# *CHAPTER VI*
# WELL-BEING AND LIVING CONDITIONS OF REFUGEES: CASE STUDIES

## INTRODUCTION

With the number of internal and external requests for UNHCR statistics on well-being and living conditions of refugees and other persons of concern continuously on the rise, the 2005 Statistical Yearbook included for the first time a chapter quantifying some of those aspects. While the overall perception was positive because such type of information was felt to respond to the needs of many internal and external users, it is important to highlight that such initiatives are only sustainable if continuous efforts are made to improve data quality and comparability.

The difficulty of ensuring data quality, geographic and time trend comparability is primarily due to the fact that data from different years, camps and countries are not fully comparable. In fact, the use of different data collection methodologies and the various changes in the reporting instruments used make the provision of a global and representative picture of UNHCR's protection and assistance activities, as well as persons of concern's needs, very difficult. Case studies using comparable methodologies and data are therefore used in this chapter to illustrate some of the protection and assistance concerns refugees and other persons of concern are facing. UNHCR is currently working on harmonizing its methodologies in order to ensure data comparability across countries, locations and years. By using selected case studies and countries, this chapter tries to illustrate the potential of the data for evidence-based decision making in the humanitarian field. By showing where the gaps are, how to plan and prioritize activities or what the policy and operational implications of the findings are, the 2006 Yearbook attempts to support the decision-making process.

Since its inception, the Standards and Indicators (S&I) programme[1] has developed into one of the main sources of quantitative information on protection and assistance. It does not only include a list of quantifiable indicators to be collected on a yearly basis and on different themes, but also sets minimum standards to assess protection, living conditions and well-being of the populations of concern. In addition to being part of UNHCR's implementation of the Results-Based-Management approach adopted in 1998, the S&I initiative also ensures that this type of information is reported in a consistent manner across UNHCR operations. Other protection and well-being information sources include UNHCR's registration software *proGres* launched in 2004, the Annual Protection Reports, the participatory assessment findings, the Health and Nutrition Information System (HNIS) in selected countries, the HIV and AIDS behavioural surveillance system, ad-hoc nutrition surveys undertaken by UNHCR and its partners as well as reports from UNHCR health coordinators and other protection data collection mechanisms.

This chapter has two main parts. The first reflects protection issues using indicators related to women and children. The second part presents health-related indicators, using both the S&I and HNIS data. For each part and topics outlined above, the chapter presents (i) a short explanation of the topic's relevance; (ii) current and potential data sources; (iii) levels and trends in refugee or refugee-like situations,

[1] See also the *Practical Guide to the Systematic Use of Standards and Indicators in UNHCR Operations* (2nd edition, February 2006) at http://www.unhcr.org/statistics/statistics/40eaa9804.pdf

where applicable, reflecting on information availability and gaps; and (iv) policy and operational implications of the findings.

## VI.1 INTERNATIONAL PROTECTION

### BACKGROUND

The primary responsibility to protect refugees and other persons of concern, especially those most at risk such as women and children, lies with States. Where Governments' capacity is weak or insufficient to ensure protection of refugees and others of concern, UNHCR and its partners carry out and monitor protection and assistance activities.

UNHCR has been mainstreaming age, gender and diversity perspective to ensure that the meaningful participation of girls, boys, women and men of all ages and backgrounds is integral to the design, implementation, monitoring and evaluation of all its policies. The overall goal is to achieve gender equality and the enjoyment of rights by all refugees. The Office has articulated global priorities and commitments for refugee women and children. Monitoring these issues requires collection and analysis of sex and age-disaggregated data, not only to determine the size of the population of concern, but also, and especially, to analyse protection-related indicators for women and children.

Indicators such as numbers of unaccompanied and separated children, frequency of military recruitment, best interests determination, response to the specific needs of children with disabilities, and provision of birth certificates allow the monitoring of protection gaps for children. For women, indicators on equal participation in decision-making processes or prevention and response to sexual and gender-based violence (SGBV) could contribute to the analysis of protection levels and gaps.

Statistics on refugee women and children can provide UNHCR with an important resource for setting objectives, assessing impact, and measuring progress in the operationalisation of protection. By defining strategic goals, specifying expected results, and enhancing accountability, the Office can improve delivery of protection to this group among persons of its concern.

UNHCR uses a range of data sources relevant to protection, including Standard Operating Procedures (SOPs) on sexual and gender-based violence which include a template for monthly reporting on SGBV. This template calls for a summary of age and sex disaggregated information on various forms of SGBV. The following sections are illustrative of the type of information available to the Office.

### A. MONITORING CHILD PROTECTION

Examples on birth registration and best interests determination are used to illustrate some protection gaps in relation to children.

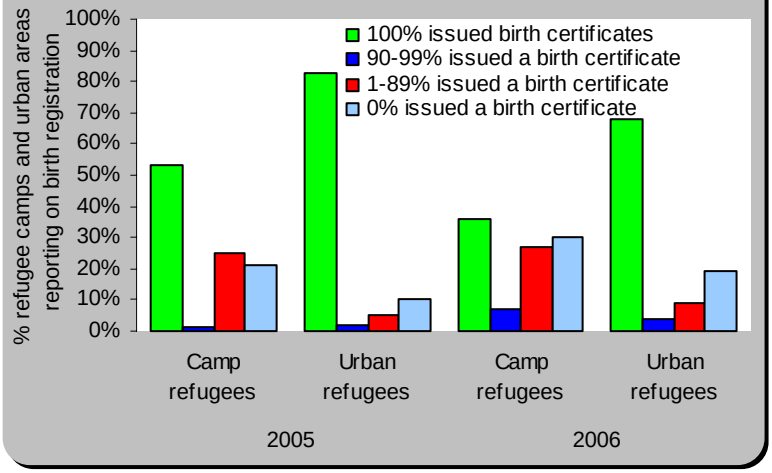
#### BIRTH REGISTRATION

Children's rights are to be enjoyed without discrimination, including differences in treatment on the basis of grounds such as the child's (or parents' or guardians') nationality, statelessness or migratory status. These rights have recently been reiterated in two Conclusions of UNHCR's Executive Committee: Conclusion on Identification, Prevention and Reduction of Statelessness and the Protection of

Stateless Persons (No. 106 (LVII) – 2006) and Conclusion on Children at Risk (No. 107 (LVIII) – 2007).

