lt;br&gt;• Public water points&lt;br&gt;• Rainwater harvesting&lt;br&gt;• Renewable energy for motorized water systems&lt;br&gt;• Refilling taps connected to municipal water supply (urban)&lt;br&gt;• CBI to cover water items (jerrycans etc.), water treatment systems at household level, water bills</td>
</tr>
<tr>
<td>Sanitation, excreta and wastewater management</td>
<td>Handwashing</td>
<td>Bathing spaces/showers</td>
<td>Hygiene Promotion/ Users’ Committees</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------------</td>
<td>------------------------</td>
<td>--------------------------------------</td>
</tr>
</tbody>
</table>
| ◦ Trench toilets with privacy screens (if culturally acceptable and if no other solutions can be provided rapidly)  
  ◦ Portable/desludgeable toilets (elevated if needed, eg in rocky/impermeable soils)  
  ◦ Daily cleaning/maintenance  
  ◦ Plastic toilet slab  
  ◦ Toilet digging kits  
  ◦ Drainage/soakpits for wastewater management | ◦ Handwash container 50L with tap and stand  
  ◦ Daily refilling/maintenance  
  ◦ CBI | ◦ Bath / shower blocks - (community shared, gender segregated)  
  ◦ Portable gender-segregated shower facilities (urban) | ◦ IEC materials  
  ◦ Hygiene kit  
  ◦ Baby kit  
  ◦ CBI for hygiene items |
| ◦ Increase toilet coverage by commencing household toilet programme, initially with one toilet shared between four families (1:20) and improving to one per household  
  ◦ Drainage upgrades  
  ◦ On or off-site desludging/wastewater disposal systems  
  ◦ Accommodation plumbing upgrades | ◦ Increase handwashing promotion at household level and ensure each shared family toilet is equipped with appropriate handwashing device.  
  ◦ CBI | ◦ Increase bath / shower coverage  
  ◦ Encourage families to build their own facilities  
  ◦ CBI | ◦ Establishment of users’ committees  
  ◦ CBI for hygiene items |
| ◦ Basic pit toilet dome slab  
  ◦ Pour flush toilet if requested by the context  
  ◦ Flush toilets installed in prefabricated buildings/containers, or other suitable structures (urban)  
  ◦ CBI  
  ◦ Sewerage systems  
  ◦ Wastewater treatment and disposal systems upgrades | | | ◦ Management of WASH services through users’ committees  
  ◦ CBI for hygiene items |
Post emergency phase

As per the UNHCR WASH Response Programme Framework above, as the population numbers stabilize or as emergency live-saving standards are met, additional extensions and upgrades are undertaken to align with local standards, targeting at least basic WASH services. In this phase, strong collaboration with development stakeholders and local authorities is paramount, aiming for longer-term inclusion in local systems. Lessons learned and key issues in such a transition by World Bank and UNHCR in Uganda are summarized in this Discussion Paper.

Note: These are not mandatory steps. In some cases, existing infrastructure and systems will already be aligned (or close to) the transition or basic levels. Sequencing is only valid in responses that are not already aligned. Depending on context, emergency responses need to move to basic levels as fast as possible, to avoid health and environmental issues, and boost sustainability of operations of WASH systems.

Checklist

- Review local standards and norms, and service levels.
• Review standards met as part of the emergency phase.

• Establish a multi-stakeholder strategy (including relevant authorities and service providers) to achieve at least basic, or safely managed WASH services.

• Leverage development actors as part of such WASH strategy.

4. Standards

UNHCR has key WASH indicators which are systematically tracked by UNHCR and partner staff through the UNHCR WASH Monitoring System (WMS). The indicators recorded in the WASH Monthly Report Card should be collected every week during emergencies while those verified by Knowledge Attitude and Practice surveys should be collected at least once during the first phase of the emergency.

The main WASH standards and indicators are summarized below. While for the emergency response they are aligned with Sphere, beyond this they take into consideration the often-protracted nature of forcible displacement which may last for decades. Emergency standards need also to be adapted, taking into consideration the cultural habits and preferences of forcibly displaced, specific climatic conditions, public health considerations, and the national standards of the hosting country – these are agreed collectively within the sector.

It is important that all WASH responders (UNHCR, other UN agencies, partners, local authorities, etc.) report through the UNHCR WMS, in order to generate comparable data and allow for consequent aligned response.

Note: where no basic standard is provided, the emergency standard is used.

a) Water Supply

The main water supply standards below, and their means of verification are applied by UNHCR.

1. Access and water quantity. People have equitable and affordable access to sufficient quantity of safe water to meet their drinking, domestic and hygiene needs.
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.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit</th>
<th>Standard</th>
<th>Means of Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Emergency</td>
<td>Basic</td>
</tr>
<tr>
<td>Water Quantity</td>
<td>Average volume of potable water available</td>
<td>litres per person per day</td>
<td>7.5 - 15</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>------------------------------------------</td>
<td>---------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Average volume of potable water collected at household level</td>
<td>litres per person per day</td>
<td>≥ 15</td>
<td>≥ 20</td>
</tr>
<tr>
<td>Households with at least 10 liters/person of potable water storage capacity</td>
<td>%</td>
<td>≥ 70%</td>
<td>≥ 80%</td>
</tr>
<tr>
<td>Schools: average volume of potable water</td>
<td>litres per pupil per day</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Health clinic/nutrition feeding centre: average volume of potable water</td>
<td>litres per outpatient per day</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Health clinic/nutrition feeding centre: average volume of potable water</td>
<td>litres per inpatient bed per day</td>
<td>50</td>
<td></td>
</tr>
</tbody>
</table>

**Water Access**

<p>| Maximum distance from household to potable water collection point | meters | ≤ 500m | ≤ 200m | Mapping |</p>
<table>
<thead>
<tr>
<th>Access to usable hand pump / well / spring</th>
<th>persons per usable hand pump/well/spring</th>
<th>≤ 500</th>
<th>≤ 250</th>
<th>Monthly Report Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to usable water tap</td>
<td>persons per usable water tap</td>
<td>≥ 250</td>
<td>≥ 100</td>
<td>Monthly Report Card</td>
</tr>
<tr>
<td>Schools: access to usable handpump/well</td>
<td>pupils per usable handpump/well</td>
<td>≤ 400</td>
<td></td>
<td>WASH in Schools Checklist</td>
</tr>
<tr>
<td>Schools: access to usable tap</td>
<td>pupil per usable tap</td>
<td>≤ 200</td>
<td></td>
<td>WASH in Schools Checklist</td>
</tr>
<tr>
<td>Health clinics/nutrition feeding centre: separated water point</td>
<td>water points/facility</td>
<td>1</td>
<td></td>
<td>Health Facility Balanced Score Card</td>
</tr>
</tbody>
</table>

**Water Quality**

<table>
<thead>
<tr>
<th>Households collecting drinking water from protected/treated sources</th>
<th>%</th>
<th>≥ 70%</th>
<th>≥ 95%</th>
<th>Annual KAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water quality tests at non chlorinated water collection locations with 0 CFU/100ml</td>
<td>%</td>
<td>≥ 95%</td>
<td>≥ 95%</td>
<td>Monthly Report Card</td>
</tr>
<tr>
<td>Water quality tests at chlorinated collection locations with FRC in the range 0.2-2mg/L and turbidity &lt;5 NTU</td>
<td>%</td>
<td>≥ 95%</td>
<td>≥ 95%</td>
<td>Monthly Report Card</td>
</tr>
</tbody>
</table>
Key considerations

Water supply systems design.

- Water supply systems should be designed to deliver at least 20 l/p/day.
- Calculations of water needs should also consider the needs of health centres, feeding centres, schools, and religious centres.
- The needs of livestock or agriculture activities should also be factored in. Thus, coordination with livelihood actors is crucial to define overall water requirements.
- When groundwater is extracted, continuous groundwater monitoring should be undertaken to ensure extraction and recharge is done within the capacity of the aquifer to recharge (safe yield).

Water quality. Water quality standards apply to all water collection locations, including those at health care facilities and schools.

Water safety

- All settings (with the exception of locations where provision is guaranteed through public provision such as in urban and in some cases rural areas) receiving forcibly displaced populations should 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.
- The most acute threats to human health associated with consumption of water are due to contamination by human or animal faecal matter. Test for residual chlorine and microbiological indicators of faecal contamination is thus paramount. The emergency operation should also ensure sufficient availability of test consumables to ensure tests can be conducted as frequent as necessary in line with a risk-based approach.
- Assess water safety using a risk assessment approach, including sanitary inspections. The Green Companion highlights potential sources of contamination and good practices to protect ground and surface water sources.

Participation. Participation of forcibly displaced persons in water supply services should be developed through capacity-building, community-led hygiene promotion activities and the establishment of active gender-balanced and representative water users' committees. Water committees should participate in the design and location of water points and the operation and maintenance of facilities and services.

Climate and environmental related considerations

- Climate change poses serious risk to the delivery of water services to forcibly displaced and host communities. It impacts water resources and water requirements and drought and heatwaves, storms and flooding make the delivery of services more complex.
- Renewable energy sources should be prioritized over carbon-based fuel generators to eliminate as much as possible fossil fuel consumption in the operation and maintenance of water pumping, treatment and distribution, as early as possible in the emergency response.
- Leakage at extraction points, in water distribution systems and at communal collection points.
points wastes water causes localized erosion, increases the risks of stagnant water, source contamination and can create water hazards, especially for young children. Leak mitigation measures should be included in the operations and maintenance of water systems.

For further information on how to reduce the environmental impact of WASH responses please refer to the Green Companion, as well as the Climate and Environmental Considerations in Emergencies entry.

b) Sanitation, excreta and wastewater management

Safe excreta disposal and wastewater management is an essential element of any WASH programme because it helps to reduce direct and indirect water-borne disease transmission, water contamination and further pollution.

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.
2. Access to and use of toilets: People have adequate, appropriate and acceptable toilets to allow for rapid, safe and secure access at all times.
3. 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.

Wastewater consists of blackwater from toilets, which is faecally contaminated, and greywater from bathing areas, laundries, kitchens and other use points, which is not generally faecally contaminated.

Key sanitation indicators, standards for emergency, transition and basic WASH services, and their means of verification are shown in the table below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit</th>
<th>Standard</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to toilet</td>
<td># of persons/toilet</td>
<td>≤ 50</td>
<td>Monthly Report Card</td>
</tr>
<tr>
<td>Households reporting defecating in a toilet</td>
<td>%</td>
<td>≥ 60</td>
<td>Annual KAP/ Monthly Report Card</td>
</tr>
<tr>
<td>Households with a household toilet</td>
<td>%</td>
<td>≥ 85</td>
<td>Monthly Report Card</td>
</tr>
<tr>
<td>Access to bath shelter/shower</td>
<td>persons per bath shelter/shower</td>
<td>≤ 50</td>
<td>5 or one household</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------</td>
<td>------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Schools: access to toilet</td>
<td>pupils per toilet</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>
</tr>
<tr>
<td>Health clinics/nutrition feeding centres: access to toilet</td>
<td>patients per toilet</td>
<td>20 outpatients per toilet</td>
<td>20 outpatients per toilet</td>
</tr>
</tbody>
</table>

**Key considerations.**
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. Access to sanitation can be scaled up through the distribution of sanitation construction materials or cash-for-toilet programming and proper monitoring.

The following should be considered:

- **Protection of water sources from fecal contamination.** No excreta containment systems (pits, tanks, seepage, sewerage or spillage) should contaminate surface water or shallow groundwater sources. Toilets should be located at least 30 metres from groundwater sources. Additional measures should be taken in locations that have a high watertable or are prone to flooding. The bottom of pits and soak-aways should be at least 1.5 metres above the groundwater table.
- **Toilet access.** Ensure that communal or family-shared toilets are evenly dispersed throughout a settlement; no dwelling should be more than 50 meters from the nearest toilet.
- **Universal access.** Make sure that all toilets can be used safely by all persons, including children, the elderly, pregnant women, persons with reduced mobility and other with specific needs. Collect data on users who have disabilities and construct dedicated toilet facilities as near to them as possible, considering the results from community consultations.
- **Handwashing.** Ensure that all toilets (public, communal, shared, and household ones) have hand-washing facilities, with soap (or a clean rubbing agent), and that arrangements are in place to ensure they remain functional. Target one handwash device per toilet block in the emergency response, and one per household when targeting basic WASH services.
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, incentives for toilet cleaning can be considered. In the case of family-shared or household level toilets, the family will be responsible for their cleaning and maintenance.

Gender disaggregated distribution. As a rule of thumb, provide three female toilets to every male toilet, based on disaggregated population numbers. Toilet blocks should be segregated by sex and marked with culturally appropriate signage.

Participation and gender-balanced representation. Ensure that programmes are developed and run in cooperation with the refugee population. Women, adolescents and marginalized groups should be consulted on the design and siting of toilet facilities. All programmes should have active gender-balanced and representative sanitation or hygiene committees. Committees should participate in the operation and maintenance of facilities and services, and eventually through contributions of labor or finances.

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. Locks and lighting (in discussion with users) should be installed during the initial emergency response.

Household toilets. Ensure as soon as possible that refugees have the means, tools, materials and appropriate technical guidance to construct, maintain and clean household toilets. It is recommended to support families if they have no means to achieve self-construction.

Bathing facilities. Ensure that refugees have access to facilities for bathing. These facilities should provide privacy and dignity. If this cannot be achieved at household level or if it is not culturally appropriate, 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.

Laundry facilities. For laundry facilities, aim to meet the needs of small communal groups of up to 16 households; avoid large public wash blocks to improve privacy and dignity and which may be easier to maintain hygiene standards.

Wastewater management. Ensure that wastewater (from tapstands, bathing, laundry, handwashing points) is disposed in soakpits or drainage systems to minimize bodies of stagnant water, which act as breeding sites for disease vectors. Coordinate with settlement planning officers, and if relevant, local authorities, to develop an overall drainage plan, transitioning out of emergency drainage systems as quickly as possible. Beyond the emergency response, services should be upgraded to include safe treatment and disposal of wastewater. In arid zones and where culturally appropriate, runoff water may be reused in sub-surface irrigation systems, e.g. for household gardening purposes.

Monitoring. Ensure that sanitation facilities are monitored regularly (toilet distribution, use, access, cleanliness, conditions, etc.).

c) Solid waste management

Uncontrolled accumulation of garbage is unhealthy and promotes rodent and insect borne disease. Solid waste management is a joint responsibility of field coordination, as well as the WASH and health sectors. In urban and dispersed settings, national/municipal systems should be
employed and, where necessary, strengthened. The main solid waste management standards below, and their means of verification are applied by UNHCR.

1. Environment free from solid waste. Solid waste is safely contained to avoid pollution of the natural, living, learning, working and communal environments.
2. Household and personal actions to safely manage solid waste. People can safely collect and potentially treat solid waste in their households.
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.

Key solid waste management indicators, standards for emergency, transition and basic WASH services, and their means of verification are shown in the table below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit</th>
<th>Standard</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Households with access to solid waste disposal facility</td>
<td>%</td>
<td>≥ 70%</td>
<td>≥ 90%</td>
</tr>
</tbody>
</table>

Key considerations.

- **Collection:** While in the emergency phase centralised solid waste management solutions may be appropriate, as the situation moves towards the provision of basic services, decentralised household level solid waste management solutions, as well as recycling and reuse, should be implemented where possible.
- **Treatment and disposal:** Safe treatment and disposal should be prioritized as quickly as possible.
- **Disposal:** Ensure solid waste disposal is properly managed, to avoid health hazards (injuries to children, mosquito breeding sites, etc.).
- **Waste minimization:** Waste minimization, including reducing, reuse and recycling, should be prioritized as quickly as possible. This should include strong community engagement activities and the development of final treatment and disposal systems.
- **Hazardous substances and e-waste:** Batteries (especially lead-acid), used oils, and broken electrical equipment can pose serious risks to public health and the environment, even in small quantities. Arrangements to collect such waste separately should be made. Prioritize interventions that prevent hazardous substances from entering the domestic waste stream over management of relatively inert domestic waste.
- **Medical waste:** 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, in line with protocols of the local Ministry of Health.

d) Hygiene
The main hygiene standards focus on knowledge and behaviour.

1. 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. This is done in close collaboration with health teams.
2. 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.
3. 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.
4. WASH in healthcare facilities: All healthcare facilities should maintain minimum WASH-related infection prevention and control standards (IPC), including in disease outbreaks. While this is the responsibility of health workers, WASH actors can play an important support role in meeting this standard.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit</th>
<th>Standard</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons per hygiene promoter</td>
<td>persons per hygiene promoter</td>
<td>≤ 500</td>
<td>≤ 1000</td>
</tr>
<tr>
<td>Households with access to soap</td>
<td>%</td>
<td>≥ 70%</td>
<td>≥ 90%</td>
</tr>
<tr>
<td>Women of reproductive age who receive and are satisfied with menstrual hygiene management materials and facilities</td>
<td>%</td>
<td>≥ 70%</td>
<td>≥ 90%</td>
</tr>
</tbody>
</table>

**Key considerations:**

**Monitoring:**

- 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). See the entry on [WASH needs assessment](#).
- The standardized expanded nutrition survey (SENS) which happens in many operations includes a short WASH module and covers the core WASH household indicators. To use resources efficiently and avoid survey fatigue, liaise with a public health/nutrition officer on
whether a SENS is already planned.

**Access to soap:**

- 250 grams/person/month should be supplied for personal hygiene only;
- Additional soap 250 grams/person/month for women and girls menstrual hygiene;
- For laundry, provide 200 grams/person/month.

These standards can be also achieved by including access to soap in CBI.

**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 mindsets.

**Key hygiene messages strategy**

- Ensure hygiene promotion activities and messages are closely coordinated with the health sector: avoid duplication of efforts, especially when health promotion can already cover hygiene related messages
- Jointly with the health sector, develop hygiene messages and IEC materials within the first three months of an emergency. Review those every six months based on monitoring feedback.
- 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, these 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 (e.g. non-use of chlorinated water, open defecation, etc.). Focus on priority groups at risk, risky practices, key interventions, and key indicators that can further inform any adjustment to the WASH response.
- Do not attempt to communicate too many messages. Concentrate on practices that are most responsible for transmitting diseases and on interventions to prevent them.

**Empowerment.** Develop and run hygiene promotion programmes in full cooperation with forcibly displaced people and the host population.

**During outbreaks of waterborne diseases** (cholera, Hepatitis E, Dengue, etc.), it may be necessary to:

- establish a task force composed of the WASH and health sectors that meets on very regular basis to make sure messages are consistent and harmonized and there is complementarity (rather than duplication) of efforts
- ensure soap is distributed regularly and used
- ensure knowledge about handwashing is increased, and household-water treatment and safe storage is demonstrated and promoted.
- work closely with health sector to tackle any gaps (in hardware or soft skills)
Monitor disease trends and outbreaks (diarrhoea, Hepatitis E, cholera etc) in settlements and health centres. The information gathered can guide efforts to prioritize WASH interventions. In close collaboration with the health sector correlate WASH trends (WASH monitoring) and water-related disease trends (public health monitoring) to inform targeted interventions.

**High risk vectors:** Elimination of high-risk disease vectors should be given the same priority as water supply, excreta management and hygiene promotion.

- 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.

5. **Learning and field practices**

   Good practices on cash-based interventions and water, sanitation and hygiene (W...

6. **Links**

   Sphere Handbook. Humanitarian Charter and Minimum Standards in Humanitarian Res...

7. **Main contacts**

   Contact Division of Resilience and Solutions (DRS)/Technical Support Section (TSS): hqsl00@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 a 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 respected:

**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

- [UNHCR, Policy on Protection and Solutions in Urban Areas](#)
- [UNHCR, Policy on Alternatives to Camps](#)
- [Sphere Handbook (2018)](#)

3. Learning and field practices

4. Links

- [Information Management Toolkit](#)
- [Good practice for Urban Refugees](#)
- [Global Shelter Cluster](#)
- [UNHCR Emergency Portals](#)
- [Global compact on Refugees (December 2018) / New York declaration Sustainable Development Goals](#)
- [Urban Refugees Website Settlement Information Portal](#)
- [UNHCR - Global strategy for settlement and shelter (2014-2018)](#)
- [Global Compact on Refugees (December 2018) / New York declaration Sustainable Development Goals](#)

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
- A multifunctional coordination team approach involving health, nutrition, shelter, site planning and WASH should be ensured at all levels as these sectors are interlinked

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,
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, Good practices on cash-based interventions and water, sanitation and hyg...

5. Main contacts

Contact Division of Resilience and Solutions (DRS)/Technical Support Section (TSS) at: hqsl00@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.

<table>
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<th>Setting</th>
<th>For consideration</th>
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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. |
● 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)

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<th>Where RH services are not yet available</th>
<th>Where the MISP or RH/HIV components already exist</th>
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Implement the minimum initial service package (MISP).