Registration of children is a very important protection tool for a number of reasons. It is the first recognition of the child's existence, assists in planning and is a means of securing other rights, including access to essential services such as health and education as well as protection, such as through legal age limits (e.g. employment and military recruitment). Birth registration is also an essential tool for preventing statelessness because it documents the relationship between the child, his or her parents and the country of birth, thereby permitting the child to acquire nationality through the principle of *jus sanguinis* (nationality transmitted by parents to children) or *jus soli* (nationality transmitted to children born on the territory of a State). For this reason, based on its mandate to prevent and reduce statelessness, UNHCR has an interest in ensuring that all children are registered at birth irrespective of the fact that UNHCR's mandate is limited to refugees, asylum-seekers and internally displaced persons. In cases where States fail to do so, UNHCR is to organise a local registration system to ensure, at a minimum, that the date, place of birth and the names and nationalities of both parents are recorded in a traceable way and to issue a written attestation of the birth.

**Fig VI.1 Newborns issued with birth certificate**




Existing data from the Standards and Indicators reports have highlighted that births are not adequately registered. Slightly more than one third (35%) of refugee camps reported that, in 2006, all newborns were issued with birth certificates, while 3 out of 10 (30%) camps reported that none of the newborns were provided with a birth certificate. The situation is more promising, however, in the urban context: of those urban locations reporting in 2006, almost 70 per cent indicated that all children received birth certificates, while less than 20 per cent reported that none of the children were registered at birth.[2] There could be a number of explanations for this, including the fact that urban refugees may live closer and have easier access to the civil registry or children in urban areas are more likely to be born in a hospital where they can be registered more easily.

The number of locations for which data is available on birth registration has risen from 73 in 2005 to 124 in 2006 for camps and from 42 to 57 for urban programmes. Although the increase in the number of countries and camps reporting makes it difficult to compare the figures for the two consecutive years, UNHCR's statistics now provide a more accurate picture of the situation. In fact, this rise appears to be a general trend witnessed for most indicators.

[2] The indicator is: percentage of newborns (asylum-seekers and refugees) issued a birth certificate. As per the guidance on the indicator, birth certificates include documents issued by the government as well as documents issued by UNHCR and other organizations, when these have been given the authority by the host government to issue them through a legal or sub-legal act or when UNHCR-issued document bears the logo and signature of the competent authority of the State.

## BEST INTERESTS DETERMINATION (BID)

One of the key priorities of UNHCR is to protect and promote, within its capacity, the rights of all children, including adolescents. The principle of the best interests of the child must permeate all protection and care issues affecting a child.[3] In order to identify what is in the best interest of the child, two procedures have been introduced: i) the best interests assessment and ii) the best interests determination (BID).

The best interests assessment is a continuous process that starts from the moment of identification, and continues throughout the displacement cycle until a durable solution is reached. The assessment regarding what option is in the best interests of the child should be conducted by the responsible officer, for any decision and action affecting children of concern to UNHCR. Measures shall be taken to ensure that the child participates in the decision.

Guidelines on how to undertake a BID were provisionally released by UNHCR in May 2006.[4] They outline in which circumstances UNHCR should undertake a BID. One of these situations is to identify the most appropriate durable solution for unaccompanied and separated children.

Data from the Standards and Indicators Report suggest that about 40 operations in which UNHCR provided care to refugees reported a substantial presence of unaccompanied and separated children by the end of 2006. About 28 of these 40 operations had put in place a system to carry out BIDs. In other words, of those countries that reported a substantial presence of unaccompanied and separated children, approximately 70 per cent conducted BIDs but not necessarily for all children.

A growing number of UNHCR operations are creating BID panels. Operations are also increasingly involving NGOs, Government representatives or representatives of international organisations in the BID panels and processes. At least 14 countries have set up multi-functional panels including Ecuador, Egypt, India, and Indonesia.

Some of the challenges regarding the implementation of best interests determination procedures at the field level include the lack of trained social workers, limited capacity and resources, limited options for solutions, and limited participation by competent national authorities.

**Box 4. Good practices from the Field**

**Thailand**. During 2005, UNHCR's Regional Office in Thailand systematically incorporated analysis on the best interests of the child into its resettlement process given the prevalence of [informal] adoptions and foster care arrangements among refugees from Myanmar. Following the expansion of the resettlement operation from the camps, additional staff was deployed to the field offices to assist in the BID process. They received a basic training in BID and interview techniques. The Office has also instituted a number of means of quality control for BIDs, e.g. Standard Operating Procedures for BIDs were drafted and a BID decision-making panel of 3-5 persons was formed and started operating in 2006. This Bangkok-based panel ultimately decides on whether or not to endorse the BID recommend-dations coming from the field.

(*UNHCR Regional Office in Thailand*)

[3] Convention on the Rights of the Child, Article 3, 1989.

[4] UNHCR Guidelines on Formal Determination of the Best Interests of the Child (provisional release), May 2006, http://www.unhcr.org/protect/protection/4566b16b2.pdf

## B. MONITORING WOMEN'S PROTECTION: AN ILLUSTRATION USING SGBV DATA

### BACKGROUND AND INDICATORS

Sexual and gender-based violence can be defined as violence that is directed against a person on the basis of gender or sex and inflicts physical, mental or sexual harm or suffering. It includes threats of such acts, coercion and other deprivations of liberty. SGBV includes but is not limited to the following: domestic violence, sexual exploitation, sexual abuse of children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, sexual harassment, sexual trafficking, and forced prostitution. UNHCR, in implementing its protection mandate, recognizes that refugees and internally displaced persons are among those most at risk of acts of violence, and in particular SGBV. Therefore, an integral part of ensuring protection is for UNHCR to work hand in hand with States (law enforcement, health and other national authorities), NGOs, UN agencies and communities towards elimination of SGBV.

UNHCR receives information on SGBV directly from people of concern as well as from partner organizations providing services for survivors. Predominantly, the available SGBV data from the refugee context is based on reported incidents, which does not provide a complete picture on prevalence rates, given that most cases remain unreported.

The Standards and Indicators Reports (SIR) provide information on five SGBV indicators: the number of cases reported, information on services provided for survivors below 18 years and for all SGBV survivors, offices conducting SGBV training for at least 10 per cent of UNHCR/partner staff and for people of concern, and the development of standard operating procedures (SOP) for SGBV. For illustrative purposes, the analysis that follows is based mainly on the SIRs from refugee camps in 2005 and 2006.

### DATA AVAILABILITY: CONSTRAINTS OF SGBV REPORTING

The availability of comprehensive and reliable statistical data on SGBV is generally challenging, especially in the displacement context because of cultural and security reasons. Communities and individual women, girls, men and boys, may not feel comfortable to share SGBV-related information because of the fear of stigma or further victimization, or the lack of adequate judicial responses. Sometimes, SGBV incidents are dealt with by the traditional mechanisms whereby cases are resolved between families and the police, health, or psychosocial actors may not be informed. In other circumstances, certain forms of SGBV which are considered to be part of the culture, like female genital mutilation, often go unreported because it is not seen as a crime or human rights violation. Practices, such as trafficking and sexual slavery, also often go under-reported. Often, survivors fear retaliation from the perpetrators or to be penalized by the law. In a refugee camp, the low reporting of cases may also indicate that there are inadequate systems for reporting and/or documenting incidents of SGBV.

There are multiple entry points for individual survivors to make reports, for example to the police, to an NGO, to a health service provider or UNHCR. The multi-sectoral nature means that data must be shared across the different actors, but the sensitivity and confidentiality concerning SGBV information makes this difficult. There is also a possibility that there is duplication in reporting because of information coming from different sources. The problem is further compounded by the fact that there is not one standard for collection of SGBV data in any sector, with different providers using

different systems. Furthermore, the classification of typologies of SGBV varies among agencies affecting any statistics broken down by type. However, the use of UNHCR Standards and Indicators helps to monitor SGBV as a broad category and is therefore not affected by different typologies; the monitoring system may, however, be influenced if forms of violence are wrongly classified as SGBV. The combination of these factors, in addition to several others, means that the Standard and Indicators Reports data may only reflect a partial picture of the situation.

## LEVELS IN SELECTED SGBV INDICATORS

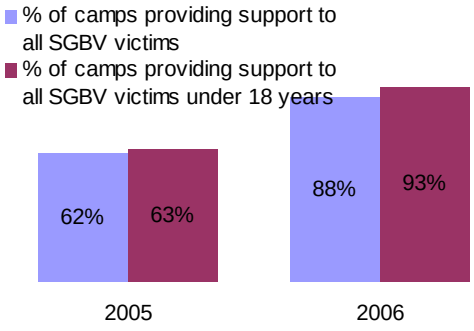
### Data availability

UNHCR efforts to improve information related to SGBV have resulted in a significant improvement in data availability. While, in 2005, only 59 refugee camps reported on the number of SGBV, this number has reached to 104 camps in 2006. At the same time, the 7,600 SGBV cases reported in 2006 was 77 per cent higher than the corresponding value in 2005 (4,300). Reporting on SGBV cases with survivors being below the age of 18 years also increased from 1,500 in 2005 to 1,800 SGBV cases in 2006 (+14%). These trends do not necessarily mean an increase in the prevalence of SGBV cases; rather, this might be a reflection of improved monitoring and reporting of cases in camps.

### Support to SGBV survivors

UNHCR Executive Committee Conclusion on Refugee Protection and Sexual Violence No. 73 (XLIV) of 1993 and the Executive Committee Conclusion on Women and Girls at Risk No. 105 (LVII) of 2006 call for survivors of sexual violence and their families to be provided with adequate medical and psycho-social care, including culturally appropriate counselling facilities. In 2005, 62 per cent of the camps that reported data met the UNHCR target of providing 100 per cent of SGBV survivors with support. The latter would include at least one of the following responses: legal, psychosocial, health or safety and security. In 2006, this increased by 88 per cent of camps having met the target of providing 100 per cent of SGBV victims with support. The corresponding rates for survivors under 18 years of age were 63 per cent in 2005 and 93 per cent in 2006. The statistics indicate that the performance in meeting the target in 2006 for survivors under 18 was slightly better than that of adult survivors.