- 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.
- Access to contraceptives
- Post-abortion care

Expand to comprehensive RH services.

- All of the MISP, plus:
  - Antenatal care
  - Postnatal care
  - Fistula detection and management
  - Adolescent sexual and reproductive health services (SRH)
  - Comprehensive GBV response
  - Comprehensive HIV services

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 line with the Public Health Administrative Instruction, 2023 and Medicines and Medical supplies guidance, 2023. 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 neontal 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 AI 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**

Public Health Section, DRS: hqphn@unhcr.org

**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. Health 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 centers, 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: screening of children under 5 and pregnant and lactating women for acute malnutrition and linkage to services.
   3. Identify and link patients in need of continuous medication for chronic non-communicable diseases, HIV or TB treatment 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.

Health systems standard 1.2: Healthcare workforce

People have access to healthcare workers with adequate skills at all levels of healthcare. Refer to entry Primary health care staffing standard.

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 Al 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


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
Mental Health and Psychosocial Support (MHPSS)

16 January 2024

Key points

- Integrate mental health and psychosocial support into programmes and systems for health, community-based protection, child protection, GBV, education and nutrition
- Revive and strengthen family and community support systems and promote positive coping mechanisms of affected individuals and their families
- Ensure that mental health care is functionally linked to, and preferably integrated into the general health system
- Take steps to introduce psychological interventions for people with prolonged emotional distress
- Facilitate intersectoral coordination, for example, through a multi sectoral Technical Working Group for MHPSS

1. Overview

Displacement puts significant psychological and social stress on individuals, families and communities. People may have experienced multiple atrocities and adversities prior to or during flight. Once they reach safety, their current living conditions may also impose significant stress and hardship, often coupled with worries about those left behind and concerns about the future. This leads to increased levels of mental health conditions and psychosocial problems.

The 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 health conditions. MHPSS is not confined to a single sector but requires a multi-sectoral approach with involvement of partners in health, education and protection (community-based protection, child protection and GBV). Addressing MHPSS issues requires that:

1. emergency responses are safe, dignified, participatory, community owned, and socially and culturally acceptable.
2. people are enabled to attend to their own well-being and that of others in their families and communities.
3. persons distressed by mental health and psychosocial problems have access to appropriate
support and care.
4. persons suffering from moderate or severe mental health conditions have access to essential mental health services and to social care.

2. Relevance for emergency operations

People affected by humanitarian emergencies often face pervasive psychological stress that causes widespread emotional suffering and may undermine people’s ability for survival. The loss and stress experienced during humanitarian emergencies cause grief, fear, anxiety, guilt, shame and hopelessness that overtax individuals’ capacity to cope. Community structures that 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. Significant stress over long periods, harms the development of children, increases the risk that they will have physical or mental health problems, and may contribute to educational difficulties later in life.

Humanitarian emergencies increase the risk of developing mental health conditions, including depression, posttraumatic stress disorder, and alcohol and substance use conditions, all of which weaken the ability of individuals to fend for themselves and care for others who depend on them. During emergencies, people with severe mental disorders (psychosis, bipolar disorder, severe forms of depression or posttraumatic stress), or intellectual and developmental disabilities, have elevated protection risks if they experience neglect, abandonment, homelessness, sexual or domestic abuse, social stigma, or are excluded from humanitarian assistance, education, livelihood opportunities, healthcare or other services. Those who care for people with severe mental health conditions can experience extreme distress, isolation and strain on financial and other resources.

MHPSS is not an optional ‘nice to have’ intervention but an essential part of the emergency response. How that response is shaped is strongly influenced by operational factors such as: available resources, presence of partners with experience in MHPSS and capacity of the national systems.

3. Main guidance

a) Emergency Phase

MHPSS as a multi-layered system

MHPSS is not a separate sector, but an integrated part of programmes in various sectors. This is visualized in the MHPSS pyramid (Illustration 1), which shows several layers of complementary support, with referral systems between the layers. It is important to pay attention to all layers, ranging from interventions that benefit all people to targeted interventions for specific groups.

Illustration 1: Pyramid of multi-layered mental health and psychosocial support
Layer 1: Provision of basic services and security in ways that protects the dignity of all people, including those who are particularly marginalized or isolated and who may face barriers to accessing services and deliver the response in a participatory, rights-based way using Age, Gender and Diversity (AGD) approaches.

Layer 2: Strengthening community and family support: enabling people to preserve and promote their psychosocial well-being through activities that foster social cohesion and through enabling communities to restore or develop mechanisms to protect and support themselves.

Layer 3: Provision of focused psychosocial support through individual, family or group interventions to those who find it difficult to cope within their own support network. Non-specialised workers usually deliver such support, after training and with ongoing supervision.

Layer 4: Clinical mental health and psychosocial services for those with severe symptoms or whose intolerable suffering rendering them unable to carry out basic daily functions. Such interventions are usually led by mental health professionals but can also be done by trained and supervised general health workers.

- Adopting an **MHPSS approach** 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 with the primary goal of improving the mental health and psychosocial well-being of persons of concern. Such activities are usually implemented in health, community-based protection, GBV, child protection, and education.

**Key steps**
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 displaced populations 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. This section describes the key steps to be taken.

i. Include MHPSS elements in assessments

Initial rapid assessments for health and protection should include 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.

Tips for doing MHPSS assessments:

- Make assessments participatory; involve persons of concern at every stage, with a particular focus on including more isolated or marginalized individuals.
- Assess both 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 disorder (PTSD), do not provide the data needed to design a comprehensive MHPSS programme.
- Do not try to estimate the prevalence of mental disorders during an emergency because such an assessment is methodologically complicated, requires specific resources and, most important, is not essential to start implementing services.
- When integrating MHPSS questions in quantitative surveys such as Multi-Sectoral Needs Assessments, consider using:
  - A single MHPSS Question (as was used in Multisector Needs Assessments in the Ukraine Regional Refugee Response) MHPSS Question for Multisector Needs Assessment
- As a rule of thumb, use WHO projections of mental disorders in adult populations affected by emergencies (Box 1)

Box 1: Point prevalence estimates for mental disorders in conflict-affected populations, adjusted for comorbidity

<table>
<thead>
<tr>
<th></th>
<th>Point prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe disorder (severe anxiety, severe post-traumatic stress disorder, severe depression, schizophrenia, and bipolar disorder)</td>
<td>5.1%</td>
</tr>
</tbody>
</table>
### Point prevalence

<table>
<thead>
<tr>
<th>Disorder (Moderate/Mild Anxiety, Stress Disorder, Depression)</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate disorder (moderate anxiety, moderate PTSD, moderate depression)</td>
<td>4.0%</td>
</tr>
<tr>
<td>Mild disorder (mild anxiety, mild PTSD, mild depression)</td>
<td>13.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22.1%</strong></td>
</tr>
</tbody>
</table>


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**ii. Promote the adoption of an MHPSS approach throughout the work of UNHCR and 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. Tools
    - [Psychological First Aid. Guide for field workers](Psychological First Aid. Guide for field workers)
    - [Psychological first aid: facilitator's manual for orienting field workers](Psychological first aid: facilitator's manual for orienting field workers)
  - Integrate MHPSS in the regular training programmes for staff working on gender-based violence (GBV), Child Protection and Community-Based Protection
- Inform managers about the importance of using MHPSS approaches in all sectors. Consider holding short briefing sessions 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.

**iii. Design and implement MHPSS interventions within health programmes**

The provision of services for mental health and psychosocial support is a regular and integral part of primary health care services. (See: [UNHCR Administrative Instruction on Public Health](UNHCR Administrative Instruction on Public Health))
Programming and UNHCR Global Public Health Strategy 2021-2025). In general, this implies that, as much as possible, one partner provides a comprehensive package of primary health care that includes essential mental health services. Specialized MHPSS partners may be required in contexts with complex mental health needs that cannot be met through the national system.

**For general health programmes**

- Ensure that mental health is included in Project Partnership Agreements with health providers
- Arrange supply of essential medication for mental disorders to health facilities, at a minimum one anti-epileptic, one antipsychotic (plus anticholinergic), one antidepressant and one anxiolytic medication.
- Organize training for general health staff in identifying and managing priority mental health conditions. Such trainings usually take 3-5 days and need to be followed by supportive supervision and refresher trainings. Tools:
  - WHO/UNHCR (2015) mhGAP Humanitarian Intervention Guide (available in various languages)
  - WHO/UNHCR (2022) Facilitation Manual mhGAP Humanitarian Intervention Guide (available also in French)
- Arrange for a mental health professional (psychiatrist, psychiatric clinical officer, psychiatric nurse) to support the primary health care facilities to manage people with complex conditions and provide clinical supervision to general health workers. As a rule of thumb, a mental health professional should be made available in refugee camps or settlements with more than 25,000 inhabitants. This professional can be an NGO staff or an employee of a governmental mental health service.
- Ensure that consultations for mental health conditions are registered in the health information system. If UNHCR’s integrated refugee health information system (iRHIS) is used, make sure that the mental health categories are used. In case mental health consultations are done by a separate MHPSS partner, their data should be included in the iRHIS or other health information systems.
- Enable community health workers (CHW) to provide basic MHPSS interventions. Mental health needs to be a part of the training curriculum and they should be regularly supervised on mental health issues. They can be trained to:
  - provide Psychological First Aid and Basic Psychosocial Skills to people in acute distress. Suggested tools see above under b)
  - Identify and refer people with severe and complex mental health issues that threaten survival.

In some operations, specialized community MHPSS volunteers are trained to do focused work.

**For partners with dedicated MHPSS expertise:**

Where partners are available with dedicated MHPSS expertise:

- Take steps to make brief psychological therapies available to people impaired by prolonged distress: consider starting with evidence-based brief psychological therapies for mild and moderate mental health conditions. (See box 2)
Arrange a referral pathway to these services from the general health providers to the MHPSS partner. Ask MHPSS partner to build MHPSS capacity in general partners for health and protection.

For more information, see the Entry on health responses.

**Box 2: Psychological interventions**

Brief scalable psychological interventions (5-8 sessions) can be delivered by non-specialized staff after a brief training and with supportive clinical supervision by a mental health professional. There are several scalable psychological methods. SEE ANNEX B of Global Public Health Strategy. One of the most widely used methods is Problem Management Plus (PM+) which is based on Cognitive Behavioral Therapy, which teaches the participants four techniques to cope better with symptoms of depression and anxiety:

- stress management,
- problem solving,
- behavioral activation,
- strengthening support.

PM+ is provided in five sessions of 90 min and can be delivered in individual format or group format. It has been translated in many languages.

**iv. Include MHPSS interventions in community-based protection**

Most communities already employ protection measures to support members facing heightened protection risks. Emergency displacement can undermine such community-based support interventions. Engaging together in response activities can help community members to restore feelings of agency and hopefulness, strengthen social connections and provide a sense of collective identity and belonging, factors that promote well-being and recovery. At the same time, certain coping strategies may harm or disadvantage marginalized groups (for example measures that restrict women's rights or exclude minority groups).

1. Discuss MHPSS strengths, needs, and challenges with the community, using culturally and contextually relevant terminology and concepts and accessible communication formats and channels.

2. Support (re)establishment of community initiatives that promote mental health and psychosocial well-being (e.g. cultural and religious activities, self-help initiatives and support groups, appropriate communal healing practices, communal arts-based activities, etc.) and partner with these initiatives to strengthen their capacity to respond to MHPSS needs (e.g. providing safe spaces in which to convene, capacity-building in MHPSS and/or group facilitation skills, using an Age Gender and Diversity - AGD - approach).

3. Integrate MHPSS in other community interventions such as sport activities, vocational training and literacy classes that can support development of coping mechanisms to alleviate stress and introduce psychosocial support projects in multi-purpose community centres.

4. Recruit and train staff and volunteers from community groups to reach and support individuals with mental and psychosocial concerns from all AGD groups.
5. Promote and support activities that reduce tensions within communities of displaced persons (i.e. tensions between ethnic groups in a refugee or IDP camp), and between displaced persons and host community members.

6. Take steps to integrate people with severe mental health conditions, persons with psychosocial, intellectual and developmental disabilities and epilepsy in programmes for community-based rehabilitation; provide support to enable them to participate in mainstream programmes. Work with communities to reduce discrimination against people with mental health conditions and address social norms that stigmatize mental health or psychosocial support needs.

For more information, see the Entry on [community-based protection](#).

### v. Design and implement MHPSS interventions within child protection programmes

It is important to 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. Such children should 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. Six core actions underpin UNHCR’s field-focused programming around child protection and MHPSS in emergencies:

- **Coordinate MHPSS within & across sectors.** See section viii below. This includes creating joint referral pathways to facilitate access of children and care takers to MHPSS services and activities and to additional support as needed. It also includes facilitating a dialogue between government and humanitarian actors to establish MHPSS-specific roles and responsibilities in the emergency response.

- **Disseminate key messages to promote MHPSS & well-being for children, families and communities.** This includes providing information for parents and caregivers about MHPSS distress and how they can support their children.

- **Orient frontline child protection workers & community actors in basic psychosocial support skills.** This includes familiarizing frontline workers and community leaders with local referral pathways and available mental health and psychosocial support services for children and caregivers.

- **Provide MHPSS through case management services.** This includes educating the child and their caregivers about mental health, coping strategies, and available support services. It also includes engaging and involving the child's caregivers and significant family members in MHPSS case management and ensuring a smooth transition and continuity of care when the child moves between different services or stages of the case management process.

- **Support new & pre-existing group-based community MHPSS activities.** This includes establishing structured recreational activities, led by community volunteers, and coordinate these with education activities.

- **Promote caregivers’ mental health and psychosocial well-being and strengthen their capacity to support children.** This includes providing 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. Additionally, it is advised where possible to support community-based early childhood care
and development programmes, to ensure that mothers of very young children are enabled to provide appropriate protection, care, stimulation and support. Where relevant, link these activities to nutrition and breast-feeding programmes.

For more information, see the Entry on Child protection and link to the forthcoming ‘Guidance Note on Child protection and MHPSS’.

vi. Design and implement MHPSS interventions within programmes for GBV prevention and response

- Establish (group) psychosocial activities within Women and Girls’ Safe Spaces (WGSS) with a focus on women and girls’ empowerment. These activities can also serve as non-stigmatizing entry points to case management for GBV survivors.
- Boys’ survivors can access support through Child Friendly Spaces or other relevant MHPSS partner trained on Caring for Child Survivors. Adult male survivors can receive assistance at designated community centres where MHPSS services are available, in health centres, or other non-stigmatizing entry points where qualified personnel is available.
- Ensure that survivors have safe access to individual or group psychosocial services including those that promote resilience strategies (e.g. women support groups/networks).
- Ensure that quality and survivor centred MHPSS services are included in the GBV referral pathway. Training GBV workforce (and medical staff involved in clinical management of rape survivors) to recognize and respond to signs of emotional distress of women/girls (psychological first aid) and to recognize signs indicating that women/girls may benefit from GBV case management or specialized mental health care.
- If survivors wish, facilitate referral to trained providers of evidence-based psychotherapies for survivors who are not functioning well because of their symptoms of mental health conditions such as depression and stress-related conditions.
- If survivors wish, 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 healthcare to survivors of GBV).
- Ensure GBV risks are effectively mitigated across all MHPSS programming in line with the IASC Guidelines for Integrating GBV Interventions in Humanitarian Action.

For more information, see the Entry on GBV Mitigation and Response.

vii. Design and implement MHPSS interventions (including Social and Emotional Learning – SEL) within education programmes

Providing educational activities to children and youth from the early stages of an emergency can reduce psychosocial and mental health impacts of extreme stressors and displacement by restoring routine and normalcy and creating hope for a better future. Fostering the development of social and emotional skills and competences and supporting the provision of school-based mental health and psychosocial services (MHPSS) are essential to child development and well-being, which require attention from the start of an emergency.

- Create conditions in learning spaces that foster social and emotional learning (SEL) allowing learners to improve mood, concentration, ability to learn and develop healthy relationships. These can be created through both teacher-led and learner-led interventions.
Promote an environment where learners in need have access to mental health services and psychosocial support. This requires the development of functional referral pathways and close coordination of education, child protection actors and child-focused MHPSS services.

Where feasible, integrate psychosocial/recreational activities into programmes delivered through temporary learning spaces and organize social and cultural events, including sports activities, in schools and non-formal education programmes, to foster social connectedness among children, parents, and the community.

Promote the establishment and operation of learning environments that learners perceive as accessible, safe and conducive. Consider both physical infrastructure (well-built, disability-friendly classrooms and separate latrines for boys and girls) and the school's culture. Take measures to stop discrimination against vulnerable learners and learners with psychosocial or other disabilities.

For more information, see the Entry on education in emergencies URBAN and CAMPS and the following resources:

- **Education 2030: A Strategy for Refugee Education** (UNHCR, 2019)
- **MHPSS and Education in Emergencies Toolkit** (MHPSS.net, 2021)

**viii. Establish coordination mechanisms for MHPSS**

In emergencies it is important to establish or maintain a multi-sectoral MHPSS coordination mechanism, adequate to the context and number of agencies implementing MHPSS. Especially in larger emergencies where there are multiple MHPSS actors, this could be a single cross-sectoral MHPSS Technical Working Group (MHPSS TWG) which should be established early in the emergency response. This group may be co-led by a health and a protection humanitarian organization and/or a governmental organization when feasible. If a major refugee emergency does not have an MHPSS TWG, UNHCR should consider creating one. The MHPSS Technical Working Group (TWG) should promote the coordination of MHPSS activities across both national actors (e.g., CBOs, government) and international actors (e.g., INGOs, UN agencies), provide technical input, and help to ensure consistent standards and quality within MHPSS work. It is not recommended to establish separate MHPSS coordination mechanism focusing only on one sector (such as health or child protection). In large or complex emergencies, consider requesting an interagency deployee to support coordination and capacity building (See box 3).

For more information, especially in mixed coordination, see:

- **IASC Handbook for Mental Health and Psychosocial Support Coordination** (2022)

**Box 3: MHPSS Surge Support**

MHPSS Dutch Surge Support (DSS) is a programme that deploys Mental Health and Psychosocial Support (MHPSS) experts to assist in relief efforts for a few weeks up to several months during or after a humanitarian crisis. DSS MHPSS work to strengthen interagency cooperation on multisectoral mental health and psychosocial support in armed conflict, refugee crises, and natural disasters. Experts can be hosted by various agencies including UNHCR, but will not work exclusively for that organization. Deployment request are done through HR units through the UNHCR Division of Emergency Support and Supplies in consultation with the Snr MHPSS Officer. See more [here](#).
Post emergency phase

In the post emergency phase, the emphasis shifts to sustainable treatment coverage across the affected areas through, inter alia, strengthening existing national mental health systems and fostering inclusion of marginalised groups (including refugees) in these systems (ref. Sphere Handbook - Mental Health Standard 2.5 Mental health care). See the Annex B (MHPSS) in the Global Public Health Strategy.

Checklist: MHPSS Coordination

- Set up a system for multi sectoral MHPSS coordination.

- If a Technical Working Group (TWG) for MHPSS is established in a refugee emergency, consider UNHCR to co-chair.

- Ensure that a representative of the MHPSS TWG provides updates to coordination meetings for protection (including child protection) and health.

4. Standards

Sphere Mental health standard (2018)

People of all ages have access to healthcare that addresses mental health conditions and associated impaired functioning.

In the Sphere Handbook, MHPSS is mentioned throughout the document, in addition to a specific Mental Health Standard ‘People have access to health services that reduce mental health problems and associated impaired functioning.

Key actions

1. Coordinate mental health and psychosocial support across sectors.
2. Develop programmes based on identified needs and resources.
3. Work with community members, including marginalized people, to strengthen community self-help and social support.
4. Orient staff and volunteers on how to offer psychological first aid.
5. Make basic clinical mental healthcare available at every healthcare facility.
6. Make psychological interventions available where possible for people impaired by prolonged distress.
7. Protect the rights of people with severe mental health conditions in the community, hospitals and institutions.
8. Minimize harm related to alcohol and drugs.
9. Take steps to develop a sustainable mental health system during early recovery planning and protracted crises.

Standard 10: Mental health and psychosocial distress (Child protection Minimum Standards 2019)

Children and their caregivers experience improved mental health and psychosocial well-being.

Core Output Indicator 10.2.1: # of individual consultations in UNHCR supported mental health and psychosocial support services

This indicator measures the number of individual consultations in mental health and psychosocial support services provided by UNHCR or its funded partners during the reporting period. The term ‘consultation’ refers to a dedicated and structured contact (a ‘session’) between a person seeking help and a person providing MHPSS services. This includes 1) psychiatric consultations, 2) psychological interventions such as counselling, psychotherapy and brief psychological interventions for individuals, couples and families, 3) community-based activities with the explicit aim to improve mental health and psychosocial wellbeing. It excludes generic activities such as the count of people attending child-friendly spaces or community centres.