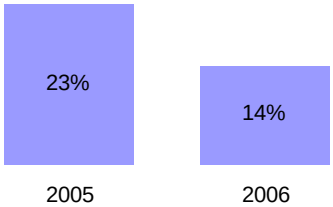
**Fig VI.2 Percentage of camps providing support to all reported SGBV cases**




### SGBV training indicators

With regard to providing training on SGBV for UNHCR and partner staff, in 2005, out of 113 camps, 63 per cent had SGBV data available. Of these, 65 per cent reported meeting the target of at least 10 per cent of UNHCR and partner staff having received SGBV training during the year. Some 35 per cent of the camps offered training but did not meet the target of at least 10 per cent. In 2006, out of 155 camps, 61 per cent had data available and of these 76 per cent reported meeting the target. About 24

**Fig VI.3 Percentage of camps providing SGBV training to 10% or more of refugees/asylum-seekers**



per cent offered training but did not meet the target.

With regard to providing SGBV training for refugees and asylum-seekers, in 2005, 73 per cent of camps had data available but only 23 per cent reported having met the standard of at least 10 per cent of the refugee and asylum-seeker population having received SGBV training. Moreover, 77 per cent offered training but did not meet the standard. In contrast, in 2006, 76 per cent of camps had data available; however, only 14 per cent of camps reported that they had met the relevant standard.

Possible explanations for the improvement in reporting on training for UNHCR staff and NGOs are three-fold: an increase in actual reporting of the training being conducted; an increase in the actual work done; or an increase on both fronts. These three possibilities all indicate a quantitative improvement for the organization. The training for asylum-seekers/refugees may have declined in 2006 due to reductions in funding which led offices to prioritize response activities over awareness raising.

Standard operating procedures (SOPs) for SGBV management

In 2005, only 44 camp locations reported having developed SOPs. However, following the introduction of new reporting instructions to UNHCR staff on SGBV Standard Operating Procedures in July 2006, a significant improvement was observed with 100 locations reported having developed SOPs by the end of the year. Despite this remarkable improvement, the level of compliance is still below the 100 per cent as stipulated in UNHCR's Global Strategic Objectives.[5] Currently, SOPs are in place in 77 per cent of camps and 55 per cent of urban programmes. Moreover, this quantitative indicator has still to be verified and interpreted from a qualitative point of view to ensure that the SOPs actually improve coordination and service delivery for SGBV survivors.

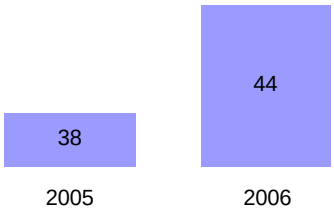
**Tab.VI.a SOPs available in refugee camps**

| UNHCR region | SOPs available 2005 | SOPs available 2006 |
|---|---|---|
| Central Africa-Great Lakes | 10 | 28 |
| East/Horn of Africa | 5 | 9 |
| Southern Africa | 1 | 4 |
| West Africa | 11 | 14 |
| Asia/CASWANAME | 17 | 45 |
| **Total** | **44** | **100** |

## CONCLUSIONS AND POLICY IMPLICATIONS

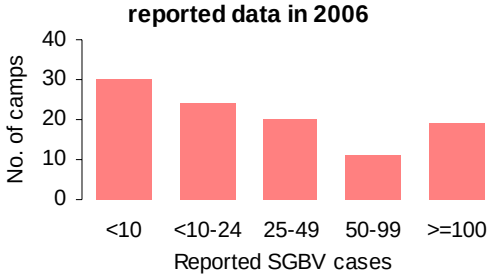
Comparing the reporting rate over a period of time allows for the identification of trends. Figure VI.4 is a comparison between 2005 and 2006 indicating an increase in the reporting rate. The average reporting rate per 10,000 persons has increased by 17 per cent. It is expected that the reporting rate will continue to increase over time which may be indicative that survivors are increasingly accessing programmes on prevention and response and that they are more aware of the need to report cases. Figure VI.5 below provides a summary of the reporting rate for 2006 which can be considered as a benchmark for comparison with 2007 and beyond. Programmes are encouraged to improve the documentation and reporting of SGBV-related information. This will increase the availability of comprehensive and reliable statistical data on SGBV which is critical for programme planning, effective response and prevention procedures and for influencing policy development and implementation.

**Fig VI.4 Number of SGBV cases per 10,000 for camps which reported data**




[5] See UNHCR's *Global Appeal 2008-2009*, pp.19-24, November 2007.

**Fig VI.5 Reported SGBV cases per 10,000 for 104 camps which reported data in 2006**




To properly interpret the data, additional research and qualitative information are crucial for a better understanding of the trends in the existing data and to determine if there is any correlation between the different indicators. Better reporting would also help UNHCR to better identify which camps and countries to target as a matter of priority and also to determine the level of additional funding required for relevant activities to address the problem. A comparison of budget allocation across operations is also required as this might impact on services and the reporting of SGBV cases. To facilitate this, UNHCR has instructed its offices to flag budgets for SGBV activities.

## VI.2 HEALTH, HIV, NUTRITION, WATER AND SANITATION

### INTRODUCTION

The public health strategy has been shaped in response to the needs of country programmes to address UNHCR Global Strategic and Regional Priorities in malaria, reproductive and child health, nutrition, HIV and AIDS, sexual and gender-based violence as well as efficient emergency preparedness to the potential Avian and Human Influenza Pandemic. Water and sanitation is a crucial sector in order for UNHCR to meet its objectives in reducing mortality and morbidity as well as improving quality of life among its persons of concern.

Public health, water and sanitation (WatSan) and nutrition/food security programmes must be delivered within a community development framework and in collaboration with refugee beneficiaries and the host community alike in order to minimize mortality and morbidity. In public health programmes, UNHCR plays a policy-making, planning, coordination, supervision, monitoring and evaluation role. To ensure a strengthened protection response, UNHCR works closely with partners who implement public health programmes in a range of challenging settings. Planning of interventions is based on the assessment of needs, vulnerabilities and risks. At the level of individuals and communities, information is used by many stakeholders for various purposes such as prioritisation of interventions or effective clinical management. Moreover, HIV protection, prevention, care and treatment programmes are crucial to reduce the burden of HIV on displaced communities.

Data used in the next section of the Yearbook was derived primarily from the Standards and Indicators and Health Information System (HIS) data collection programmes. The role of a HIS is to generate, analyse and disseminate routine public health data to rapidly detect and respond to health problems and epidemics, monitor trends and address public health priorities, evaluate effectiveness and quality of interventions as well as service coverage (*see also Chapter I on data sources*).

### PUBLIC HEALTH TRENDS

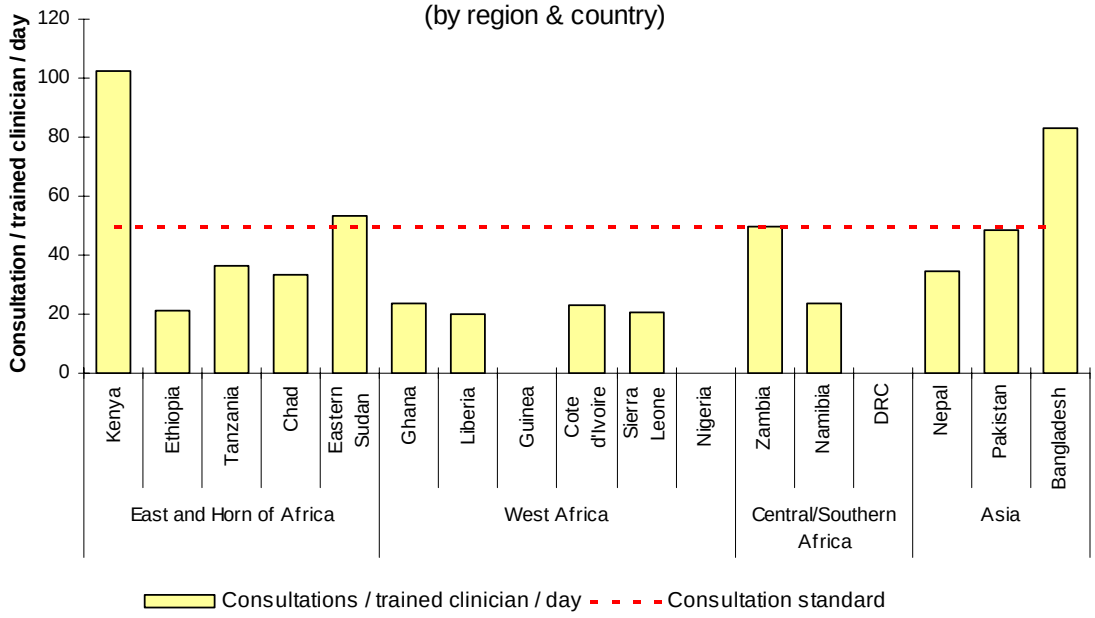
#### ACCESS TO HEALTH

Adequate access to primary health care services, basic nutrition, water and sanitation minimum standards is the precondition to avoid unnecessary mortality and morbidity. On a primary health-care level, access to health is monitored by the

number of consultations per trained clinician per day. This gauges the work (patient) load of clinical staff and health facilities and offers some evidence as to the quality of care.

Figure VI.6 below shows the average number of consultations per trained clinician per day per country for 2006. The upper limit for the number of patients that a clinician is able to attend to per day has been set by UNHCR at 50. The table indicates that the patient load is far too high to ensure quality clinical work in Kenya, Eastern Sudan and Bangladesh. In Kenya, for instance, a clinician would see on average 102 patients per day, pointing to an average time per patient of 3.5 minutes (based on a clinic time of 6 hours per day). It also highlights that the number of facilities and clinicians is insufficient to cover the needs of the population. The recommended annual maximum number of people per health clinic facility and per clinician is 10,000. Yet, particularly in protracted refugee settings, this elevated patient load may also be explained by a disproportionately high prevalence of chronic and psycho-social conditions.

**Fig VI.6 Annual Mean of Clinical Workload 2006**
(by region & country)




## MORTALITY

Figure VI.7 below shows the crude and under-five mortality rates among refugees in camps by selected country. The Sphere standards, or upper limits, for mortality levels are defined with 1.32 deaths per 1,000 per month in Africa and 0.75 deaths in Asia for crude mortality. The respective values for under-five mortality rate have been set at 3.42 deaths in Africa and 1.77 in Asia.[6]