Annexes

IASC, The Mental Health and Psychosocial Support Minimum Service Package, 2022
The Sphere Handbook, 2018 - 2.5 Mental health
UNHCR Global Strategy for Public Health 2021-2025, Annex B: Mental Health and Psychosocial Support
Standard 10: Mental health and psychosocial distress

5. Learning and field practices

Accessible to UNHCR staff only

UNHCR (2021): An Introduction to Public Health in Refugee Settings: Module 3: M...
This is an online orientation course to strengthen the competencies of health sector actors working in emergencies to establish, support and scale up Mental Health and Psychosocial Support (MHPSS) in emergencies operations (11 modules, 7 hours total).

WHO (2021): Introducing Mental Health and Psychosocial Support (MHPSS) in emerg...

UNHCR (2023) Rohingya refugee volunteers combat stresses of camp life with men...

UNHCR (2017): Q&A: Far from being traumatized, most refugees are 'surprisingly ...

6. Links

UNHCR’S Mental health and psychosocial support webpage IASC Reference Group on Mental Health and Psychosocial Support in Emergency Set... The Mental Health & Psychosocial Support Network Executive Committee of the High Commissioner's Programme Conclusion No. 116 (LX... Toolkit: Minimum Service Package for MHPSS (2022) Mental Health and Psychosocial Support (UNHCR Global Community of practice - ac...

7. Main contacts

For questions, please approach the Senior Mental Health and Psychosocial Support Specialist within the Public Health Section in the Division of Resilience and Solutions: hqphn@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.

**4. Standards**

- Sphere standards 2018
- WHO, Vaccination in acute humanitarian emergencies
- UNHCR Integrated Refugee Health Information System (iRHIS)

Sphere Child health standard 2.2.1: Childhood vaccine-preventable diseases

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 effect 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

[Link to 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

[Link to The Sphere Handbook, 2018]

5. Links
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 proxy indicator of the quality of care. A high consultation rate in combination with appropriate health utilization rate may indicate under staffing in the facility.
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 costs. The UNHCR medical referral database is available to partners for this purpose.
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 Al 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
Settlement Typologies in Emergencies

01 February 2024

**Key points**

- In emergencies, affected populations may settle in diverse types of settlements.
- Decisions on settlements are difficult to reverse in the future; irrespective of the size and magnitude of the emergency, planning assumptions and approaches should carefully evaluate the possibility of a sustainable longer-term settlement.
- A sound settlement response strategy shall combine several settlement approaches, which may be highly context specific.
- The types of settlements where affected population (decide to) live will define several aspects of an emergency response.
- Assessing the carrying capacity of settlements and their hosting areas is paramount.
- Climatic and environmental considerations must be integrated into settlement planning from the start of an emergency.

**1. Overview**

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 more permanent living arrangements, of people forced to flee their areas of origin.

Well-designed settlements take into consideration spatial allocation of functions while maintaining equilibrium between the needs of the population, the availability and allocation of resources, socio-economic dynamics, amelioration of living conditions, provision of services, among others. A settlement must address the needs of the community at large and be designed with the active involvement of displaced populations, hosting communities, partners, and different sectors.

This entry aims at defining the most common settlement typologies and highlights a series of considerations regarding their characteristics, that may determine how humanitarian responses will take shape.
2. Relevance for emergency operations

Emergency responses may happen in diverse forms of settlements. Whether humanitarian actors will be able to meet life-saving needs at speed and scale, and the level of complexity of such responses, is highly dependent on how well serviced these settlements are, what is their carrying capacity, exposure to hazard risks, and how the displaced population will be able to cope with what is offered in these settlements, among other factors. Understanding the different typologies and their characteristics enables informed decisions on the outset of an emergency, and limits planning decisions that will have a negative impact on both host and displaced communities.

3. Main guidance

1 - Settlement Considerations

This section looks at common settlement typologies and what needs to be considered to develop them to host affected people (either before their arrival, or if they have already settled in). Ensure that the following information is available and informs either the selection process of, or the development/expansion of new settlement:

- **Spatial analysis** that describes the availability, uses, and suitability of land.
- Evaluation of the **carrying capacity** of hosting areas, which is defined as the number of people, animals, or crops that a given territory can support. Site carrying capacity is therefore shaped largely by the available natural resources, their quality, and the competition to access them.
- The availability of **natural resources** and associated risks if they cannot be sustainably utilized: availability of **water** of acceptable quantity and quality; **wood** for construction and other needs.
- Feasibility of setting up **supply chains** and swift distribution of aid, including logistical facilities for transport of goods, airstrips, space for warehousing, etc.
- **Market assessments**, including local availability of construction materials, labour force, private sector companies that could be mobilized, etc.

2 - Overview of Settlement Typologies

Below is a brief overview of the main settlement typologies. They may have different characteristics based on whether they are in urban, peri-urban or rural areas.

<table>
<thead>
<tr>
<th>Settlement Typology</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> <em>Individual accommodation in communities</em></td>
<td>☺ People living in individual housing or with host families in cities, towns, villages</td>
</tr>
</tbody>
</table>
|   | **Formal settlement** | - Planned settlements where official land is allocated for a group of asylum seekers, refugees or IDPs. They are accommodated in on purpose-built settlements with access to facilities and services.  
  - An official management entity is assigned.  
  - Camps are a type of formal settlement. |
|---|---|---|
| 3 | **Informal settlement** | - In an informal settlement, a group of asylum-seekers, refugees or IDPs choose to settle in self-identified spontaneous sites.  
  - Self-settled settlements can be located on state-owned, private or communal land, with or without negotiations with the local population or private landowners. |
| 4 | **Collective center** | - An accommodation, where a group of asylum-seekers, refugees and IDPs reside / are accommodated in pre-existing buildings such as community centres, town halls, schools or unfinished buildings or newly established ones.  
  - They often occur when there is a sudden influx and rental markets are overwhelmed.  
  - Collective centres are intended to be of a temporary nature. |
| 5 | **Transit Center** | - A transit center is used at the beginning of a new emergency with often high influx and is hosting asylum-seekers, refugees or IDPs pending transfer to a suitable formal settlement, individual private accommodation, or to areas of return. |

### 2.1 Individual Accommodation in Communities

Access to spontaneous community support mechanisms can encourage self-reliance, independence and a sense of belonging. In this type of settlement, displaced people commonly rent apartments, or are hosted by relatives, friends, or people previously unknown. Usually, such arrangements entail that forcibly displaced live on land or in properties that are mostly owned by local people. While this may result in a rapid solution, shelters that are either rented or shared may not be adequate. The host population may have limited resources. Absorption capacity may be limited and competition for scarce resources may result in tensions and lack of peaceful coexistence. In these cases, support should be considered at both neighborhood level (e.g. through Quick Impact Project and area-based approaches), or at household level, to either the hosting family, or to the owner via shelter repairs/upgrades in exchange of a lower/free rent.

Additional information can be found in EHB section [Alternatives to Camps](#).
2.2 Formal Settlements

Formal Settlements are a form of settlement specifically conceived to host people affected by crises and disasters. Refugees or IDPs living there receive centralised protection, humanitarian assistance, and other services from local governments and humanitarian actors. Formal settlements are designed and developed to offer basic services to its residents and have formal recognition/approval from the authorities. The term “Camp”, widely used among the humanitarian community, is one type of formal settlements.

Additional Information on formal settlements can be found under the EHB entry Formal Settlement Considerations.

2.3 Informal Settlements

Informal settlements are characterized by

- **Lack of tenure security**, as people usually settle in a given area or building without prior formal authorization from the landowner or the government;
- Poor or non-existent **basic services** such as water, sanitation, solid waste management and electricity;
- May **not comply with current planning and building regulations** and is often situated in geographically and environmentally hazardous areas.

Due to their socio-economic vulnerability, forcibly displaced people may choose to settle in such self-identified sites. They can be scattered across large areas and can be rather mobile as evictions happen. As informal settlements are a wide phenomenon in urban settings in least developed contexts, forcibly displaced often decide to settle along the urban poor. Informal settlements can also emerge at the fringes of agricultural fields, where the owner of the land agrees for forcibly displaced to access part of the land to settle in exchange for (cheap/free) labour.

Some informal settlements, however, can be formalized and upgraded if the site is suitable and approval is granted by the authorities. In such instances, thorough consideration should be given to the impact of climate related risks and hazards, and the feasibility and cost to mitigate those risks, versus the option of resettling, before committing (usually large) resources. These processes can take a long time, depending on the context-specific complexities.

More information can be found in the EHB entry Informal Settlements.

2.4 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, farms, etc. These facilities are seldom fit for habitation and must be rehabilitated and/or upgraded to meet basic living conditions for affected people. Collective centres are usually used as short-term accommodation to gain time to provide more suitable shelter. They can quickly respond to shelter needs when a sudden and large-scale need for accommodation arises, rental markets are overwhelmed or unaffordable, or for persons with specific needs. Collective centres
are intended to be of a temporary nature.

Additional information can be found in the EHB entry **Collective Centres**.

### 2.5 Transit Centers

A transit center is used at the beginning of an emergency to host forcibly displaced people pending transfer to a suitable formal settlement or individual private accommodation, or to return to areas of origin. They can be found:

- In the proximity of border crossing points;
- In inland locations that can facilitate further transfer to other locations of choice (train/bus stations, airports, etc.);
- Scattered around safe areas near to other settlement typologies where forcibly displaced people may be redirected to (e.g. formal settlement, urban centers, etc.)

More information can be found on the entry on the **Transit Centres**.

### 3 - Shifting from camps and other forms of settlements to Human Settlements

A **camp** is a type of formal settlement which is usually imagined as a **temporary solution** to address the most immediate needs of forcibly displaced, with little opportunities for integration as **freedom of movement may be limited**, and opportunities for self-reliance and solutions are out of sight. However, in protracted situations as well as in cases where the displaced population may integrate with the nearby hosting community, a **camp approach should be formulated toward a human settlement** one, taking into consideration the long-term livelihood opportunities of the integrated community, as well as the **gradual independence of the displaced population from external aid support**. The **Master Plan Approach** is a good foundation to ensure that a camp can move to a more formal settlement that eventually evolves into an **inclusive, integrated human settlement**. The same concepts also apply to any other form of settlements (e.g. informal ones).

### 4 - Settlement typologies and most frequently used shelter solutions

The table below summarizes the various settlement options with associated shelter solutions as often found in many emergency contexts:

<table>
<thead>
<tr>
<th>Settlement Typology</th>
<th>Most Frequently Used Shelter Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Accommodation in Communities</strong></td>
<td>Plastic sheeting</td>
</tr>
<tr>
<td></td>
<td>Shelter kit</td>
</tr>
<tr>
<td></td>
<td>Local construction (room extension)/rehabilitation/basic repairs in exchange for free rent</td>
</tr>
<tr>
<td></td>
<td>CBI</td>
</tr>
</tbody>
</table>
| **Formal Settlement** | Tents  
Shelter kit  
Plastic sheeting  
Temporary shelters  
Local construction materials  
Refugee Housing Units  
CBI |
|-----------------------|-------------------------------------------------
| **Informal Settlement** | Tents  
Plastic sheeting  
Shelter kit  
CBI |
| **Collective Center** | One room accommodation  
Plastic sheeting  
Shelter kit  
Local construction (rehabilitation/repair/adaptation)  
CBI |
| **Transit Center** | Tents  
Shelter kit  
Plastic sheeting  
Temporary shelters  
Local construction materials  
Refugee Housing Units  
CBI |

5 - Protection objectives valid across all settlement typologies

- Provide a **safe and healthy living environment** for forcibly displaced and stateless persons at settlement/community scale.
- **Support self-reliance**, allowing displaced persons to live constructive and dignified lives.
- Protect displaced persons from a range of risks, including **eviction, exploitation and abuse, overcrowding, poor access to services, and hazards**.
- 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.
- Ensure that host arrangements are sustainable and that hosted refugees **do not put a strain on host families**. Living conditions should remain adequate and hosting should not reduce access to services.

6 - Underlying principles and standards valid across all settlement typologies

- Settlement designs and developments should reflect the needs of persons of concern, their
cultural habits and their capacities. An inclusive approach fosters ownership, improves maintenance of settlements and can generate information and support that may be crucial to a programme's success and sustainability. Thus, meaningful participation of persons of concern in accordance with UNHCR's Age, Gender and Diversity approach is essential.

- **UNHCR Master Plan Approach to Settlement Planning Guiding Principles** is a key reference when defining a settlement response.
- Settlement interventions need to be planned and implemented to mitigate, to the extent possible, the impact on the natural environment and to prevent risks resulting from hazard like landslides, floods and earthquakes, water scarcity, etc.
- Accessibility to land constitutes a fundamental element for 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.
- Displaced persons should be supported to become self-reliant, enabling them to contribute to their host country and find long-term solutions for themselves.
- Forcibly displaced and stateless persons 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.

7 - Protection Risks valid across all settlement typologies

- Prolonged stay in formal settlements or collective centres can result in stress and tensions and can lead to social conflicts. Developing settlements following the Master Plan Approach from the beginning is critical for the wellbeing of both host and displaced population.
- Relations with the host community as well as within forcibly displaced communities might deteriorate if the carrying capacity of settlements is overstretched and they have to share limited resources - for example, the depletion of water and firewood in adjacent areas.
- High population density significantly increases protection and health risks.
- Environmental contamination may cause health problems for residents and those living near them. Environmental damage, especially related to water and sanitation, is likely in the immediate vicinity of settlements.

8 - Key considerations valid across all settlement typologies

- Displacement tends to last longer than expected: camps, formal and informal settlements are rarely occupied for short-term. Planners should always expect that once put in place, settlements are likely to exist over a long period of time. Service provision over that period of time is likely to remain the responsibility of humanitarian actors, and integration with local existing services will be challenging.
- Seldom does one settlement option fit the needs of the entire displaced population. Explore the available options and solutions displaced persons may have already found and agree the most suitable settlement options, and humanitarian assistance plan, with the host government.
- 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.
To reduce the risk of conflicts over land, from the start collaborate closely with local authorities, technical departments, and inform yourself of local rules and regulations on land tenure, public works and housing.

- Identify hazards (such as flooding, landslides, strong winds). If there are seismic risks, seek specialized technical advice.
- 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.
- Coordinate and liaise with other sectors, including protection, HLP, water and sanitation and livelihoods, to ensure solutions are integrated.
- Involve development actors as early as possible. Consider how both humanitarian and broader development objectives can be advanced by sharing information, plans, projections and other resources.
- Ensure that the emergency settlement response is implemented and managed by adequate expertise (in house or via partners). Consider deployment of skilled settlement officers at the onset of emergencies.

9 - Resources and partnerships

- Affected populations (forcibly displaced and hosting communities).
- Local and central authorities, municipalities.
- Community and religious leaders.
- National and international NGOs.
- Other UN and international organizations.

Checklist

- Pursue alternative to camps and formal settlements to the extent possible by advocating for forcibly displaced to choose where to live.

- Meet the needs of the most vulnerable who may have no other choice but settle in substandard settlement and shelter.

- Ensure UNHCR Master Plan Approach to Settlement Planning Guiding Principles are informing the settlement response.

- Irrespective of the size and magnitude of the emergency, assumptions and approaches should evaluate the possibility of a sustainable longer-term settlement.

- 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.

- Determine the suitable settlement solutions for the needs of the displaced population. Determine follow up actions such as: which informal settlements should be upgraded, which populations should be relocated at which protection risks, should formal settlement be developed, etc.

- Assess supply and logistical requirements and constraints; put in place arrangements to address them.

- Monitor the impact and effectiveness of programmes over time.

Annexes

UNHCR Needs Assessment for Refugee Emergencies (NARE) Checklist

UNHCR Policy on alternatives to camps, 2014

UNHCR, UNHabitat Guidance for Responding to Displacement in Urban Areas, 2022

4. Links

The Sphere Handbook 2018 UNHCR Master Plan Approach to Settlement Planning Guiding Principles

5. Main contacts

Technical Support Section, Division of Resilience and Solutions - DRSTSS@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)

<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></td>
<td>⚬ 24/7 emergency obstetric and neonatal care.</td>
</tr>
<tr>
<td></td>
<td>⚬ Prevention of gender-based violence (GBV) and clinical management of rape (CMR).</td>
</tr>
<tr>
<td></td>
<td>⚬ High impact STI/HIV prevention and continuation of ART / EMTCT (elimination of Mother-to-Child Transmission).</td>
</tr>
<tr>
<td></td>
<td>All of the MISP, plus:</td>
</tr>
<tr>
<td></td>
<td>⚬ Antenatal care</td>
</tr>
<tr>
<td></td>
<td>⚬ Postnatal care</td>
</tr>
<tr>
<td></td>
<td>⚬ Family planning</td>
</tr>
<tr>
<td></td>
<td>⚬ Post-abortion care</td>
</tr>
<tr>
<td></td>
<td>⚬ Fistula detection and management</td>
</tr>
<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>
</tr>
<tr>
<td>Timeframe: 0-6 months.</td>
<td>Timeframe: &gt;6 months.</td>
</tr>
</tbody>
</table>

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

- 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

Principles & Standards for Settlement Planning

02 February 2024

Key points

- UNHCR discourages the establishment of camps and formal settlements that may limit enjoyment of basic rights for forcibly displaced and stateless people.
- Alternatives to camps should be pursued, whenever possible, while ensuring that forcibly displaced people are protected and assisted effectively and are able to achieve solutions.
- Protection and assistance can be compromised when settlements are established in unsuitable geographical locations. Use the Multi-sectoral Site Assessment Form for the
selection of settlements locations

- Failing to develop settlements based on good standards can result in unnecessary further loss, distress and risks for forcibly displaced persons
- Follow the principles of the Master Plan Approach to Settlement Planning
- As forced displacement grows in time and scale, settlement planning shall remain dynamic, adaptable and capable of responding to changes during and after a crisis

1. Overview

This entry provides guidance and minimum standards that should be considered when planning and developing settlements for forcibly displaced and stateless persons as part of an emergency response. The ultimate aim is for displaced communities to live with security and dignity in a healthy environment which improves their quality of life, while meeting life-saving needs and also enhancing self-reliance, resilience and solutions.

While the principles and standards provided here are usually used to plan and develop formal settlements, they can be applied to other types of settlement (e.g. when upgrading informal settlements).

2. Relevance for emergency operations

This entry focuses on standards, principles and indicators, that should be considered in emergency operations when planning and developing settlements to host forcibly displaced, stateless people. This is a critical step as it has implications in the ways other sectors (shelter, WASH, health, education, livelihood, etc.) will shape their response to adjust to the specific characteristics and locations of settlements.

3. Main guidance

1. Guiding principles in settlement planning

Settlement planning is the physical organization of sites and locations where forcibly displaced may (decide to) settle. Appropriate, tailor-made settlement planning has a positive effect on the health and wellbeing of a community, enhancing their protection, assistance and solutions. It also facilitates swift humanitarian delivery of equitable and efficient delivery of goods and services.

The choice of settlement location is also 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 protection benefits and contribute to local
development, a settlement in the wrong geographical location can pose a threat to the protection and assistance of displaced persons and have negative consequences on the local development and the peaceful coexistence of communities.

Settlement plans should follow the below principles:

1. Start site selection/assessment and settlement planning at the earliest stages of a response (ideally during preparedness).
2. In addition to providing security, host governments are ultimately responsible for allocating land for camp and settlements. Make sure proposed sites are conducive to protection, assistance and solutions for the persons UNHCR cares for.
3. Early planning assumptions can endure for decades. Because decisions on site selection are difficult to reverse, seek and make use of technical support from the beginning.
4. Decisions on settlements' location should involve national and local Governments as well as host and forcibly displaced communities.
5. Consider how housing, land and property rights (HLP) affect site use, including access to water and pastoral and agricultural activities.
6. Follow a people-centered approach, promoting self-reliance and enabling communities to develop suitable solutions themselves.
7. Systematically apply an Age, Gender and Diversity (AGD) approach to ensure that all forcibly displaced people and their hosting communities have equal access to their rights, protection, services and resources, and are able to participate as active partners in the decisions that affect them.
8. Consider the characteristics and identity of the area, the environment, and of the people and their habitat. Beside technical drawings, the plan should provide social features including host communities, and the social organization of forcibly displaced people.
9. Avoid high density settlements, whatever the circumstances. Ideally camp/settlement should be no larger than 20,000 people.
10. Reduce aid dependence through spatial allocation of functions, such that displaced persons can increase their independence, and potentially integrate fully with host communities.
11. 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 affected people is protected.
12. Ensure climate related and other hazards are identified, from the onset of planning, and that adequate mitigation measures have been planned, taking into consideration both existing and long-term threats (for example due to climate change).
13. Screen for environmental considerations, from the onset of the emergency response; run a rapid environmental assessment as early as possible, enabling risk-informed decisions (using tools like NEAT+).
14. Be dynamic, adopt bottom-up approach and use modular planning. Settlement designs should be able to meet the needs of individual families while being adaptable and responding to changes in a crisis situation.
15. Consider that assistance to forcibly displaced last longer than expected. Take this into
account when planning and developing settlements, and estimating resources required to meet standards on the long run.