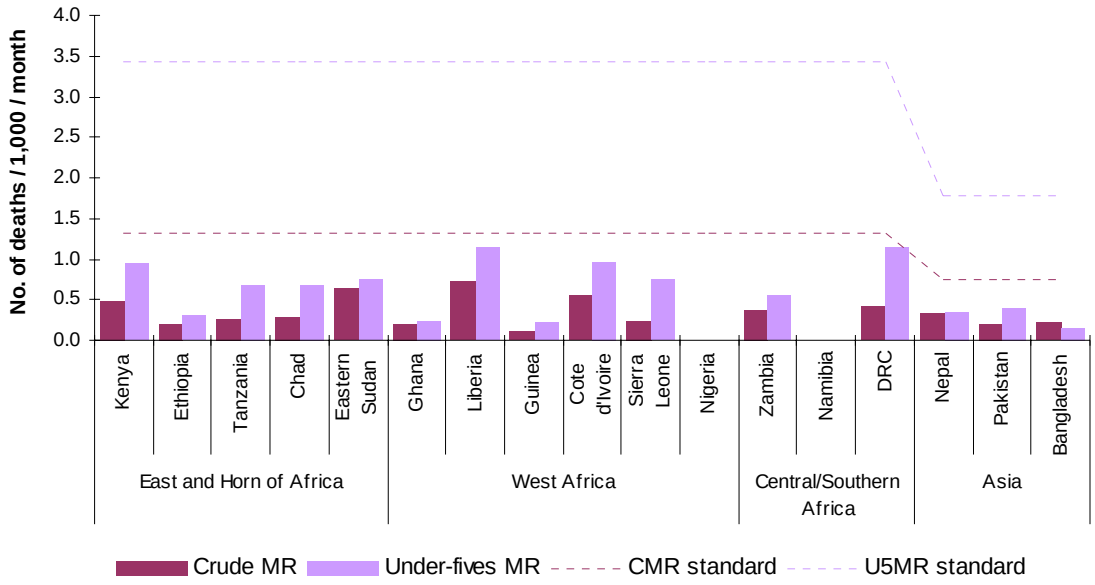
### *Crude and under-five mortality*

The mortality rates for all ages and for under-fives children are consistently below the upper limits (indicated by the dotted lines) indicating that, on average, mortality rates for refugees in camps are lower than for the host population. This, however, is an assumption, not a real comparison. It is based on the fact that the dotted lines represent an average of an upper limit for a "normal" mortality rate in Africa and Asia. Yet, the data quality and consistency of reporting is problematic in some countries. It

[6] The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response.

is important to keep in mind that under-reporting and missing data may skew realistic rates.

**Fig VI.7 Mortality rates among refugee populations 2006**
(by region & country)

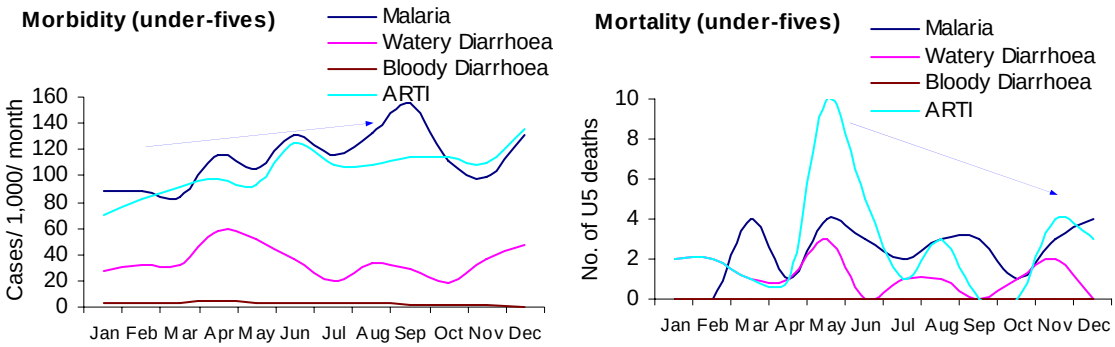



Routine mortality data collection is important. However, it is also known that there is often a difference in findings from data derived from such routine surveillance and, for instance, mortality surveys. The latter would likely produce higher rates. The advantage of routine surveillance is that a deteriorating situation can be detected and responded to without delay.

*Mortality and morbidity by cause*

The graphs below for Kakuma camp, Kenya (Figure VI.8) show that malaria and acute respiratory tract infections (ARTI), the main diseases and causes of mortality, peak nearly simultaneously: during and after the rainy season. The example also shows that despite a continuous increase in incidence, mortality can be reduced (blue arrows). This provides evidence of functioning quality curative care (effective case management) as well as prevention, i.e. information-education-communication materials, distribution of bed nets, blankets etc.

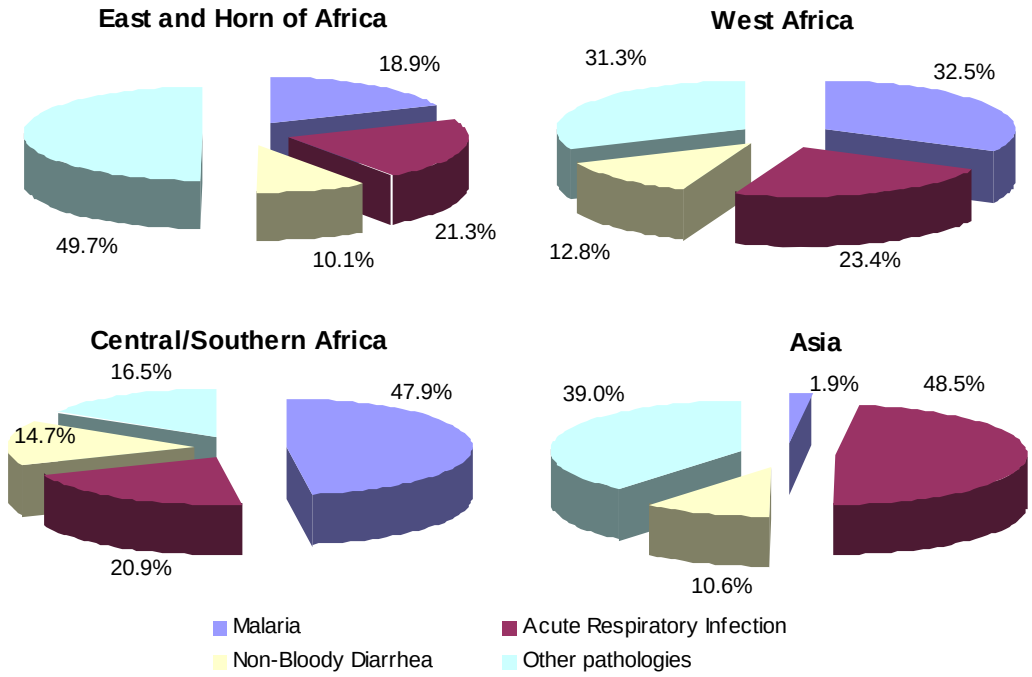
**Fig VI.8 Comparison between disease-specific under-fives mortality and morbidity in Kakuma camp, Kenya 2006**