16. Settlements layout should promote community ownership and maintenance of public infrastructures (such as water points, toilets, showers, facilities for washing clothes, waste management).

17. Have provision for an exit strategy when forcibly displaced and stateless persons find durable solutions.

18. Consider national development plans to ensure that settlement plans are economically, socially and environmentally sustainable.

19. Local and international partners should be engaged whenever and soon as possible. UNHCR takes full operational responsibility only when circumstances require and is in the interest of the forcibly displaced.

20. Apply UNHCR Master Plan Approach to Settlement Planning Guiding Principles (see below).

2. Master Plan Approach Principles

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><strong>Principle 1</strong></td>
<td></td>
</tr>
<tr>
<td>National legislation, policies &amp; plans provide a framework for settlement design.</td>
<td>⚬ 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.</td>
</tr>
<tr>
<td><strong>Principle 2</strong></td>
<td></td>
</tr>
<tr>
<td>Environmental considerations drive design.</td>
<td>⚬ 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.</td>
</tr>
<tr>
<td><strong>Principle 3</strong></td>
<td></td>
</tr>
<tr>
<td>Defining site carrying capacity.</td>
<td>⚬ 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.</td>
</tr>
<tr>
<td>Principle 4</td>
<td>Decisions about density must be taken in context.</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Site density is in ‘harmony’ within the physical context.</td>
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<table>
<thead>
<tr>
<th>Principle 5</th>
<th>Supporting safe and equitable access to basic services.</th>
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<tbody>
<tr>
<td></td>
<td>Equitable access to basic services for the displaced population and the host community is ensured.</td>
</tr>
<tr>
<td></td>
<td>Development and upgrading of existing services facilities have been prioritized over the creation of new parallel services.</td>
</tr>
<tr>
<td></td>
<td>Travel distance to basic services is within standards.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Principle 6</th>
<th>Providing an enabling environment for livelihoods and economic inclusion.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principle 7</th>
<th>Addressing housing, land and property issues, an incremental tenure approach.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Risk of conflict link to land tenure has been addressed and mitigated.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Principle 8</th>
<th>Defining localized critical design drivers.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Site layout is informed and respond to physical and social factors and the spatial needs over time.</td>
</tr>
<tr>
<td></td>
<td>Residential areas, key services and infrastructures are not susceptible to the risk of natural hazards such as flash floods and landslides</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principle 9</th>
<th>Follow natural contours in the design of road and drainage infrastructure.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Site layouts respond to the natural topography and drainage patterns of the site.</td>
</tr>
<tr>
<td></td>
<td>An effort has been made to reduce construction and maintenance cost of road and drainage infrastructure.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principle 10</th>
<th>Finalizing the settlement layout.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Site layout takes into account the social organization of the displaced population under the bases of an Age, Gender, and Diversity approach.</td>
</tr>
<tr>
<td></td>
<td>The physical layout considers fire risk mitigation strategies and complies with standards for the provision of basic service.</td>
</tr>
</tbody>
</table>

Table 1 - Masterplan Approach Guiding Principles

3. Protection objectives
Locate settlements in areas that may not cause any distress to people (e.g. international borders, frontlines, sensitive sites such as military installations, etc.).

Advocate for the recognition that every person, including every person forced to flee their home, is entitled to freedom of movement.

Assist forcibly displaced people to meet their essential needs and enjoy their economic and social rights with dignity, contributing to their own self-reliance and finding long term solutions for themselves.

Plan and manage settlements in a manner that encourages affinities, and mitigates potential friction, between forcibly displaced and host populations.

Ensure that settlement programming sets safeguards in place to prevent any action from inadvertently increasing marginalization, vulnerability, exclusion and stigmatization.

Ensure that forcibly displaced people and their hosting communities enjoy their rights on an equal footing and participate in decisions that affect their lives.

Ensure that settlement and related policies and decisions are driven primarily by the best interests of forcibly displaced people (rather than the interests of other actors).

4. Protection Risks

- Prolonged stay in settlements that do not allow people to enjoy basic rights (e.g. freedom of movement, privacy, access to livelihood opportunities, etc.) can result in dependency from external aid, reduce the ability of forcibly displaced people to be self-reliant, eventually leading to stress and social conflict.

- Substandard settlements can increase protection risks, including gender based violence (GBV), sexual exploitation and abuse (SEA). Closed environments, including those of formal settlements, may be conducive to exploitative and manipulative activities.

- Proximity to sensitive areas such as international borders may expose forcibly displaced people to mental health and psychological issues, and protection threats.

- High population density significantly increases health and environmental 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.

5. Resources and partnerships

Staff

- A variety of (technical and non-technical) support staff may be needed depending on the number, scale and complexity of settlements where the emergency response is delivered.

- It is important to liaise closely with other sectors, including but not restricted to shelter, WASH, health, protection, education and livelihood.

Partners

- Government, municipalities and any other relevant authority
- UN, NGOs, other humanitarian actors
Private sector.
Representatives of forcibly displaced people and host communities

**Post emergency phase**

Even if an emergency response can be considered over, important considerations should be made to project settlements on the **long run**:

- **Camps and settlements are rarely occupied for short-term.** Once put in place, camps are likely to exist over a long period of time - in many cases **years or even decades**.
- Where **assistance and services provided to forcibly displaced may create disparities with the host community**, consider implementing Community Support Projects (CSPs), sharing goods and services, or advocate for increased development and/or governmental support. Eventually, on the long run a balance will need to be agreed upon between national and international standards, also factoring SDGs.
- Consider **maintenance and upgrades for shelter, infrastructures and facilities**, involving the residents through effective settlement governance and community participation / mobilization mechanisms.
- Service provision over that period is likely to remain 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.

In the event of formal settlement decommissioning:

- Ensure service contracts and agreements are modified or terminated appropriately (including 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).
- Ensure latrines, rubbish pits, and washing facilities are safely decommissioned.
- Ensure the site is returned to its previous condition, unless alternatives plans have been developed and agreed by national authorities and surrounding communities.
- Prepare a list of environmental concerns and prepare plans to address them.

**Checklist**

- **Identify a suitable site**, in consultation with Government, and carry out thorough suitability assessments. Use the Multi Sectoral Site Assessment Form.

- **UNHCR neither rents nor purchases land for forcibly displaced people.**
- Identify **relevant and qualified actors** to implement the programs.

- **Establish coordination mechanisms** with key stakeholders. Form them as early in the process as possible.

- Consider **local guidelines, regulations and practices**. Ensure adequate and effective liaison with local and national Government offices and other sectors.

- Develop proposals and concepts into working drawings, with detailed specifications, bill of quantities (BoQ), tender documents, etc.

- Commission / produce **environmental assessments** and incorporate their recommendations in implementation plans.

- Conduct **soil tests, hydrological surveys, detailed topographical surveys**, etc.

- Draft and establish **project management** documents, checklists and operating procedures.

- Work with other programmes and supply on procurement and award processes.

- Establish frameworks and reporting criteria for **continuous monitoring**.

- Develop and deliver **completion and handover certification**.

- Develop and deliver **maintenance plans**.

- Advocate for a **public address system** (if non-existing).

- Prepare an exit strategy and plans for decommissioning from the start.
4. Standards

There are several indicators determining the adequacy of settlement for forcibly displaced persons.

1. Site selection criteria
Sites for settlements should be selected in consultation with a range of sectors, including WASH, shelter, protection, as well as with technical specialists such as hydrologists, surveyors, planners, engineers, and environmental engineers. The operational context will determine site selection criteria.

The following factors need to be considered when selecting sites for displacement settlement:

| Topography, drainage, soil conditions | • Bear in mind that the physical features of the site will reduce or affect the amount of usable space.  
• The topography of the land should permit easy drainage and the site should be located above flood level. Rocky and 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 toilets, and of drainage systems.  
• Subsoil should permit good infiltration (permit soil to absorb water and retain solid waste from toilets). Very sandy soils may have good infiltration; but toilet pits may be less stable.  
• Maximum depth of toilet pits should have 1.5 meters of safety distance from highest ground water level.  
• The groundwater table should be at least 3 meters below the surface of the site.  
• Avoid excessively rocky or impermeable sites as they hamper construction (for shelter, toilets, roads, drainage, etc.).  
• Sites where the land is suitable for vegetable gardens or small-scale cultivation would be preferred. |

• Refer to UNHCR’s Master Plan Approach Process Checklist for additional information.
| Water resources | Choose locations that are reasonably close to an adequate source of water of good quality. Once located, water sources should be protected.  
  | Choose locations that are on/near high ground that has good surface water run-off and drainage.  
  | 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 to the extent possible. |
|-----------------|-------------------------------------------------------------------------------------------------|
| Land Rights     | UNHCR neither purchases nor rents land for settlements that host forcibly displaced people.  
  | Forcibly displaced people 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.  
  | With Government and host community, agree and clarify the entitlement of forcibly displaced people to carry out given activities (forage for food, firewood without compromising the environment, collect timber and other shelter materials such as grass or mud, gather fodder and graze animals). Take into full consideration the long-term consequences over scarce natural resources and make early plans to avoid or minimize damages, also on the longer term |
| Accessibility   | Ensure the site has an adequate road infrastructure; access to it should be reliable, including during the rainy/winter season.  
  | Assess the site's proximity to national services, including health facilities, schools, markets and towns. Access to mainstream services is encouraged wherever possible and avoids the need to develop parallel services for the population in the settlement.  
  | Liaise with development agencies, including related Government ministries, to secure improvement of access routes. |
| Security and Logistics | The site should be located a sufficient distance from international borders (minimum 50km or one day's travel) and conflict zones, and other potentially sensitive areas (such as military installations).  
  | Avoid locations that experience extreme climatic conditions, or present evident health, environmental or other risks.  
  | High winds can damage shelters and increase fire risks.  
  | Evaluate seasonal variations. Sites that are ideal in the dry season may be uninhabitable in the rainy season. |
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 diseases.
- Avoid sites within 1 day's walk of an environmentally protected area (such as a wild-life reserve).
- Take steps to ensure access to a sustainable supply of cooking fuel, in collaboration with local forestry authorities, and in negotiation with the host community.

Table 2 - Site selection factors of importance

Use the Multi-sectoral Site Assessment Form to guide the selection of new sites, and for the extension of existing ones. Environmental assessment components are mainstreamed throughout this document, incorporating aspects from the Nexus Environmental Assessment Tool (NEAT+) as well as contributions from WASH, energy and environment sectors.

2. Space allocation

The size of a settlement and area per capita is critical as crowded conditions lead to increased morbidity and stress, also complicating service delivery. The provision of adequate space, both outside and inside shelters and for basic services, is an essential requirement.

The ‘average area per person (Sqm.)’ indicator measures the average living space to which a person has access in a settlement. This space should accommodate all services while promoting dignified living conditions

- **45 sqm per person is the recommended standard**
- **30 Sqm** per person is necessary for shelter plots, roads, foot paths, educational facilities, sanitation, firebreaks, water storage, distribution points, markets, storage for relief items and administration and security. It excludes any land for significant agricultural activities or livestock.
- **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.
- Going below the **minimum standard (e.g. less than 29 sqm/person)**, is strongly discouraged. Although it may have to be considered for specific situations (e.g. when certain services are already present; in transit centers where household gardens are not required; very specific topographies that may limit meeting the minimum standard; etc.).
- Take into account the necessity of accommodating future expansions, including for the **natural demographic growth** (average of 3-4% per year).

<table>
<thead>
<tr>
<th>Population size</th>
<th>Minimum settlement area (sqm)</th>
<th>Minimum settlement area (hectares)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,000 persons</td>
<td>225,000</td>
<td>22.5</td>
</tr>
</tbody>
</table>
3. Emergency standard for planning settlements

The plan 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 should ideally have a metric scale between 1:1,000 and 1:5,000.

<table>
<thead>
<tr>
<th>Description</th>
<th>Minimum Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered living area</strong></td>
<td>3.5 sqm. per person minimum</td>
</tr>
<tr>
<td></td>
<td>In cold climates and urban areas 4.5 sqm. to 5.5 sqm. See <a href="#">Emergency Shelter Standard</a> entry for more guidance.</td>
</tr>
</tbody>
</table>
| **Fire Safety**              | 30 m of a firebreak every 300 m  
Minimum of 2 m between structures – ideally 2 times the height of the structure |
| **Gradient for camp site**   | 1 to 5 %, ideally 2 to 4%                                                        |
| **Drainage**                 | Appropriate drainage needs to be put in place, especially relevant in all locations that experience a rainy season. |

Table 3- Minimum standard for planning settlements

4. Modular Planning Units

- Settlement planning should **begin from the scale of the individual family plot**, addressing needs at household level, such as their distance to water collection points, access to communal services, recreation facilities, access to showers and toilets, waste management, etc.
- A **tailor-made modular approach** enables the **rationalization of facilities and the management of the settlement**. At the same time, it fosters a sense of **familiarity and originality** in settlements. It is essential to avoid rigid layouts, that would give a sense of alienation. Consider that the cultural specificities of a displaced population will affect the
It is advisable to consider the **social structures and relations** within forcibly displaced people and their nearby hosting communities, including clans, ethnic groups and extended family arrangements, as well as their traditional settlement layouts and shelter preferences. The cultural specificities of the displaced population, will influence all modules layout with the community one being the most critical. This consideration will yield a greater degree of satisfaction, and sense of ownership, while fostering social connections within the displaced community.

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 (max)</td>
</tr>
</tbody>
</table>

Table 2 – Indicative modular planning units

5. **Settlement Planning Standards for services and infrastructure**

The following are recommended settlement planning standards for services and infrastructure.

For public services (e.g. health and education), consider whether existing facilities that are near the settlement location can be used (rather than creating parallel systems inside the settlement). Make sure to involve other sectors such as shelter, WASH, health, education, livelihood and protection to adjust standards to the specific context and population’ needs and vulnerabilities.
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Staffing Density</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communal toilet (*)</td>
<td>1 per 50 persons - emergency phase</td>
<td>Separate toilet areas for men and women. For long-term accommodation use one household latrine per family.</td>
</tr>
<tr>
<td>Toilet distance (*)</td>
<td>Not more than 50m from shelter</td>
<td>Latrines must be close enough to encourage their use but far enough to prevent problems with smells and pests.</td>
</tr>
<tr>
<td>Shower (*)</td>
<td>1 per 50 persons</td>
<td>Separate, well drained, shower areas for men and women</td>
</tr>
<tr>
<td>Water tap stand (*)</td>
<td>1 per 500 persons</td>
<td>To be increased to 1:250 persons or less as the emergency stabilizes</td>
</tr>
<tr>
<td>Water distance (*)</td>
<td>Max. 500m from household</td>
<td>’To be decreased as the emergency stabilizes</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>Feeding centre</td>
<td>1 per 20,000 persons</td>
<td>1 per settlement</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>Communal areas (gathering)</td>
<td>As appropriate</td>
<td>Provided with night lighting and shaded areas/shelters. Layout designed with the participation of women, men, girls and boys</td>
</tr>
<tr>
<td>Service</td>
<td>Area Size/Location</td>
<td>Considerations</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Warehousing/Storage area</td>
<td>15 to 20 Sqm. Per 100 persons</td>
<td>Consider priority locations such as toilets, wash areas, public service areas, roads. Refer to the Energy Needs for more details.</td>
</tr>
<tr>
<td>Solar Lighting</td>
<td>As appropriate</td>
<td></td>
</tr>
<tr>
<td>Registration area</td>
<td>As appropriate</td>
<td>May include arrivals area, medical triage, 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>Highly discouraged (unless specific circumstances apply)</td>
<td>Security fencing may give a false sense of security. It may also give the impression that freedom of movement is limited, and give a negative connotation to the people living inside the settlements</td>
</tr>
</tbody>
</table>

(*) Read the Wash in Emergencies for more details.

Table 4 – Site planning standards for services and infrastructure

Annexes

UNHCR Policy on alternatives to camps, 2014

UNHCR, Multi-Sectoral Site Assessment Form, 2021

UNHCR, UNHabitat Guidance for Responding to Displacement in Urban Areas, 2022

UNHCR Needs Assessment for Refugee Emergencies (NARE) Checklist

5. Links
Strategic Considerations in Shelter Responses

30 January 2024

Key points

- Shelter cannot be looked at in isolation; any response must consider the settlement or the context in which the households are sheltered. A variety of shelter options should be always considered.
- An emergency shelter response should meet life-saving needs while considering its potential evolution and the need for more durable solutions over time.
- Shelter design criteria should address hazard risks and safety, timeliness and construction speed, lifespan, privacy, tenure security and cultural appropriateness, thermal comfort; environmental considerations, cost, standards and building codes.
- Promote local design and construction techniques as much as possible.
- Involve forcibly displaced people and host communities from an early stage of the response design, so as to leverage their capacities and skills, and make sure that the shelter response will meet their most urgent needs.
- Coordinate closely with protection staff to monitor and mitigate protection risks related to potentially exploitative situations (rental accommodation, host arrangements), tenure insecurity, GBV, etc.

1. Overview

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 responses, especially in emergencies, generally involve a mix of shelter solutions. Shelter is often one of the most significant household costs, even more in the case when people had to flee their homes. Where the affected population is located will also impact the response; dense urban areas have specific characteristics and therefore the shelter solutions may differ from rural areas or dispersed settings.

The adaptation of shelter responses to local contexts should account for the climate, cultural practices and habits, local skills, and availability of construction materials. The use of familiar materials and shelter types, aligned with the preferences and practices of the forcibly displaced or local population, contributes to a more effective and culturally sensitive response.

The guidance provided in this entry is valid across a number of different contexts (urban, rural and dispersed settings; formal and informal settlements; etc.). This entry should be read in conjunction with the one on Shelter Needs Assessment.

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.

2. Relevance for emergency operations

In emergencies, the right to adequate shelter for the forcibly displaced and stateless persons is of paramount importance as it directly addresses their immediate protection and well-being. Shelter responses play a crucial role in determining the overall living conditions of those affected by emergencies and are instrumental in addressing the diverse needs of displaced populations.

A shelter not only serves as a physical barrier against the elements but also provides a secure and healthy living environment that ensures privacy, comfort, and emotional security. The provision of shelter is integral to safeguarding displaced and stateless individuals from harsh weather conditions, offering a space to live and store belongings, and fostering a sense of dignity and stability during times of crisis.

While shelter responses in emergencies may follow standard solutions which are rather temporary in nature, considerations as the kind of shelter needed, what materials and design to use, who constructs them and how long they last will differ significantly in each situation.

3. Main guidance

Protection objectives

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 to all, irrespective of a displacement status, and therefore is valid in all stages of the displacement cycle - prior to, during and after displacement. Adequacy of housing includes security of tenure, availability of services, materials, facilities and infrastructure, affordability, habitability, accessibility, location, and cultural adequacy. Specific protection objectives met
through shelter responses are:

- Meet life-saving needs and discourage further displacement by providing a secure and healthy living environment with privacy and dignity. Shelters should provide sufficient covered living space to undertake essential household and livelihood activities including cooking, sleeping, learning, socializing, storing belongings, etc.
- Protect the affected population from a range of risks, including eviction, exploitation and abuse, overcrowding, and poor access to services. Threat of eviction is greater when persons of concern settle in land and property without permission.
- Recognize, and encourage other actors to recognize, that every person, including the forcibly displaced and stateless persons, is entitled to move freely, in accordance with human rights.
- Assist the forcibly displaced and stateless persons to meet their essential needs and enjoy their economic and social rights with dignity, contributing to their self-reliance and finding long term solutions for themselves.
- Ensure that forcibly displaced and stateless persons enjoy their rights on equal footing and are able to participate in decisions that affect their lives (AAP principle).
- Shelter assistance should prioritize the most vulnerable, including women (in particular female-headed households), children, older people, persons with disabilities, marginalized groups, etc. (AGD approach).

**Underlying principles and standards**

In all circumstances (urban or rural/dispersed settings, in temporary or more permanent dwellings), shelter response should consider the following criteria:

- Shelter layout, size and their locations should provide adequate living conditions, sufficient to give persons a sense of ownership and help them regain their livelihoods, while minimize the risk of further displacement.
- Shelter responses, including designs and construction techniques, should empower displaced populations to choose, build and/or maintain their own shelters with the necessary organizational and material support.
- Should be cost effective, using local materials to the extent possible, and adequately reflect cultural preferences and traditional lifestyle of the affected population.
- 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. Seek expert technical support in areas at risk of earthquakes.
- Should have the least possible impact on the natural environment. Careful consideration should be given to the sourcing of local materials to minimize environmental damage.
- Shelter responses will need to adapt to space constraints especially in the medium to long term (shelter extension through modular approaches, or two-story shelters, for example). The design of shelter should, to the extent possible, provide for modification by its occupants to suit their individual needs, while considering local rules and regulations.

For more detailed standards (covered living space, height, etc.) please consult the entry on "Emergency shelter solutions and standards".
Protection Risks

- 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.
- Vulnerable groups such as female headed households and persons with disabilities might have difficulties looking for or 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. Shelter design and response 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.
- Displaced people can also find it difficult to prove their identity and HLP rights, hampering their lives both in displacement and during return to areas of origin.
- Conflict may arise with the host community if the presence of displaced populations increases strain in rental markets and local services, making access to resources such as affordable housing and water more difficult.
- If shelter options are unaffordable for forcibly displaced, they may adopt negative coping mechanisms, such as:
  - be at risk of eviction if they do not have enough tenure security;
  - live in overcrowded conditions;
  - occupy public spaces such as parks, schools, public squares, which erode peaceful coexistence with local communities;
  - prioritize cheap accommodations, settling in high risk areas (e.g. flood/cyclone prone) and undesirable land (e.g. near landfills, ravine banks, canals, roads or railways, unused warehouses, factories or land that surround those facilities) where they are exposed to environmental and health risks, with little to no access to services;
  - separate families: children may be forced into early marriages, or sent to live with others, exposing them to neglect and abuse;
  - engage in survival sex or illegal acts;
  - be exploited by their landlords.

Operational Guidance

In emergencies, a variety of shelter solutions are used – either supplied by humanitarian actors and local authorities, found by the affected people themselves, or provided by hosting communities. It is likely that any operation will require a combination of approaches to meet the needs of the displaced population, including through cash-based interventions (CBI). Deciding which options to provide will be a key determinant in the quality of life the affected population are able to achieve during their displacement.

 Nonetheless, if the needs assessment and the design of a response takes time, affected people may settle in new areas, find alternative arrangements (e.g. with hosting families), or start occupying buildings and lands without tenure security, or start living in hazard prone places. Therefore, an immediate shelter response is paramount to meet the needs of, at least, the most vulnerable.
Transit centers, collective centers, and other forms of multifamily shelter can meet the need for covered space quickly if empty buildings or other solutions can be identified. Nonetheless, individual family shelters are preferred as they provide greater privacy, psychological comfort, and emotional safety. They also provide better safety and security for people and possessions, and help to preserve or rebuild family unity.

The UNHCR family tents are often 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. Provisions for repair materials should be considered. In general, tents are difficult to heat as walls and roof provide limited insulation. However, UNHCR has developed a winterization kit for the family tent for cold climate. They can be an expensive item if not in stock (airlifting cost).

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. In more traditional cultures, extra privacy may be requested by the affected population, for instance through porches or screens that prevent outsiders seeing inside the shelter.

If certain criteria are met, Cash Based Interventions (CBI) can greatly help meeting the needs of affected people quickly, at scale, and in a flexible manner. CBI can indeed help covering rental and/or other shelter related costs, either for materials, rehabilitation or upgrades. Considerations on the feasibility of CBI should be examined jointly with sector experts, especially to determine the viability of meeting shelter needs through such flexible modality.

The table below summarizes the various settlement options with associated shelter solutions as often found in many emergency contexts:

<table>
<thead>
<tr>
<th>Settlement typology</th>
<th>Most frequently used shelter Solutions</th>
</tr>
</thead>
</table>
| Planned settlement, transit centers, informal settlements | ◦ Tents  
  ◦ Shelter kit  
  ◦ Plastic sheeting  
  ◦ Temporary shelters  
  ◦ Local construction materials  
  ◦ Refugee Housing Units  
  ◦ CBI |
| Individual accommodation (hosting or rented arrangements) | ◦ Plastic sheeting  
  ◦ Shelter kit  
  ◦ Local construction (room extension)/rehabilitation/basic repairs in exchange of free rent  
  ◦ CBI |
 Collective centers

- Plastic sheeting
- Shelter kit
- Rehabilitation/repair/adaptation

For pros and cons of each of the shelter solution indicated above, please refer to the entry on "Emergency shelter solutions and standards".

Specific considerations for shelter responses in Urban Areas

Operating in urban contexts requires a holistic and spatial approach, often within an existing complex system that already faces systemic challenges to the delivery of basic service welfare. While all considerations made thus far still stand for responses in urban areas, the following factors will influence the choice of appropriate shelter solutions:

- **Accessibility.** Urban environments may not guarantee adequate access and mobility for persons with specific needs. Support from neighbors, especially in case of language barriers, may be more difficult.
- **Targeting.** Displaced populations may blend into the urban poor making targeted assistance challenging, but ever more important to ensure resources reach the intended recipients.
- **Housing, Land and Property (HLP) issues.** Most cities develop rapidly and informally. Land use plans and ordinances are often out of date, as are cadastral records. Risks of evictions are therefore heightened for both forcibly displaced and poor inhabitants.
- **Civil society.** Community organizations and civil society can play an important role in supporting the response. Their capacity, expertise and accountability must be taken into account.

For a more comprehensive guidance on the urban response, this entry must be read in conjunction with the following relevant entries Settlement overview, and Rental accommodation strategy considerations.

**Key management considerations**

- Consult and involve local and national authorities, and the affected population. To reduce any risk related to HLP or lack of compliance with local standards, 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.
- Permission to occupy public or private buildings should be set out in legal agreements. This reduces the risk of eviction.
- Identify climate related hazards (such as flooding, landslides, strong winds). If there are seismic risks, seek specialized technical advice even for the design of a simple shelter.
- At the outset of a crisis, it is sensible to consider a mix of shelter and settlement options that have to be discussed with affected people, hosting communities and authorities. Initial strategies can include the adaptation of unused public buildings, arrangements with
community groups, support for rent and to hosting families. Basic services like water, sanitation, access to energy need to be also available.

- Develop information strategies to increase the community's involvement in and ownership of shelter planning and maintenance.
- Establish and apply quality assurance measures. These may include to adequately train staff and laborers in relevant construction and quality assurance techniques.
- Coordinate and liaise with complementary sectors, including protection, HLP, cash, water and sanitation, energy, livelihoods, etc. to ensure solutions are integrated.
- Monitor carefully the protection risks associated with poor or unaffordable shelter; develop intersectorial responses to mitigate such risks.
- Work closely with development agencies and government authorities that may have complementary expertise and resources, especially for urban programs.
- Collaborate closely with local actors, grassroots movements, organizations, and government authorities that can help to map the location of forcibly displaced people or assess levels of the vulnerability in households and areas where they have settled.

Ensure that the emergency shelter response is implemented and managed by adequate expertise (in house or via partners). Consider deployment of skilled shelter or settlement officers at the onset of emergencies.

**Resources and partnerships**

- The affected population
- Local or central government authorities, municipalities, city officials
- Community and religious leaders
- Host community
- Other UN agencies, international and local organizations
- Academic institutions
- Orders of engineers and architects
- Private sector

**Post emergency phase**

As the immediate emergency response stabilizes and life-saving needs have been largely met, the post-emergency phase would prioritize more sustainable shelter solutions and longer-term approaches ensuring long lasting protection and resilience for forcibly displaced and stateless persons.

Following a comprehensive reassessment of shelter needs, responses are adapted to align with the evolving dynamics of affected population. Community empowerment, sense of ownership, tenure security, intentions to stay and access to income become pivotal, involving affected populations in decision-making and fostering skills for sustainable shelter provision.

**Key Action Points:**

- Continuity in livelihood support programs is crucial, ensuring ongoing self-reliance and economic stability. This may include exploring income-generating activities related to shelter construction.
Prioritize durable solutions, the focus is on shelter options that uphold the principles of "a life in dignity" and address long-term housing needs.

Advocacy for access to HLP rights aims to reduce eviction risks and enhance access to essential services.

A robust monitoring framework guides adaptive strategies, ensuring flexibility in response to ongoing feedback and emerging challenges.

Continued coordination with governmental agencies, NGOs, and international organizations remains, while also seeking inclusion of forcibly displaced into shelter and housing development plans and financing mechanisms. Collaboration with local businesses is explored to enhance economic opportunities.

**Developing a Strategic Shelter Response**

- 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 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. For more information see the entry on Shelter needs assessment.

- Locate and map the location of forcibly displaced and stateless persons.

- Based on the assessment prioritize lifesaving activities and priorities and anticipate medium and long term shelter needs.

- Identify and prioritize shelter assistance for the most at risk groups (female-headed households, large families, elderly, people with disabilities, etc.). Vulnerability indicators for households and individuals should be contextualised. When doing this, consider their socio-economic vulnerabilities as they may be a barrier to affordable shelter.

- Identify the range of shelter solutions preferred by and available to the affected population. For more information see the entry on Emergency shelter solutions and standards.

- Analyse available accommodation options, housing affordability and availability, and the absorption capacity of host communities.
• Ensure that the affected population participates in the planning process.

• Develop a shelter response that includes arrangements to transition from shelter assistance to more durable and sustainable long-term solutions.

• Assess supply and logistical requirements and constraints; put in place arrangements to address them.

• Monitor the impact and effectiveness of programmes over time.

Annexes

UNHCR Policy on alternatives to camps, 2014

UNHCR, UNHabitat Guidance for Responding to Displacement in Urban Areas, 2022

UNHCR Policy on Refugee protection and solutions in urban areas, 2009

UNHCR Shelter Design Catalogue January, 2016

4. Learning and field practices

Shelter Centre on-line library

UNHCR Shelter and Sustainability Guide

Family Tent

New Self Standing Tent

Shelter Strategy Standard Format

Shelter and Settlement Preparedness and Response Checklist

Refugee Housing Unit 1.2 Fact Sheet
5. Links

NRC/Shelter Centre, Urban Shelter Guidelines, Assistance in urban areas to popu... Handbook for the Protection of Internally Displaced Persons

6. Main contacts

Technical Support Section, Division of Resilience and Solutions - DRSTSS@unhcr.org

Emergency Shelter Solutions and Standards

30 January 2024

Key points

- Ensure minimum standards of covered living space per person are respected
- Shelter solutions should be adapted to the geographical context, climate, cultural practice and habits, and local availability of skills and accessibility to adequate construction materials in any given context
- Consider the life span of shelter materials as they deteriorate with time. Further to the initial distribution, installation or construction, replacement, reinforcement or maintenance may be required
- Individual family shelter should always be preferred over communal accommodation as it provides the necessary privacy, psychological comfort, and emotional safety. Whenever possible, displaced people should be empowered to choose where to live, and to build their own shelters, promoting a sense of ownership and self-reliance
- 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 range of emergency shelter solutions and expected standards when providing emergency shelter.

Emergency shelter needs are best met by using locally available, sustainably sourced materials and construction methods. Only if adequate quantities cannot be quickly obtained locally, should emergency shelter material be brought into the country. The simplest structures and building methods are preferable, if they offer adequate safety and protection from weather conditions. Materials should be, to the extent possible, environmentally friendly and obtained from sustainable sources, especially wood, sand, etc. 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.

2. Relevance for emergency operations

A shelter is not just bricks and mortar, or a tent, but a means to protect those uprooted. In emergencies, it is fundamental to provide shelter as part of the life-saving responsibilities and mandate of humanitarian actors, so that forcibly displaced people can enjoy a secure and healthy living environment that protects them from weather conditions, and offer them privacy, dignity, comfort, and emotional security.

3. Main guidance

Each type of emergency shelter may present 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>
<thead>
<tr>
<th>Shelter solution</th>
<th>PROs</th>
<th>CONs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family tents</td>
<td>Valuable in immediate relief phase; lightweight (for transport and distribution); proven design; can be winterised; large production capacities; quick to install.</td>
<td>inflexible; may be unstable in high winds or heavy snow; difficult to heat. Where tents are used for long durations, 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; known product, familiarity of their usage in many contexts; low cost.</td>
<td>Does not offer strong resistance against high winds or rains; negative environmental impact if not disposed of properly. Need extra materials to make a shelter, eg wood: 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 consider sustainable sources of framing material which is suitable to support plastic.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</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; long lasting if adapted to local climatic conditions.</td>
<td>High unit cost; long shipping time; long production time; transport challenges; assembly challenges; inflexibility in customization; disregards cultural and social norms.</td>
</tr>
<tr>
<td>Refugee housing units</td>
<td>Durable and weather-resistant, lightweight and portable, modular design.</td>
<td>Higher unit cost in comparison to local solutions; may not fit cultural preferences and sensitivities; limited thermal insulation.</td>
</tr>
<tr>
<td>Rental subsidies/CBI</td>
<td>Greater sense of independence and freedom of choice; greater integration in a community; influx of income to host community.</td>
<td>Competitive market may result in price increases; inflation and speculation may occur; difficult to implement in places where financial institutions are not present, or cash transfer is not implementable; upgrades or repairs may be needed.</td>
</tr>
</tbody>
</table>
Shelter rehabilitation/upgrade

Aiming at more durable solutions; more adapted to developed/cold climate contexts.

More costly; takes more time; need to ensure HLP rights; need to respect local building codes, regulations and plans.

For transit and collective centers, please refer to related entries. For shelter upgrades, rehabilitation and more long term solutions, please refer to the entry on shelter guidance.

**Emergency shelter considerations in warm climates**

Minimum standards for floor space in warm climates are as follows:

- Minimum 3.5m² of covered living space per person in tropical or warm climates, excluding cooking facilities or kitchen.
- Minimum height of 2m at the lowest point, with greater height being preferable to aid air circulation and ventilation.
- It is expected that in warm climates and based on cultural habits, certain activities will happen outside (e.g. cooking), hence kitchen space is not factored into above standard. Shaded external space adjacent to the shelter can be established, if possible, for these activities.

The design of shelter should, if possible, provide for modification by its occupants to suit their individual needs (e.g. internal partitioning for greater privacy), including future expansion.

In more developed contexts or where forcibly displaced people have access to income opportunities, more space should be factored in for extra belongings (e.g. washing machines, fridges), or for running home businesses (tailoring, hair dressing, etc.). Similar considerations for extra living space should be made when WASH facilities (bathing and toilet facilities) are provided at family level. Ensure close coordination with WASH actors in this regard. Check the WASH entry for more details.

**Emergency shelter considerations in cold climates**

Where cold weather with wind, rain and snow prevails over extended periods (3 to 5 months), minimum standards for floor space are as follows:

- Minimum 4.5m² to 5.5m² indoor living space per person.
- Max 2m ceilings to reduce the heated space.

In cold seasons/climates, more time will be spent inside the shelter (cooking, eating, studying), and more space is required to store belongings (e.g. warm clothes, blankets, etc.). In particular, persons with specific needs will require heated, enclosed spaces.

As for the standards in warm conditions, the design of shelter should, if possible, provide for modification by its occupants to suit their individual needs (e.g. internal partitioning for greater
privacy), including future expansion.

In more developed contexts or where forcibly displaced people have access to income opportunities, more space should be factored for extra belongings (e.g. washing machines, fridges), or for running home businesses (tailoring, hair dressing, etc.). Similar considerations for extra living space should be made when WASH facilities (bathing and toilet facilities) are provided at family level. Ensure close coordination with WASH actors in this regard. Check the WASH entry for more details.

Shelters in cold conditions have to resist snow weight and wind forces, hence they are more complex and expensive. Thus, local conditions need to be considered in the standards for shelter in such situations. The following should be considered:

- Structural stability (to withstand snow- and wind-loads).
- Insulation of walls, roofs, floors, 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 response 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. Body 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, sealing tapes and insulation materials. 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 and the use of a clean energy source. Fire risks must also be considered.

**Post emergency phase**

The SPHERE standards (2018) remain the internationally recognised quantifiable minimum
standards for humanitarian responses. 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 emergency response. In protracted situations, an approach that is able to breach the division between emergency, transitional, and durable shelter and that links relief, rehabilitation and development should be sought.

Standards to be applied to transitional and/or durable shelters will depend on the context, and will be commonly defined by shelter partners and in close coordination with government authorities and development partners.

**Checklist**

- Evaluate geographical context, climate, cultural preference and local resources.

- Provide 3.5m² covered space per person in warm climates, and 4.5-5.5m² per person in cold climates.

- In arid climates that may present both cold and hot seasons, use the standard for minimum covered living space based on safest standards (i.e. based on cold standards).

- Ensure structural stability and consider modification by occupants (e.g. extra space, more internal partitioning, etc.).

- Acknowledge SPHERE standards as a minimum.

- Adapt shelter solutions based on local factors. Establish locally adjusted standards especially in more developed contexts.

- Collaborate with shelter partners, government, and development partners.

- Plan for more durable solutions beyond the emergency phase.
Annexes

UNHCR Policy on alternatives to camps, 2014

UNHCR, Shelter and Sustainability, 2021

UNHCR, Shelter Design Catalogue, 2016

4. Learning and field practices

Accessible to UNHCR staff only: UNHCR Shelter & Settlement Assessment Toolbox ...

Shelter Center Humanitarian Library

UNHCR Self Standing Tent

Assembly of an RHU Better Shelter

Family Tent

Refugee Housing Unit 1.2 Fact Sheet

5. Links

Global Shelter Cluster The Sphere Handbook 2018 UNHCR, The Master Plan Approach to settlement Planning, 2019

6. Main contacts

Technical Support Section, Division of Resilience and Solutions - DRSTSS@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


4. Main contacts

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

Rental accommodation

18 May 2020

Key points
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](https://www.unhcr.org/)

[Sphere Project, the Humanitarian Charter and Minimum Standards in Disaster Response, (2011)](https://www devuelve.org/)

[Shelter Centre, Shelter after disaster](https://www.sheltercentre.org/)

[UN Habitat, Rental Housing. An essential option for the urban poor in developing countries](https://www.un.org/)

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.
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 ensuring 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 is 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, *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**
Livelihoods and Economic Inclusion

29 January 2024

Key points

- Immediate access to livelihoods and economic inclusion contributes in vital ways to stabilization, and ensures food security, resilience and self-reliance for forcibly displaced and stateless populations

- UNHCR recommends that, to improve economic inclusion of forcibly displaced and stateless people in programmes and services, operations should convene and partner with organizations that specialize in livelihood stabilization and economic development, job creation, entrepreneurship support, and financial services from the onset of the emergency

- CBI is the preferred modality of assistance. However, if the market assessment establishes that cash is not feasible, local procurement of necessary items should be prioritized to support local businesses and prevent distortion of local markets

- Displaced and host populations should be contracted to perform necessary services and construction in the emergency response. However, the cash for work modality is a temporary, labor-intensive, short-term intervention which needs to pave the way to formal employment opportunities in collaboration with relevant partners

- According to the RCM, UNHCR will co-coordinate the livelihoods and economic inclusion sector working group with the government

1. Overview

Forcibly displaced and stateless populations can be protected and obtain long-term solutions more successfully when they have livelihoods and inclusion opportunities and participate economically from the onset of an emergency. Economic inclusion implies giving all members of society, including non-citizens and vulnerable and underserved groups, access to labour markets, land, financial services, entrepreneurial expertise, jobs, 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 depletion of their assets and reverting to aid-dependency and negative coping mechanisms, to contribute to their host economies, and to
be prepared for the future.

2. Relevance for emergency operations

Economic inclusion starts from the moment a displacement situation begins. If humanitarian assistance, service provision, market linkages and educational services are well-directed from the start, there are better opportunities for economic inclusion in later phases of displacement. Humanitarian assistance, including food and cash, shelter and household items can help forcibly displaced populations meet basic needs and obtain immediate protection. This might limit the need to sell assets or engage in negative coping mechanisms. However, to design a meaningful response, it is essential to engage the affected population in economic activities from the onset, bridging between their skills, experience, assets, preferences and market needs. This includes payment for work conducted in the emergency response, development of market opportunities within or outside the location or camp, linkages with local or regional markets and private sector, facilitating access to resources and infrastructure, etc. To facilitate for this approach, UNHCR or partners must conduct or utilize available relevant (labour) market analysis (rapid assessments can be utilized in the emergency phase) and gather as much information as possible on existing skills and capacities amongst the population. The Minimum Economic Recovery Standards (MERS) are the internationally recognized consensus on best practices for building economic resilience for crisis-affected communities.

It is important to engage the local and displaced population, as well as local government, partners and private sector in defining the most appropriate response for the specific location and in ensuring accountability to affected populations throughout the programme cycle. UNHCR and partners should leverage existing systems and services, and **not create parallel services**, unless necessary, due to non-existent services in the emergency location.

3. Main guidance

**Objectives**

- To meet food security and 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.
- To support socio-economic inclusion and improved co-existence.
- To facilitate participation in local economies, including tax contribution.
- To support local market systems and economic development.
- To limit negative impact on local markets and environment.
- To facilitate transition to stabilization and pave the way towards durable solutions.