## MORBIDITY

Children under the age of five are among the most vulnerable and health-risk susceptible groups in refugee populations. Figure VI.9 below transcribes the disease burden in under-five years of age children in selected countries by region. The two single most prevalent diseases are malaria (nearly 50 per cent in the selected southern African countries) and acute respiratory infections. Regional differences in the impact of these diseases between Africa and Asia but also across African regions are highlighted in Figure VI.9. Malaria is the main disease in West and Southern Africa causing at least one third of the morbidity of refugees. It, however, represents less than 20 per cent of morbidity in the East and Horn of Africa. Watery diarrhoea follows with 10 to 15 per cent among under-five consultations. Respiratory infections represent nearly half of all under-fives consultations in Asia.

**Figure VI.9 Proportional morbidity (main diseases) of under-five consultations in selected countries by region**

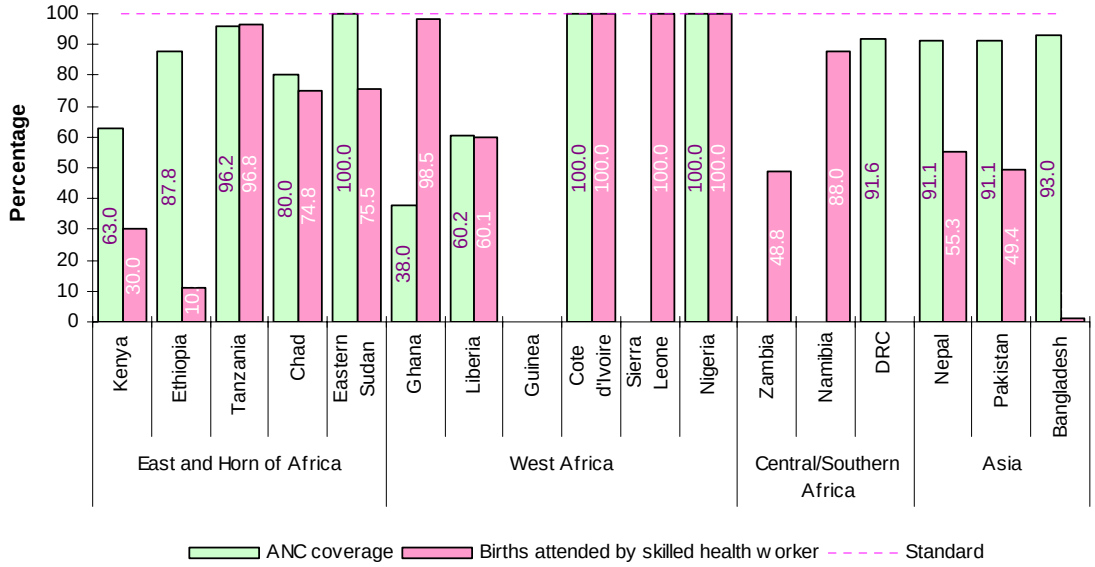



## REPRODUCTIVE HEALTH

Antenatal coverage is generally high in most settings. However, lack of qualified midwives, ill-equipped delivery rooms, and cultural beliefs often prevent deliveries from taking place in health centres (e.g. only 10 per cent of births in Ethiopia attended by skilled health worker, 17 per cent in Nepal). Alternative safe delivery opportunities such as community (midwife) services exist, but fall short of attaining the goal of safe delivery practices overall. Nearly 90 per cent of refugee women in Ethiopia, for instance, utilize antenatal services, but only 10 per cent deliver with a skilled midwife in attendance (*see Figure VI.10 below*).

Other reproductive health priorities such as family planning and SGBV suffer from the lack of data availability and inconsistent reporting. Although reporting is problematic for highly sensitive and stigmatized issues such as sexual violence, UNHCR and its partners must continue to make every effort to ensure availability, access and quality of such services to tackle such priorities.

**Fig VI.10 Antenatal coverage and birth attendance, 2006**
(by region and country)




## HIV AND AIDS

UNHCR is at the forefront of combating HIV and AIDS among refugees and IDPs. The Office strives to develop well-coordinated multi-sectoral and multi-partner approaches in close partnership with refugees and other persons of concern, host communities, governments, civil society, and other UN partners, including UNAIDS. UNHCR endeavours to integrate refugees in the HIV policies and programmes of the countries of asylum. Ensuring that conflict-affected communities have access to the full spectrum (prevention, care, treatment and mitigation) of services related to HIV and AIDS and incorporating issues of general health and livelihood support will reduce their vulnerability considerably as circumstances change. A big challenge is to adapt programming and services to the cultural and religious beliefs of the affected populations (e.g. issues relating to sex, sexuality and condom use) and overcome issues of poverty and social instability that prevail amongst these populations.

### SUMMARY OF REFUGEE INCLUSION IN HIV/AIDS NATIONAL STRATEGIC PLANS

As a result of UNHCR and its partners' advocacy, there has been a marked increase in the number of host countries including refugees in their HIV/AIDS National Strategic Plans (NSPs). Without inclusion in NSPs, protection of and programming for refugee populations are often overlooked.