**Underlying principles and standards**

Key principles:
Convene internal and external stakeholders to support economic inclusion.

- Strengthen tailored livelihood support based on socio-economic profiling and market needs.
- Assist refugees to contribute to (and be included in) local development plans and processes.
- Avoid the provision or creation of parallel systems and services.

**Protection Risks**

Protection risks that may need to be addressed include:

- Gender-based violence.
- Sexual exploitation and abuse.
- Risky coping mechanisms (including survival sex, child labour, engagement in illegal activities).
- Obstacles to access and enjoy assistance and other services.
- Lack of access to formal and informal markets and labour opportunities.
- Legal and policy systems may not adequately respect, protect and fulfil rights.
- Racism, xenophobia, discrimination, misinformation, disinfection and hate speech.
- Exploitation, underpayment, poor working conditions, and lack of protection in the workplace.
- Depletion of assets, leaving people vulnerable.
- Restraints on, or prevention of, freedom of movement.
- Child labour and exclusion from education.
- Over indebtedness.

**Other risks**

- Support programmes may discriminate between refugees and host communities, and lead to rising tensions between communities.
- There may be a shortage of appropriate partners, especially development partners and private sector.
- Programme models may create dependence rather than self-reliance.
- Livelihood programmes may create frustration or protection risks if they have no impact, or their impact is deferred.
- Local people may perceive that refugees are competing with them for jobs, services and resources.
- Overexploitation of natural resources and risk of climate hazards.
- Loss of skills and capacities, if not utilized.
- Lack of support from local government.
- Lack of knowledge about the rights of forcibly displaced and stateless persons.

**Key decision points**

- Assess existing and potential livelihood opportunities and services. Because they may know the context and have links with the local population, local institutions that are perhaps not typical UNHCR partners may be well equipped to support and promote livelihoods and economic inclusion interventions. Examples include financial and business
development service providers, private sector organizations, public and private training and research institutions, and local development actors. Use market assessments and value chain analysis (where appropriate) to analyze local markets and cross-check the findings against ProGres data or other statistical data (if available) on refugee profiles, to match employment/self-employment opportunities with refugees' skills, knowledge, and experience. Ensure meaningful community engagement, based on age, gender and diversity considerations, and accountability to affected populations. Promote the diversification of livelihoods, build resilience, and consider sustainability, how both refugees and host communities make a living, and the capacity of the area to absorb refugees and the skills and services they bring. Assess how programmes and interventions will affect market systems, people, natural resources, infrastructure and public systems, and foresee measures to reduce the environmental footprint of humanitarian assistance.

- Consider from the outset market access and proximity to markets, jobs and economic opportunity related services for newly arriving displaced populations, particularly in refugee or settlement camp set ups.
- Although some volunteerism is promoted to ensure community engagement and ownership within the displaced population, always aim to ensure refugees and displaced populations are fairly remunerated through contractual arrangements for the work they do for UNHCR and partners inside or outside camps or settlements, based on local rules and regulations. Salaries and incentives should be based on the local context, using minimum salary as generic guidance and local salary scales to define the value of the different types of work.
- Assess the potential impact of bringing in goods and services from the outside and how these will affect local markets and the surrounding economy. According to the UNHCR Policy on Cash-based Interventions - 2022-2026, cash is always the preferred modality of assistance. If for specific reasons CRI/NFI becomes necessary, CRIs and other items may be available locally and local procurement should therefore always be considered the preferred option, to strengthen local markets and businesses or in some cases, reduce carbon footprint.
- Set-up solid monitoring and evaluation systems and evidence-informed decision-making processes.
- Avoid, as much as possible, the creation of parallel services by always seeking inclusion in existing programmes, services, or opportunities before developing new interventions. Operations should seek partners and institutions 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 management considerations

To strengthen self-reliance successfully, livelihood and economic inclusion interventions need to be supported through an inclusive and integrated area-based development approach by a range of multi-sectoral teams working in education, CBI, protection, programmes, solutions, community services, development, communications, and other disciplines. Success also depends on cooperation with local government, 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 and partner livelihoods and economic inclusion staff in the field.

Partners
Partners who take a market-oriented approach and are familiar with displacement issues, economic empowerment, and climate resilience.

Operational partners with specific expertise in financial services, technical and vocational training, entrepreneurship, employment services, and agriculture and rural development.

Development actors, private sector, local authorities and government agencies.

Post emergency phase

In the medium and long-term, support should secure, through advocacy and facilitation, 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, work permits, and documentation, 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, multi-partner strategic planning.

Checklist

- Program planning:
  - Analysis of legal framework and enabling environment (utilize existing, if available).
  - Socio-economic profiling of the population.
  - Rapid market assessment, including physical access and opportunities.
  - Secure land for agriculture, access to financial services, and space/infrastructure for markets and/or production.
  - Institutional mapping (who is operating/available in the area?).
  - Assess whether it is viable to include refugees in existing programmes and services.
  - Set-up solid monitoring and evaluation systems and evidence-informed decision-making processes. M&E occurs throughout the programme cycle.
Partner selection:

From the institutional mapping, which of the following partners are available?

- Financial and business development service providers.
- Private sector (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.

If relevant partners are not available/able to work in the area:

- Convene and partner with organizations that specialize in livelihoods and economic development. Do they possess the necessary expertise?

4. Standards

The Minimum Economic Recovery Standards (MERS)

The 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.

Annexes
5. Links


6. Main contacts

Contact the Livelihoods and Economic Inclusion Unit, UNHCR Division of Resilience and Solutions (DRS). At: livelihood@unhcr.org.

Shelter needs assessment

25 January 2024

Key points

- Conduct an initial rapid assessment of shelter and settlement needs 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 including local authorities
1. Overview

In the event of forced displacement, whether in an urban or dispersed setting, and in the event of the establishment of formal settlements, the first step is to understand the needs of the affected population. An initial shelter and settlement assessment provides crucial information to establish a shelter response in a given context, and the capacity, layout and services needed across settlements. Moreover it offers essential elements to plan and design shelters beyond the emergency phase.

2. Relevance for emergency operations

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 including HLP, WASH, Health, among others). The Needs Assessments for Refugee Emergencies (NARE) checklist, a highly customizable initial multi-sectoral needs assessment is often used and contains a specific section with relevant questions to inform settlement development and shelter response.

The overall Emergency Needs Assessment in relation to shelter and settlement should provide sufficient information to identify the immediate life-saving priorities, anticipate potential problems, including insufficient space and overwhelmed accommodation opportunities, and identify forcibly displaced people with adequate shelter provided from their own resources, and the strategies they are using to cope. The emergency needs assessment should also identify and mitigate potential shelter and settlement-related tensions between new arrivals and the host community and identify the type and level of support required for both communities.

3. Main guidance for shelter needs assessment

The information collected during the initial rapid needs assessment will be key to develop a comprehensive shelter and settlement strategy which will structure and phase the sectoral response to address the needs of forcibly displaced people, and which will evolve over time to adapt to changing needs. Assessors should gather sufficient information in order to effectively guide the following actions:

- Enable forcibly displaced people to access and live in dignity in safe and secure settlements that improve their social, economic and environmental quality of life as a community
- Ensure the involvement of forcibly displaced people throughout the planning, design and implementation phases of shelter and settlement responses
- Identify most suitable settlement option or combination of options according to the context (host family support, transit/collective centres, formal/informal settlements, rental accommodation, sharing with family or relatives, etc.)
- Provide appropriate emergency shelter as needed, while ensuring minimum space of
covered shelter area is provided (minimum 3.5m² per person)
- Adapt shelter to protect forcibly displaced people from extreme weather conditions
- Ensure access to basic services
- Develop a comprehensive shelter and settlement response. Plan for and identify longer term shelter solutions

**Recommended methodology for shelter needs assessment**
To understand the dynamics of a displacement 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 secondary data analysis to determine what information is available, and primary data collection. Information can come from other sectors and/or organizations. It's preferable to initiate data collection as soon as possible, even in the preparedness phase. Any missing information should be included in the primary data collection.

A **secondary data review** should always be done in order to determine what information already exists. The critical background information should include:

- Traditional shelter types of both displaced population and host community, as well as climate and cultural practices that may influence settlement planning and shelter needs and related responses.
- Identification of persons with specific needs requiring shelter (re)construction assistance or specific shelter options (disability and access)
- Building practices of forcibly displaced in areas origin (e.g. building types, sizes, construction materials, physical architecture, etc.).
- Identify which national government departments are responsible for shelter and housing, settlement planning and public infrastructures
- National building codes, standards and regulations
- **Housing, land and property** ownership practices and laws in hosting areas (e.g. renting, leasing, ownership, compulsory acquisition)
- Availability of land, empty buildings and other facilities that could host most vulnerable forcibly displaced people
- Historical data on climate related (drought, floods, cyclones, etc.) and other hazards (e.g. earthquakes, presence of UXOs, structural safety of buildings, etc.) in areas where forcibly displaced people may settle/have settled
- Availability of construction materials (e.g. natural resources, nearby stockpiles, regional suppliers, etc.). Include market surveys (availability and costs of construction materials, rental options, etc.)
- Existing infrastructure and services surrounding the area where forcibly displaced people are settled
- Existing shelter and settlement response capacity among other UN agencies, NGOs, CSOs, line ministries, local municipalities, etc.

**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, as well as the location where forcibly displaced people are settled/will settle (e.g. scattered contexts). Data collection can be carried out using the following methodologies:
Community Observation
Community Key Informants
Focus Group Discussions
Household Key Informant
Infrastructure/Facilities Inspection Visits

The following are examples of key information to be gathered through primary data collection and analysis:

- Analyze Demographics (age and gender breakdown, persons with specific needs, etc.)
- Analyse Movement trends, arrival rates, and potential future trends to inform the shelter and settlement response
- Assess Resources and Physical Security: jointly with protection specialists, evaluate protection needs as well as coping mechanisms (e.g. moving into cheaper shelter, living in informal settlements, etc.).
- Assess whether there are any potential conflicts with hosting communities in relation to different levels of access to shelter
- Determine the level and type of intervention based on assessment findings. Share information with relevant sectors for a coordinated response (esp. WASH, HLP, etc.).
- Identify the most suitable settlement options that enable the population to access and live in secure settlements with dignity
- Determine if people can self support construction of shelter
- Through intersectoral coordination, ensure access to basic services (WASH, electricity, etc.) in settlements, buildings or other facilities hosting forcibly displaced

Additional key informant questions and focus group discussion questions can be found in the Sphere Rapid Shelter Assessment and the Settlement Development, Shelter and CRIs in the NARE Checklist

Key guidelines and assessment questions for selection of new sites and extension of existing sites can be found in the Multi-sectoral site assessment form.

Resources and partnerships

Staff

- A shelter and/or settlement planning 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
Checklist

- Conduct Secondary Data Analysis for shelter and settlements providing critical background and context information which should include assessment of existing infrastructure and services, traditional shelter types, availability of materials, land and facilities, etc.

- Conduct Primary Data Collection, use methodologies such as community observation, key informants, focus group discussions, household key informants, and infrastructure/facilities visits.

- Analyze Demographics and Movement Trends, Assess Resources and Physical Security.

- Determine the level and type of intervention based on assessment findings. Share information with relevant sectors for a coordinated response.

- Identify the most suitable settlement options, Enable the population to access secure settlements. Provide emergency shelter and core relief items (CRIs) per minimum standards. Ensure access to basic services.

- Develop Shelter and Settlement Strategy. Conduct Follow-Up Assessments. Perform Shelter Condition Assessments to transform emergency shelters into more durable shelter Solutions.

Annexes

The Sphere Handbook, 2018

UNHCR Needs Assessment for Refugee Emergencies (NARE) Checklist

WFP, UNHCR - Joint Assessment Missions: a Practical Guide to Planning and Implementation,
4. Main contacts

Technical Support Section, Division of Resilience and Solutions: DRSTSS@unhcr.org

Nutrition needs assessment

18 January 2024

**Key points**

- Review pre-crisis data and conduct initial assessment analysis to understand the nutrition status before the crisis as a reference point for assessing the impact of the crisis on nutrition outcomes.
- Conduct a rapid nutrition needs assessment at the onset of the emergency to understand the nutrition situation, estimate needs and identify groups with specific needs and/or that have the greatest need for nutritional support.
- Collaborate with other sectors such as health, food security, WASH, shelter and protection to ensure joint assessment and to plan on how to address interlinked needs.

1. Overview

In the context of emergencies, protecting the nutritional status of vulnerable groups becomes paramount to prevent acute malnutrition, diseases, and mortality. Malnutrition stems from a complex interplay of factors beyond just food scarcity, including poor care and feeding practices, limited access to healthcare, and unsafe environments. Children under two years of age are at heightened risk due to feeding difficulties and risks associated with inappropriate feeding practices.

In the first 6 months of a refugee nutrition emergency, conducting a rapid nutrition needs assessment is essential to gather crucial data for response planning. The assessment aims to understand the overall nutrition situation, estimate needs, and identify vulnerable groups at risk of malnutrition. The assessments should be carried out at the various stages of an emergency following standardized guidelines. By identifying acute malnutrition prevalence using MUAC and
bilateral edema screenings in children aged 6-59 months, immediate and targeted interventions can be implemented to address their nutritional needs. Additionally, focusing on pregnant and breastfeeding women, as well as children aged 6-23 months, ensures their specific requirements are met during this critical period. Key to the success of the treatment and prevention of malnutrition interventions is effective coordination and collaboration among all stakeholders involved in these interventions.

2. Relevance for emergency operations

Nutrition needs assessment plays a pivotal role in guiding efficient and effective emergency response operations. By quickly identifying the scale and severity of malnutrition within the refugee population, humanitarian teams can allocate resources and prioritize interventions. The data obtained through the assessment informs decision-making, allowing for evidence-based planning and implementation of nutrition interventions. It ensures that vulnerable groups, especially infants and young children, receive timely and appropriate support to prevent and treat malnutrition during emergencies.

3. Main guidance

Emergency Phase

i. Compile pre-crisis information and conduct analysis of initial assessments to establish the nature and likely severity of the nutrition situation.

- Gather information about malnutrition levels and infant and young child feeding practices before the emergency.
- Review what the likely causes of malnutrition are, including immediate, underlying, and basic factors. Consider the displacement crisis as a potential basic cause. Use relevant secondary data obtained from sources such as UNHCR's databases and reports and those of other UN agencies such as UNICEF and WFP, NGOs working in the affected areas, and key informants.
- Gather characteristics and cultural habits of the refugee population that might affect food preference, influence the effectiveness of coping strategies or early interventions.
- Review the results of the assessment carefully and use the findings to construct the pre-assessment situation. This includes the baseline understanding of the nutritional status before the crisis, likely impact of the crisis on nutrition outcomes and vulnerable groups within the population who might be at a higher risk of malnutrition during the crisis. This is useful to inform initial planning.

ii. Primary data collection steps:

- The food security and nutrition checklist under the Needs assessment for refugee emergencies (NARE) multi-sectoral tool, should be used in the first two to three days of the emergency. This should be accompanied or followed by the nutrition screening and infant and young child feeding in emergencies assessment either immediately or within the first two weeks of the emergencies following below.
Assess the nutrition situation by conducting bilateral oedema screening and mid upper arm circumference (MUAC) screening for all children aged 6-59 months at a reception centre during registration or initial contact. It is also recommended to conduct MUAC screening for pregnant and breastfeeding women, if possible.

Screen households with an infant younger than 6 months at a reception centre during registration or initial contact using a short questionnaire on feeding practices to determine if the child is facing any breastfeeding difficulties.

Conduct focused group discussions (FGD) or key informant interviews (KI) to obtain a general assessment of infant feeding among children aged 6-23 months.

Ascertain if there are any feeding problems related to breastfeeding, care of non-breastfed infants, and complementary food.

Determine if infant formula and/or baby bottles/teats have been distributed since the emergency started.

Identify priorities expressed by parents/caregivers regarding feeding their infants and young children from birth to 2 years of age.

iii. Identify groups with specific needs or that have the greatest need for nutritional support. Engage with communities to identify at-risk groups, paying attention to age, sex, disability, chronic illness, or other factors. (FGDs or KIs)

iv. Review information on the causes of undernutrition from primary or secondary sources, including the community’s perceptions and opinions. (Review multisectoral initial reports or liaise with the various multi-sectors to gather information). Use the **conceptual framework of malnutrition** as a guide.

v. Assess resource capacity to lead and support the response.

vi. Determine an appropriate response based on an understanding of the context, the emergency, cultural habits among the refugee population and specific refugee vulnerabilities. Consider both prevention and treatment options.

Related risks:

- Inadequate data and assessment may lead to an inaccurate understanding of the nutrition situation and hinder effective response planning.
- Failure to consider cultural habits and preferences may result in ineffective interventions and low community engagement.
- Insufficient attention to specific vulnerable groups may lead to unequal access to nutritional support.
- Inadequate coordination among different sectors may impede the implementation of a comprehensive and efficient response.
- Lack of resources or capacity may limit the scale and effectiveness of the response efforts.

**Presentation of results:** The findings of an initial rapid nutrition assessment should be reported using the Rapid MUAC & IYCF-E screening report template.
Post emergency phase

As the emergency progresses to the post-emergency phase, continue conducting nutrition assessments and monitoring nutrition indicators to evaluate the impact of interventions. Collaborate with development partners and local authorities to ensure a smooth transition and sustainable nutrition solutions for the affected population where possible.

Nutrition Needs Assessment Checklist

- Initiate a rapid nutrition needs assessment promptly at the onset of the emergency.

- Use MUAC and bilateral edema screenings to assess acute malnutrition in children aged 6-59 months.

- Focus on pregnant and breastfeeding women, as well as children aged 6-59 months, for specialized nutritional support.

- Collaborate with other sectors to address the underlying causes of malnutrition and improve overall living conditions.

Annexes

The Sphere Handbook, 2018

UNHCR, Rapid Nutrition MUAC and IYCF-E assessment report template, 2023

Global Nutrition cluster/UNICEF/USAID, Nutrition humanitarian needs analysis guidance, 2018

4. Links

The Sphere Handbook - Food security and nutrition Standardized Expanded Nutrition Survey guidance Nutrition humanitarian needs analysis guidance Harmonised Training Package (HTP): Resource material for training and learning...
5. Main contacts

UNHCR Public Health Section, Division of Resilience and Solutions: hqphn@unhcr.org

Sexual and Reproductive Health (including HIV)

19 January 2024

Key points

- Gaps in the provision of Sexual and Reproductive Health (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, as 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, individuals selling or exchanging sex and clients, and LGBTIQ+ individuals
- SRH must be integrated into public health packages and linked to other relevant service sectors, including when strengthening SRH supply chain management

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 people 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 possible with comprehensive SRH services and sustained throughout humanitarian response.

2. Relevance for emergency operations

During conflicts, natural disasters and public health emergencies, SRH needs are often overlooked with staggering consequences, leaving women and girls disproportionally affected. Despite many advances, it continues to be a challenge to ensure the availability of essential and quality SRH services throughout all phases of displacement. Without access to adequate delivery and emergency services both during and following pregnancy and childbirth, the risk of serious illness and death increases for both the woman and baby. It is estimated that 60% of preventable maternal deaths and 50% of newborn deaths occur in contexts of conflict, displacement, and natural disasters. In addition, displaced women may lose access to contraception and/or experience sexual violence, exposing them to increased risk of HIV and other STIs, unintended pregnancy, unsafe abortion and serious mental health consequences.

Adolescents in humanitarian settings are especially vulnerable to sexual violence, which further increases the risks of unintended pregnancy, unsafe abortions and STIs, including HIV. Complications from pregnancy and childbirth are among the leading causes of death for 15-19-year-old girls, while babies born to adolescent mothers face a higher risk of dying compared to those born to older mothers. Early marriage, adolescent pregnancy and childbearing also interfere with their ability to go to school and jeopardize employment opportunities.


3. Main guidance

Emergency Phase

Guiding framework and lifesaving SRH priorities

In response to the clear need for SRH services in humanitarian emergencies, the international community developed a set of minimum standards for response known as the Minimum Initial Service Package (MISP) for SRH. The MISP defines which SRH services are most lifesaving and identifies priority actions that should be implemented at the onset of a crisis and prompts planning for expansion of these services to comprehensively address SRH needs. UNHCR and
partners work to ensure that all MISP components are implemented as soon as possible at the onset of an emergency (ideally within 48 hours and no later than 3 months) and to scale up to comprehensive services as soon as feasible during the emergency phase and beyond.

The key objectives of the MISP are to:

1. Ensure the health sector/cluster identifies an organization to lead implementation of the MISP.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Plan the transition to comprehensive SRH, integrated into primary health care.

**MISP Objective 1** - Coordination is essential in any emergency. The lead SRH organization puts in place the SRH Coordinator, who functions within the health sector/cluster. The SRH Coordinator ensures that all health agencies working in each of the crisis areas address SRH and implement or refer to SRH services; provides guidance on and technical support for the coordinated procurement of SRH supplies; identifies skilled health workers to implement MISP services; and identifies effective and confidential referral mechanisms between health service delivery points and between health services and other service sectors.

**MISP Objective 2** - To prevent sexual violence and respond to the needs of survivors from the onset of an emergency, it is essential to: work with other sectors, especially the protection or GBV sub-sectors, to put in place preventative measures at community, local, and district levels, including health facilities, to protect affected populations, particularly women and girls, from sexual violence; make clinical care and referral to other supportive services available for survivors of sexual violence; and ensure confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.

**MISP Objective 3** - To reduce the transmission of HIV and other STIs from the onset of the humanitarian response, the SRH Coordinator, health program managers, and service providers must work with the health sector partners to: establish safe and rational use of blood transfusion; ensure application of standard precautions; guarantee the availability of free lubricated male condoms and, where applicable, female condoms; support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an anti-retroviral therapy (ART) 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; and ensure the availability in health facilities of syndromic diagnosis and treatment of STIs.

**MISP Objective 4** - To prevent maternal and newborn morbidity and mortality, the following life-saving interventions must be available and accessible in any humanitarian crisis: clean and safe delivery, essential newborn care, and emergency obstetric and newborn care (EmONC) services; a 24 hour per day 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital; post-abortion care in
health centers and hospitals; and supplies and commodities for clean delivery and immediate newborn care (where access to a health facility is not possible or is unreliable).

**MISP Objective 5** - At the onset of an emergency, it is important to ensure contraceptives are available to prevent unintended pregnancy. The SRH Coordinator, health program managers, and service providers must work to: ensure availability of a range of long-acting reversible and short-acting contraceptive methods (including male and female condoms and emergency contraception) at primary health care facilities to meet demand; provide information, including information, education, and communication (IEC) materials, and, as soon as possible, ensure contraceptive counseling that emphasizes informed choice, effectiveness, and supports client privacy and confidentiality; and ensure the community is aware of the availability of contraceptives for women, adolescents, and men.

**Post emergency phase**

**Longer-term standard (post-emergency phase)**

The MISP not only entails coordination to make lifesaving SRH services available, but it also aims to address comprehensive SRH needs and demands as soon as possible. This requires a sound understanding of the local situation and opportunities related to health system functioning.

**MISP Objective 6** - Plan the transition to comprehensive SRH, integrated into primary health care

SRH is a lifetime concern for both women and men, from infancy to older ages. UNHCR recognizes that how SRH needs are met at one stage in life has implications for SRH outcomes and needs during other stages of life. Therefore, to adequately meet the health needs of refugees throughout their life course, UNHCR works to build on the MISP and provide a more comprehensive package of SRH services. This includes:

- 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 morbidities (e.g., cervical cancer, obstetric fistula, female genital mutilation, etc.).
- Health promotion and education, counseling services, community outreach
- Adolescent friendly services and tailored services that are accessible and acceptable, culturally appropriate, and responsive to gender and life course requirements.

**Checklist for Monitoring Implementation of the MISP for SRH**

- The MISP checklist is available in English, French, Spanish, Arabic and Russian
4. Standards

Please refer to the following document for key standards and indicators:

*MISP implementation checklist*

Annexes

UNHCR, Global Strategy for Public Health 2021 - 2025

UNHCR, Adolescent Sexual and Reproductive Health in Refugee Situations- A Practical Guide to Launching Interventions for Public Health Programmes, 2019

WHO, UNFPA, UNHCR, Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings, 2020

UNHCR/UNFPA Operational Guidance: Responding to the health and protection needs of people selling or exchanging sex in humanitarian settings, 2021

5. Learning and field practices

*MISP Distance Learning Module (available in English, French, Spanish, Arabic, P...*

Accessible to UNHCR staff only: Clinical Management of Rape & Intimate Partner ...

Basic Emergency Obstetric and Newborn Care (BEmONC) in Crisis Settings, Select ...

SRH Clinical Outreach Refresher Trainings for Crisis Settings (S-CORTS)

Newborn Health Resources: Training & Tools for Improving Newborn Health in Huma...

Video: Kangaroo care saves pre-term babies in Cameroon refugee camp

Video: preventing small vulnerable newborns

Video: Adolescent Sexual & Reproductive Health in Emergencies

From words to actions: systematic review of interventions to promote sexual and...

Accessible to UNHCR staff only: Working with LGBTIQ+ People in Forced Displacem...
6. Links

Inter-agency Field Manual on Reproductive Health in Humanitarian Settings UNHCR Sexual and Reproductive Health Accessible to UNHCR staff only: UNHCR operational guideline on improving maternal... Newborn Health in Humanitarian Settings – Field Guide Accessible to UNHCR Public Health online community: Operational Guideline for I...

7. Main contacts

Contact the Public Health Section, Division of Resilience and Solutions:

hqphn@unhcr.org

Energy needs

24 January 2024

Key points

- Ensure potential energy needs are addressed during the emergency preparedness planning and response phase, particularly related to household level needs for lighting and cooking, and for community facilities (water, education, health)

- Ensure that funding proposals and response plans address the energy needs of affected people as well as the facilities serving them

- Always consider the provision of renewable energy (e.g., solar energy and sustainably procured biomass) over fossil fuel and unsustainable natural sources such as firewood

- Seek the support of and complementarity with agencies specialized in the energy sector, including development actors, which can support emergency responses and beyond, to mitigate potential negative impacts on the environment associated with the unsustainable use of firewood and fossil fuel during a sudden influx of forcibly displaced people

1. Overview
Meeting the energy needs of forcibly displaced people and their host communities while protecting the natural resources they depend on (particularly firewood) are critical cross-cutting issues for UNHCR, including during emergency responses. Uncontrolled use of firewood can lead to deforestation and environmental degradation, increasing risks of flooding and landslides, and soil erosion among others. Competition over scarce biomass between forcibly displaced and their hosting communities also creates protection risks, notably Gender Based Violence (GBV) and threatened peaceful coexistence. Furthermore, the use of fossil fuel to operate generators leads to air pollution, carbon dioxide emissions and on the long run it has high operational costs. Once the environment has been damaged, its rehabilitation and the repair of long-term negative consequences are difficult and expensive, so precautionary measures even in emergencies, to avoid or limit damage, are critical.

Please read this entry together with the entry on environment.

2. Relevance for emergency operations

Energy needs should be considered cross-cutting sectoral concerns and addressed from the onset of an emergency, preferably beforehand by emergency preparedness planning. The emergency phase is a critical moment when energy needs can be considered and addressed, enhancing safety and self-reliance, and environmental degradation avoided or managed. The emergency phase should also be in line with the UNHCR Strategic Framework for Climate Action, with the aim of limiting environmental degradation and enhancing climate resilience.

3. Main guidance

Protection objectives

- To provide safe, timely and reliable access to energy for household needs such as cooking, lighting, heating, cooling, phone charging, etc.
- To provide safe, timely and reliable access to energy for community level infrastructures, such as motorized water systems, health facilities, schools and streetlights.
- To protect forcibly displaced people and their hosting communities from gender-based violence (GBV), that often occur at night in unlighted areas (toilets, washing zones, playgrounds, workshops) or while searching for firewood.
- To protect forcibly displaced people and their hosting communities from physical risks such as landslides and floods, when uncontrolled collection of firewood for cooking purposes causes severe land degradation.
- To reduce tension between forcibly displaced and local communities over scarce natural resources such as firewood.

Risks related to unmet energy needs

- If they lack fuel or access to other forms of energy, forcibly displaced people may adopt unsafe and harmful coping strategies. For example, they may sell part of their food ration to purchase cooking fuel, increasing the risk of malnutrition; searching for firewood that is not sustainable; or burn plastics or other waste as cooking/heating fuel or as a fire starter,
exposing them to toxic chemicals. Similarly, if services depend on fossil fuels instead of renewable energy, the lack, or high cost, of fossil fuels can lead to service interruptions, resulting in, for example, the use of unsafe water sources or lack of necessary health care.

- Forcibly displaced people may acquire pneumonia, cardiovascular diseases, or lung cancer or put their health at risk in other ways by cooking or heating their shelter with bad fuels or equipment.
- Beyond exposing forcibly displaced people to GBV risks, 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.
- Erosion after removing vegetation for cooking needs often creates large gullies that may cause deadly and damaging landslides.
- Unsustainable use of natural resources, particularly wood, causes biodiversity loss and desertification.
- Greenhouse gas emissions contribute to global warming and climate change.

**Key decision points**

At the start of an emergency response, integrate energy needs in rapid and/or multisectoral needs assessment such as Needs Assessment for Refugee Emergency (NARE) or Multi-cluster / sector Initial Rapid Needs Assessment (MIRA), so that the response can take informed decisions. Include considerations around energy needs, existing energy access, and technologies that are locally available. As part of emergency response, consider including emergency stoves, fuel (ideally for at least 4-6 months), a solar lantern and where appropriate heating stoves and fuel. Choose preferably local options wherever possible, including use of Cash-Based Interventions, based on the “why not cash approach” over in-kind. Fuel should come from sustainable sources, such as sustainably procured biomass, and be clean, such as Liquified Petroleum Gas (LPG), electricity, or solar energy. As early as possible, identify renewable energy options, such as solar energy, to respond to energy needs at both household and communal level.

Conduct a market survey to determine locally available cooking fuel, lighting and heating technologies. The survey should assess the degree to which supplies can be obtained for the duration of the response. Evaluate if the proposed response will interfere with the local economy.

Environmental protection measures should be put in place to mitigate the impact of energy needs through the search and collection of biomass:

- Mark trees in and outside the camp that should not be cut.
- Depending on local context and vegetation coverage, establish a buffer zone (e.g. 5 metres, or more if required) around all surface waters (streams, rivers, lakes...) within which vegetation should be left intact. The extension of the area needs to be contextualized based on local vegetation, climatic conditions, etc.
- Prepare and run an environmental awareness campaign using various appropriate forms of communication, to sensitize communities on the importance of preserving scarce natural resources, especially for cooking needs.
Consider training and sensibilization activities for energy-saving practices, energy-efficient use, and maintenance and repairs of basic energy equipment (solar lanterns, cooking stoves, etc.).

**Key cross-sectorial considerations**

Relevant sectors should address energy concerns from the outset of an emergency. Through adequate financing, enhance protection and self-reliance, prevent degradation, implement identified mitigation measures, and train staff and partners on using renewable energy sources to the extent possible. Consider solar energy over diesel generators when feasible even during the emergency phase (e.g. solar lanterns, solar home systems, solar water heaters, solar street lights, solar powered water pumps, solar systems for health care facilities and schools, etc.).

**Resources and partnerships**

- Government ministries (energy, environment, natural resources, climate change).
- Development actors
- Affected communities: forcibly displaced persons and host communities.
- National, regional and global private sector organizations with relevant expertise (energy, environment).
- Local and international NGOs, faith-based organisations, Civil Society Organizations (CSO) with relevant expertise.

**Checklist**

- Embed energy needs in sectorial discussions (e.g. in protection, settlement, shelter, WASH, basic needs, CBI, health, education, etc.). Ensure wide representation of all involved and relevant stakeholders.

- Undertake a rapid needs assessment that include energy needs at both household level, and community infrastructures that need energy for their functioning (water systems, health care facilities and schools as a bare minimum).

- Develop a response plan in association with government counterparts, selected partners and technical services.

- By means of a needs assessment, consult both the forcibly displaced and host communities on habits and traditions that might increase the burden on the environment, related to meeting energy needs – including for cooking, lighting, heating, and powering energy-fed systems.
• Identify affordable products and services that beneficiaries can access easily and affordably, with the aim of improving local provision, market development, and job opportunities.

• 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 (e.g. solar).

• If biomass is used for energy needs (esp. cooking), consider the use of sustainable ones (e.g. briquettes from agriculture activities), in conjunction with energy efficient technologies (e.g. pressure cookers and other fuel efficient stoves).

• Draw up and implement awareness-raising campaigns on energy use. These should benefit forcibly displaced as well as hosting communities.

• Test and establish a preliminary monitoring system.

• If need be, provide training for partners and community mobilizers that build their capacity to implement, monitor and evaluate energy-related responses, including energy-saving best practices, energy-efficient use, and maintenance and repairs techniques.

• Consult the UNHCR Green Companion for further advice on how to ensure energy needs are met in an environmentally sustainable manner.

4. Standards

8.2 core outcome indicator (UNHCR COMPASS)

Proportion of forcibly displaced and stateless people with primary reliance on clean (cooking) fuels and technology [SDG 7.1.2 Tier 1].

9.2 core outcome indicator (UNHCR COMPASS)

Proportion of forcibly displaced and stateless people who have energy to ensure lighting.
5. Learning and field practices

Learning component: Access to Clean Energy for Refugees

- Uganda Case Studies: Full report - Leaflet
- Rwanda Case Studies: Full report - Leaflet
- Kenya Case Studies: Full report - Leaflet
- Ethiopia Case Studies: Full report - Leaflet

6. Links


7. Main contacts

Contact the Technical Support Service (TSS), Division of Resilience and Solutions (DRS): hgsi00@unhcr.org

Protection considerations for integrated settlement responses

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,
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
- UNHCR Master-Plan-Approach to Settlement Planning 2019
- IASC Gender in Humanitarian Action Handbook, 2018

### 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

- DRS/Shelter and Settlement Section
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
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</td>
</tr>
<tr>
<td>Role (out-patient services)</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>Nurses (out-patient services)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role</th>
<th>1 : &lt; 10,000</th>
<th>Role</th>
<th>1 per stabilization center of 10 beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition Supervisor</td>
<td>1 : &lt; 10,000</td>
<td>Nutrition Auxiliary Workers</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Nurse/Clinical Officer trained in Mental Health</td>
<td>1 : &lt; 25,000</td>
<td>Qualified Laboratory Technician (diploma)</td>
<td>1 : &lt; 15,000 where there are full laboratory services</td>
</tr>
<tr>
<td>Qualified Pharmacist (diploma)</td>
<td>1 : &gt; 50,000 -100,000 or for a cluster of smaller camps</td>
<td>Laboratory Assistant (certificate)</td>
<td>1 – 2 : &lt;15,000</td>
</tr>
</tbody>
</table>

**Community Health Care**

<table>
<thead>
<tr>
<th>Role (Sphere)</th>
<th>1-2 : 1,000</th>
<th>Role</th>
<th>1-2 : 1,000 persons in refugee camps where GAM is above 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Workers</td>
<td>1,000</td>
<td>Nutrition Outreach Workers</td>
<td></td>
</tr>
</tbody>
</table>

**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

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 number 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)

6. Main contacts

UNHCR Division of Resilience and Solutions, Public Health Section: hqphn@unhcr.org
Designing nutrition programmes in emergencies

18 January 2024

Key points

- In emergencies, where malnutrition is a concern, implement nutrition interventions to improve the immediate food security, health, and nutritional well-being of displaced populations.
- Design the response to consider various factors influencing nutritional status, including environmental factors, Water Sanitation and Hygiene (WASH), access to health services, food and nutrition security, and shelter, with close collaboration among sectors.
- Focus on stabilizing the situation and preventing/reducing malnutrition prevalence, especially among vulnerable groups like women and young children.
- Take decisive actions to ensure access to safe and sufficient nutritious food, address acute malnutrition, tackle micronutrient deficiencies, and support optimal breastfeeding and appropriate complementary feeding of infants and young children during emergencies.

1. Overview

Designing and managing nutrition programs in emergencies involves a range of interventions to prevent and treat malnutrition among displaced populations. A person's nutritional status is influenced by various factors, including access to safe and nutritious food, water sanitation and hygiene (WASH), public health services, and shelter. Where these are inadequate, the risk of malnutrition increases. The overall objective of the nutrition response in emergencies is to stabilize the situation, reduce malnutrition prevalence to acceptable levels, and improve nutrition opportunities, particularly for vulnerable groups like women and young children. To achieve this, nutrition sub-sectors work closely with public health, WASH, shelter, food security, and livelihoods sectors, to address immediate and underlying causes of malnutrition while seeking long-term solutions. Key nutrition-specific objectives include ensuring access to sufficient nutritious food, managing acute malnutrition, addressing micronutrient deficiencies, and supporting breastfeeding and appropriate complementary feeding practices.

2. Relevance for emergency operations
Interventions that prevent and treat malnutrition in emergency operations are of paramount importance due to their direct impact on the health and well-being of displaced populations, especially vulnerable groups like women and young children. By addressing malnutrition, these interventions prevent life-threatening deterioration of nutrition status and enhance the overall humanitarian response. By implementing comprehensive nutrition programs in conjunction with other sectors like public health, WASH, shelter, and food security, emergency operations take a holistic approach to tackle the root causes of malnutrition. This integrated approach not only stabilizes the nutrition situation during the crisis but also builds resilience within the affected communities, leading to a more sustainable and effective response in the long run. Furthermore, targeting the specific nutrition needs of vulnerable groups and promoting self-reliance through complementary feeding practices ensures a faster recovery and contributes significantly to efforts to prevent the crisis from exacerbating further.

3. Main guidance

1. Emergency Phase

As refugees continue to arrive, it is crucial to implement a comprehensive nutrition response plan to address the needs of vulnerable populations. This plan outlines key points to ensure rapid screening, estimation of people in need, and appropriate interventions to combat malnutrition and improve the nutrition situation among refugees. Additionally, coordination with relevant partners and regular monitoring are essential to achieve successful outcomes. Lastly, certain risks and challenges need to be considered to ensure the plan's effectiveness and sustainability.

**Rapid nutrition screening:** To ensure the well-being of refugees, upon arrival, conduct initial rapid nutrition screening to identify individuals at immediate risk. Continuously screen for acute malnutrition at transit, reception centres, and within the community to monitor the nutrition situation and to identify individuals who need treatment. Refer to the sectoral coordination: [UNHCR Public health tool kit](#) for specific details.

**Co-ordination with relevant sectors and partner/s:** To facilitate a coordinated approach and maximize efficiency, establish strong coordination among public health subsectors including general health, reproductive health, mental health and psychosocial support and nutrition programs to ensure seamless coverage of all needs. Collaboration with education, WASH, Shelter, Protection is also crucial. Facilitate referrals and individual follow-ups to ensure continuity of care.

**Estimating people in need:** To accurately assess the scale of nutrition assistance required, gather relevant data from registration section or UNHCR ProGres to determine the target group proportions, including, children aged 0-6 months; children aged 6-23 months; children aged 0-59 months and pregnant and breastfeeding women. If disaggregated data for children aged 0-59 months is unavailable, assume this group represents 20% of the population. Assume that among children aged 0-59 months 10% are aged 0-6 months and 30% are aged 6-23 months. Assume 7% of the total population are pregnant and breastfeeding women, with 4% being pregnant.

**Estimating the number of people in need of nutrition assistance:** To determine the
extent of nutrition assistance required, use the prevalence of Global Acute Malnutrition (GAM) along with standard thresholds and historical data to estimate the number of people in need. Focus attention on refugee situations categorized as of medium to extremely high concern for malnutrition, breastfeeding, and food consumption to guide decision-making. See the various severity categorisation under the standards and indicators annex.

Estimating the **prevalence of Global Acute Malnutrition (GAM)** for a response plan over 12 months: To plan for a sustained response, obtain prevalence estimates of GAM from reliable nutrition surveys such as SENS (Standardized Expanded Nutrition Survey), SMART (Standardized Monitoring and Assessment of Relief and Transitions), or MICS (Multi Indicator Cluster Survey). If only MUAC (Mid-Upper Arm Circumference) data is available from rapid assessments, use the proportion of children with MUAC <12.5cm (MUAC malnutrition) as the estimated prevalence. Use the prevalence and estimated incidence to calculate the total number of people to be included in the response plan for 12 months. If incidence data is not available at the beginning of an emergency, apply an incidence correction factor of 2.6 for both severe and moderate acute malnutrition. Calculate specific incidence estimates using longitudinal program data when programs have been running for 6-12 months, and heterogeneous conditions are expected. See additional details under the standards and indicators section.

**Key nutrition-specific interventions:** To ensure adequate nutrition for all refugees, ensure access to safe and sufficient nutritious food through in-kind or cash assistance. Provide dry ready-to-eat meals (e.g., high energy biscuits) and water in the first 72 hours at border points, hot meals at transit/reception centres, and general ration when cooking is possible at the household level. Offer targeted complementary food as indicated for groups with increased nutrition needs, such as pregnant and breastfeeding women, children under five, and people living with chronic diseases (e.g., HIV/TB). This can be through blanket supplementary feeding or cash for nutrition. Support optimal breastfeeding practices and appropriate complementary feeding for infants and young children. Micronutrients reduction initiatives like Vitamin A supplementation among children, iron and folate supplementation among pregnant and breastfeeding women and deworming should also be considered as indicated by the context.

**Monitoring the nutrition situation:** To track progress and respond to emerging needs effectively, regular monitoring should be established to track changes in nutrition status and effectiveness of interventions in place. Conduct follow-up assessments to measure the impact of interventions and adjust strategies as needed. Ensure collaboration with other sectors and stakeholders for integrated data collection, joint monitoring, analysis and feedback to inform coordinated responses.

Related risks:

- Inadequate resources or a shortage of skilled personnel will curtail an effective nutrition response including for example hindering comprehensive screening, leading to potential undetected cases of malnutrition and subsequent increased risk of disease and deaths.
- Lack of communication and collaboration among partners may result in fragmented services and gaps in the nutrition response.
- Reliance on incomplete or inaccurate data may lead to an underestimation or overestimation of the population in need, impacting resource allocation.
Solely relying on historical data may not account for changing conditions or emerging nutrition challenges.
Limited access to accurate survey data may affect the precision of prevalence estimates.
Supply chain disruptions or logistical challenges may hinder the timely delivery of food and nutrition supplies.
Inconsistent monitoring or insufficient data collection may impede the ability to track progress and identify emerging nutrition concerns.

Post emergency phase

As the emergency progresses to the post-emergency phase, collaborate with development partners and local authorities to ensure a smooth transition and sustainable nutrition solutions for the affected population where possible.

Checklist for Designing nutrition programmes in emergencies

- Conduct rapid nutrition screening among new arrivals and ensure continuous screening.
- Gather data on target groups in need of assistance.
- Estimate the number of people in need based on GAM prevalence, food security situation and identified infant and young child feeding issues.
- Provide safe and sufficient nutritious food through in-kind or cash assistance.
- Provide complementary food and micronutrient supplements to vulnerable groups with increased nutrition support needs.
- Support optimal breastfeeding and appropriate complementary feeding.
- Coordinate with relevant partners and use key tools for planning.
- Monitor the nutrition situation to review progress and adapt response to the evolving situation.
## 4. Standards

### Interpretation of key nutrition indicators to guide decision-making on addressing acute malnutrition in the short and long term.

<table>
<thead>
<tr>
<th>Severity scale</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Very High</th>
<th>Extremely high</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevalence of GAM based on WHZ&lt;-2 and/or bilateral pitting oedema among children 0-59 months</strong></td>
<td>&lt; 5%</td>
<td>5.0 to 9.9%</td>
<td>10.0 to 14.9%</td>
<td>15.0 to 29.9%</td>
<td>≥30%</td>
</tr>
<tr>
<td><strong>Prevalence of GAM based on MUAC &lt;125mm and/or bilateral pitting oedema among children 6-59 months</strong></td>
<td>&lt; 5%</td>
<td>5 to 9.9%</td>
<td>10 to 14.9%</td>
<td>≥15%</td>
<td></td>
</tr>
<tr>
<td><strong>Prevalence of GAM based on MUAC &lt;210/230mm among Pregnant and Lactating Women (PLW)</strong></td>
<td>&lt;12.6%</td>
<td>12.6-19.9%</td>
<td>20-24.9%</td>
<td>25-34.9%</td>
<td>&gt;35%</td>
</tr>
<tr>
<td><strong>Prevalence of stunting based on HAZ &lt;-2 among children U5</strong></td>
<td>&lt; 2.5</td>
<td>2.5 to 9.9%</td>
<td>10.0 to 19.9%</td>
<td>20.0 to 29.9%</td>
<td>≥30%</td>
</tr>
<tr>
<td><strong>Prevalence of anaemia (Hb &lt;11g/dL) in children 6-59 months</strong></td>
<td>&lt; 5%</td>
<td>5.0 to 19.9%</td>
<td>20.0 to 39.9%</td>
<td>≥40%</td>
<td></td>
</tr>
<tr>
<td><strong>Prevalence of anaemia (Hb &lt;11g/dL) in women</strong></td>
<td>&lt; 5%</td>
<td>5.0 to 19.9%</td>
<td>20.0 to 39.9%</td>
<td>≥40%</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusive breastfeeding for infants 0-5 months</strong></td>
<td>&gt;70%</td>
<td>50-70%</td>
<td>30-49.9%</td>
<td>11-29.9%</td>
<td>&lt;11%</td>
</tr>
<tr>
<td><strong>Infants 0-5 months that are not breastfed who have access to Breast Milk Substitutes supplies and support in line with the Code and the IFE Operational Guidance’s standards and recommendations</strong></td>
<td>&gt;60%</td>
<td>40-60%</td>
<td>20-39.9%</td>
<td>10-19%</td>
<td>&lt;10%</td>
</tr>
<tr>
<td><strong>Food consumption score</strong></td>
<td>Acceptable and stable</td>
<td>Acceptable but deterioration from typical</td>
<td>Borderline</td>
<td>Poor</td>
<td>Poor</td>
</tr>
</tbody>
</table>

Source: [https://www.nutritioncluster.net/resources/nutrition-humanitarian-needs...](https://www.nutritioncluster.net/resources/nutrition-humanitarian-needs...)

### Key formula for estimating people in need of nutrition assistance,

**Severe acute malnutrition cases for under five children (with and without medical complications)**

Number of SAM children 6-59 months in need treatment (SC and OTP) = SAM prevalence x population of children 6-59 months x K (SAM incident factor)

**Moderate acute malnutrition cases for under five children**

Number of MAM children 6-59 months in need = MAM prevalence x population of children 6-59 months x K (MAM incident factor)

**Severe acute malnutrition cases for women (without medical complications)**

Number of SAM PLW in need = SAM prevalence x population of PLW

**Moderate acute malnutrition cases for pregnant and lactating women**

Number of MAM PLW in need = MAM prevalence x population of PLW

**Exclusive breastfeeding (EBF) in emergencies for children 0-6 months**

Number of children 0-5 months in need of EBF support = Population figures x % of children 0-5 months x (1-EBF proportion)

**Women (pregnant and lactating) in need of feeding counselling and support**

Number of PLW counselled (one-on-one) on IYCF = Population figures x % of PLW x Proportion of PLW individually counselled on IYCF

**Children in need of supplemental feeding support to prevent malnutrition**

Number of children 6-23 months in need of Blanket Supplementary Feeding Program (BSFP) or Fortified Nutrition Supplement (FNS) = Population of children aged 6-23 months x Expected coverage for BSFP or FNS

**Pregnant and lactating women in need of supplemental food support to prevent malnutrition**

Number of MAM PLW in need of BSFP or High Energy Biscuits (HEB) = population of PLW x Expected coverage for BSFP or HEB

### Annexes
5. Links

NutVal.Net WHO, Food and nutrition needs in emergencies Harmonised Training Package (HTP): Resource material for training and learning ... Sphere handbook- Food security and nutrition

6. Main contacts

UNHCR Public Health Section, Division of Resilience and Solutions: 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 UNHCR Guidance on Emergency Preparedness includes a List of Preparedness Actions, which operations are encouraged to implement as part of contingency planning. In particular, in the preparedness phase, undertake a light-touch review of the context, focusing on the policy environment that will inform the strategic direction of the education response.

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.

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**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.

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**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).

Collective centre rehabilitation

10 March 2019

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 collecti...

**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
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).

Nutrition specific interventions to prevent and treat malnutrition in emergencies

19 January 2024

Key points

- Addressing acute malnutrition and micronutrient deficiencies in emergencies is crucial because it has a significant impact on the health, well-being, and overall survival of affected populations.
- Community management of acute malnutrition (CMAM) is an effective standard approach for treating malnourished individuals in emergencies.
- Infant and young child feeding in emergencies (IYCF-E) programs save lives and prevent malnutrition. Creating awareness and providing support for appropriate infant and young children feeding practices is crucial in a refugee nutrition emergency.
- Ensuring micronutrient adequacy and dietary diversity is essential for vulnerable populations. Assessing the presence of micronutrient deficiencies and targeting high risk groups is essential to improve the overall health and wellbeing of the refugee population.
- Collaboration among partners and adherence to standards and guidelines is important for effective implementation of the various nutrition interventions.

1. Overview

In emergencies, nutrition specific interventions are crucial to manage acute malnutrition, prevent micronutrient deficiencies, and support optimal and appropriate infant and young child feeding practices. This document outlines key principles and actions for addressing malnutrition and promoting optimal infant and young child feeding during the critical early phase of refugee
2. Relevance for emergency operations

Nutrition-specific interventions, including Community-Based Management of Acute Malnutrition (CMAM), Infant and Young Child Feeding in Emergencies (IYCF-E), and micronutrient supplementation, are essential components of emergency response efforts, particularly in refugee crises. These interventions directly address the immediate nutritional needs of vulnerable populations. CMAM empowers communities to identify and treat acute malnutrition, while IYCF-E promotes healthy feeding practices for infants and young children and support for their mothers or caretakers. Micronutrient supplementation prevents deficiencies, collectively reinforcing UNHCR's commitment to community engagement, protection, and provision of essential health services.

3. Main guidance

Emergency Phase

Acute malnutrition management

Acute malnutrition is a severe health condition characterized by rapid deterioration in nutritional status. Global Acute Malnutrition (GAM) serves as a measure of acute malnutrition, reflecting recent nutritional deterioration in children aged between 6 and 59 months. The UNHCR's objective is to maintain the prevalence of acute malnutrition below 10% among the refugee population. To support this UNHCR and its partners must ensure the availability of appropriate treatment programs for acutely malnourished refugees. This involves supporting refugee access to host community facilities, ensuring their capacity aligns with refugee needs, and establishing new facilities if necessary.

Treatment programs should adhere to the principles of community-based management of acute malnutrition (CMAM) as outlined by the World Health Organization (WHO), UNHCR, and national guidelines. CMAM focuses on identifying malnourished individuals, providing suitable treatment, and ensuring follow-up care. The model comprises various components tailored to the severity of malnutrition.

Key response actions include:

- Systematic screening of individuals for malnutrition using anthropometric measurements Mid Upper Arm Circumference (MUAC, weight-for-height/length), followed by applying validated cut-off points for classification. Priority for treatment is determined based on severity.
- To treat severe acute malnutrition (SAM), inpatient and outpatient services should be made available. This should be in collaboration with UNICEF to ensure the supply of therapeutic products and capacity building support for staff as outlined in the UNHCR/UNICEF global MOU. Wherever feasible, programmes should leverage and strengthen existing health system capacity.
Cases of SAM with medical complications require stabilization as inpatients, where therapeutic feeding, medical treatment, and monitoring are administered. Transition to outpatient care is initiated once stabilization is achieved.

Treating SAM that doesn't necessitate inpatient care involves outpatient therapeutic care. Support includes provision of ready-to-use therapeutic food (RUTF), medical care, and consistent follow-up visits for monitoring, nutritional counseling, and caregiver support.

Treating moderate acute malnutrition (MAM) entails outpatient services in collaboration with WFP, ensuring the provision of supplementary food products as per the UNHCR/WFP global MOU. Supplementary feeding programs provide wet or dry rations or facilitate access to a complementary healthy diet.

Establishing robust links between the various CMAM program components (community mobilization, communication, active case-finding, referral, follow-up, inpatient management, outpatient treatment, and supplementary feeding) and health and prevention services. Informing the community about malnutrition and involving the population in efforts to enhance nutrition outcomes is crucial.

Nutrition support for malnutrition management should also systematically include pregnant and breastfeeding mothers and be integrated into care and treatment services for people affected by HIV/AIDS and TB patients. The support should also be sensitive to age, gender, and disability.

A comprehensive monitoring and evaluation framework to track CMAM performance should be established. This should include coverage, quality, and treatment outcomes. Regular review and analysis of this should inform program adjustment and improvements.

**IYCF-E (Infant and Young Child Feeding in Emergencies)**

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.

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 should be adopted. Community outreach workers and staff in health and nutrition centres at transit/reception centres, refugee settlements 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.

UNHCR and partners must ensure support services and facilities for infant and young child feeding should always be available to refugees at the various service provision contact points.

Key response actions include:

- Ensure availability of breastfeeding and complementary feeding support infrastructure including the establishment of baby friendly spaces at the various contact points at reception centers, within the health and community structures. These should have the
capacity to offer infant and young child appropriate feeding screening, promotion, counselling and psychosocial support where indicated or referral for support. Initial information dissemination to demystify any identified myths and misconceptions around ability of women to breastfeed in emergencies should be also ensured.

- Ensure programs provide clear messages to encourage early initiation of breastfeeding, exclusive breastfeeding for the first 6 months and continuation of breastfeeding for all infants who are breastfed or are mixed fed. Note higher risk infants, children, and mothers that may face increased feeding difficulties in emergencies including (but are not limited to) low birth weight infants, any wasted children, children with disabilities, HIV exposed infants, and orphaned infants and mothers who are malnourished or severely ill. Mother-child pairs facing timely initiation and continuation of breastfeeding difficulties should be identified and provided with appropriate support.

- For infants who are exclusively dependent on formula milk, ensure early identification and support to access code compliant sustainable infant formula supply, and equipment for safe preparation and feeding, in line with country specific standard operating procedures.

- Promote the provision of age-appropriate complementary foods for infants and young children 6-23 months and availability and continuity of a nutritious diet for pregnant and breastfeeding women.

- Despite the ratification of the [International Code of Marketing of Breastmilk Substitutes](https://www.who.int/professionaldevelopment/nutrition/drink/infantfeeding/en/) by many countries, nearly every emergency provides a new example of inappropriate donations of powdered infant formula and other infant foods. These donations have been shown to displace breastfeeding in crises. Ensure prevention and control by assessing whether Breast Milk Substitutes (BMS) donations is an issue and ensuring the communication of code compliance. UNHCR does not call for, support, accept or distribute commercial products targeted to infants or young children, including BMS (infant formula, other milk products, commercial complementary foods) and feeding equipment (such as bottles, teats, and breast pumps). Required BMS supplies should be purchased by UNHCR or a designated partner and provided as part of a sustained package of coordinated care based on assessed needs. This should be compliant with International Code of Marketing of Breast milk Substitutes as reflected in the [Infant and Young child feeding in emergencies operational guidance](https://www.unicef.org/health/infant-and-young-child-feeding-emankees-operational-guidance).

- Using the IYCF multisectoral framework of action all sectors should consider the specific needs of infants, young children, breastfeeding mothers, and carers to enabling easy access to basic services (e.g., shelter, security, food assistance, Water Sanitation and Hygiene promotion (WASH), health) and also to ensure that humanitarian assistance does not undermine safe IYCF pract(ices with inappropriate interventions See video detailing the IYCF linkages with other sectors.

- In collaboration with the other nutrition partners consider issuing a joint statement and SOP to help secure immediate, coordinated, multi-sectoral action on IYCF at the onset of the emergency calling for all involved in the response to the refugee crisis to protect, promote, and support the feeding and care of infants and young children and their mothers as well as pregnant women noting this as critical to support maternal and child health and survival, growth, and development and to prevent malnutrition.

**Micronutrient Deficiency Reduction Interventions in Emergencies**
Micronutrient deficiencies can easily develop or worsen during an emergency, presenting significant health risks, particularly for vulnerable groups such as children and women. Limited access to diverse food and poor dietary diversity plays a major role in this. Children and mothers deficient in micronutrients face increased susceptibility to infections, illnesses and even mortality. Addressing these deficiencies is crucial for their survival, as well as their overall growth, and development.

Key response actions:

- Assess prevalence and identify high-risk groups: Micronutrient programs must be strategically designed based on a clear understanding of contributing factors and the risks associated with deficiencies. It's essential to identify the main causes of micronutrient deficiencies, such as inadequate access to nutrient-rich foods, inadequate care for women and children, limited healthcare services, and unhealthy environments. This assessment should consider factors like the existing diet compared to recommended nutritional intake, feeding practices, cultural food habits, and access to healthcare services.
- Ensure access to food, nutrition, and health programs: The prevention and management of micronutrient deficiencies during emergencies heavily rely on comprehensive food, nutrition, and health interventions. It's imperative to ensure that the general food ration and/or dietary intake adhere to international nutritional standards for micronutrient adequacy. When these standards are not met, the consideration of micronutrient-fortified supplementary options becomes crucial, especially for children and women with increased nutrient requirements. In instances of identified deficiencies, supplementation (e.g., vitamin A campaigns for children, iron, and folate supplementation for pregnant and breastfeeding women) and appropriate treatment should be provided.
- Reinforce important health and nutrition practices: Apart from dietary interventions, it is equally vital to emphasize the need for appropriate IYCF practices, disease and parasite control, water, sanitation, and hygiene (WASH), and access to healthcare services. These factors play a critical role in preventing and addressing micronutrient deficiencies in emergencies.

Key overall considerations:

- UNHCR must ensure that adequate food/cash for food assistance, programmes to treat acute malnutrition, and infant feeding support are provided either by integration of refugees into the national systems or where this fall short through improvement or establishment of these services. Where indicated establish partnership agreements early so that interventions can be implemented rapidly by ministry of health or NGO partners in collaboration with WFP and UNICEF.
- An experienced nutritionist from UNHCR or a trained UNHCR public health officer with proficient nutrition in emergencies knowledge should lead the nutrition response in cases of severe under-nutrition and/or infant feeding is a general problem.
- UNHCR should also ensure that the nutrition situation is monitored and reported regularly, using the basic integrated refugee health information system (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.
Post emergency phase

Transition malnutrition management from emergency to early recovery phase and ensure continuity of IYCF-E programs and micronutrient intervention.

4. Standards
**Performance Indicators**

**A: Community Management of acute Malnutrition**

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

Indicators for assessing the effectiveness of UNHCR (therapeutic and supplementary feeding programmes) for children in refugee settings who are less than 5 years old.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>TSFP (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/settlems</td>
<td>&gt;80%</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.

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

***Defaulted**: The proportion of children in the program 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 children who died from any cause while enrolled in the program.

Coverage: Coverage should usually be monitored by 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 Standardized Expanded Nutrition Survey (SENS).

**B: Infant and Young Child feeding**

**IYCF Indicators**

<table>
<thead>
<tr>
<th>IYCF Indicators</th>
<th>UNHCR Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely initiation of breastfeeding</td>
<td>≥85%</td>
</tr>
<tr>
<td>Exclusive breastfeeding under 6 months</td>
<td>≥75%</td>
</tr>
<tr>
<td>Continued breastfeeding at 1 year</td>
<td>≥80%</td>
</tr>
<tr>
<td>Continued breastfeeding at 2 years</td>
<td>≥60%</td>
</tr>
<tr>
<td>Introduction of solid, semi-solid or soft foods</td>
<td>&gt;60%</td>
</tr>
</tbody>
</table>

Breastfeeding mothers have access to skilled counselling 1Y/N

Caregivers have access to timely, appropriate, nutritionally adequate, and safe complementary foods for children aged 6 to 23 months 1Y/N

No BMS code violations or code violations donations of breastmilk substitutes (BMS), liquid milk products, bottles and teats dealt with in a timely manner 1Y/N

Caregivers have access to Code-compliant supplies of appropriate breastmilk substitutes (BMS) and associated support for infants who require artificial feeding 1Y/N

**C: Micronutrient Deficiency Reduction Interventions**

<table>
<thead>
<tr>
<th>Micronutrient adequacy Indicators</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin A supplementation in the last 6 months coverage (6-59m)</td>
<td>≥80%</td>
</tr>
<tr>
<td>Prevalence of ascorbic acid in children aged 6-59 months and in women 15-49 years</td>
<td>&lt;20%</td>
</tr>
<tr>
<td>Deworming coverage within past 6 months (12-59m)</td>
<td>≥75%</td>
</tr>
<tr>
<td>Consumption of iron-rich or iron-fortified foods (6-23 months)</td>
<td>&gt;60%</td>
</tr>
</tbody>
</table>

5. **Policies and guidelines**

**Annexes**

WFP, Food and Nutrition Handbook, 2018

UNHCR, Infant and young child feeding practices: Standard Operating Procedures for the Handling of Breastmilk Substitutes (BMS) in Refugee Situations for children 0-23 months, 2015

UNHCR, Infant and Young Child Feeding in refugee Situations: A multi-Sectoral Framework for Action, 2018

UNHCR Operational Guidance on the Use of Special Nutritional Products to Reduce Micronutrient Deficiencies and Malnutrition in refugee Populations, 2011

The Sphere Handbook, 2018
6. Links

Food and Nutrition handbook, WFP 2018 Infant and young child feeding practices: Standard Operating Procedures for the... UNHCR Operational Guidance on the Use of Special Nutritional Products to Reduce... The Sphere Handbook - Food security and nutrition

7. Main contacts

UNHCR Public Health Section, Division of Resilience and Solutions: hqphn@unhcr.org