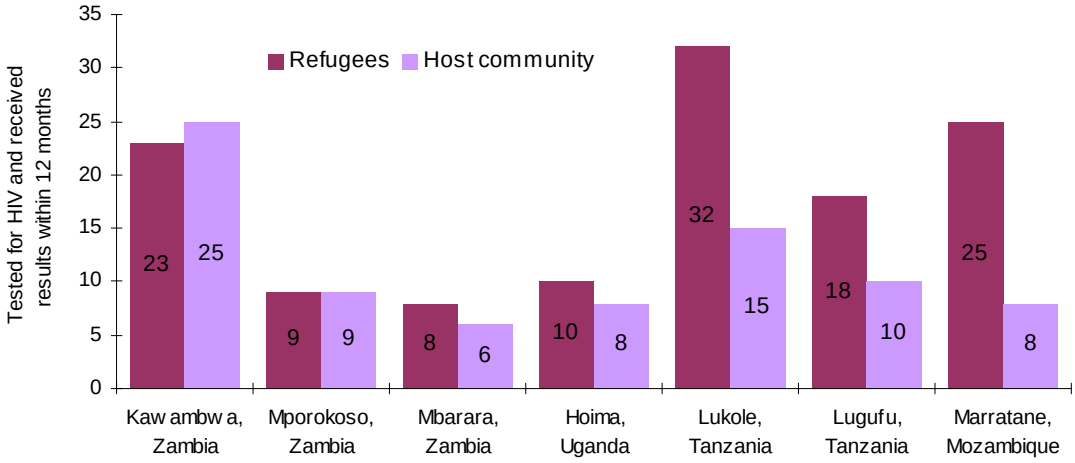
Prior to 2005, only 17 countries hosting more than 10,000 refugees included the latter in their NSPs. Since then, the total number of countries has increased to 32 with the largest increase occurring in Africa. Here, prior to 2005, only 14 countries had included refugees in their NSPs whereas the current number stands at 24. Much more however needs to be done, in particular the inclusion of refugees in Asia and IDPs in general into NSPs. In Asia, for instance, only 6 countries hosting more than 10,000 refugees also mentioned them in their NSPs.

### UTILISATION OF HIV VOLUNTARY COUNSELLING AND TESTING (VCT) SERVICES

Behavioural Surveillance Surveys (BSS) conducted among refugees and their host communities in Zambia, Uganda, the United Republic of Tanzania and Mozambique

found that uptake of HIV VCT services varied widely within countries, between refugees and their host communities, and across refugee populations. In Zambia, one quarter of the refugee population and their surrounding communities in Kawambwa had been tested and received their HIV results in the past 12 months before the survey, while in Mporokoso, less than 10 per cent of both populations had done the same. Access to and uptake of VCT services was limited for both refugees and their surrounding populations in both Mbarara and Hoima in Uganda. Conversely, in Tanzania and Mozambique, refugees were far more likely than their host communities to have been tested and learned their HIV status in the past 12 months. The results of the BSS supported UNHCR and the District National AIDS Commissions to critically review the VCT services in Uganda and Zambia.

**Fig VI.11 Refugees and host community tested for HIV and received results within 12 months**




## Box 5. Case study: HIV trends in returnee areas – Southern Sudan

In 2006, UNHCR implemented a BSS in Juba Municipality, South Sudan, in order to establish baseline HIV-risk behaviour to inform interventions in the area. The survey also provided the first population-level demographic information available in the area since the 2005 peace agreement. Despite widespread fears that returning refugees would "bring" HIV with them back to the area, survey findings, triangulated with census and HIV surveillance data, indicated that there are already more individuals infected with HIV in Juba among populations who were not displaced outside of Sudan than among returned refugees.

**Tab.VI.b Population estimates of the number of PLWH/A* by displacement status in Juba Municipality, South Sudan, 2006**

| | Total pop. | Refugees (8% of pop.) | IDPs (23% of pop.) |
|---|---|---|---|
| Estimated population of Juba Municipality ** | 150, 841 | 12,067 | 34,693 |
| Estimated population 15-49 years old | 68,331 | 7,516 | 15,716 |
| Estimated population 15-49 currently infected with HIV/AIDS *** | 2.3% | 5.0% | 2.8% |

* Persons living with HIV/AIDS.

** Based on pre-census estimates provided by the South Sudan Commission for Census, Statistics and Evaluation, November 2006 and assuming same age structure for refugees and IDPs.

*** Based on a national HIV prevalence estimate of 2.3% (UNAIDS 2003) for the total population and IDPs. Based on a high estimate of 5% HIV prevalence for refugees (multiple surveys, UNHCR) where the highest prevalence was found in Kakuma, Kenya. Refugee prevalence likely overestimated.

Juba will likely experience an increase in HIV prevalence if prevention activities are not stepped up significantly - but this would by no means be due to the returning refugees. In fact, HIV already has a significant foothold in the area, with 20 per cent of VCT clients in Juba testing positive for the virus in 2006. The BSS also found that while male refugees reported more casual sex partners than other male groups, they also had significantly higher condom use. Male and female returning refugees were three times more likely to have had an HIV test and know their HIV status as people in Juba Municipality who had never been refugees. A higher prevalence of Sexually Transmitted Infections (STI) symptoms was also reported for female IDP (10%) and non-displaced groups (8%) than among female refugees (4%).

# NUTRITION

Prevention of acute malnutrition and micronutrient deficiencies among refugees and other persons of concern to UNHCR continues to be a priority in UNHCR's Global Strategic Objectives and programmes.

## ACUTE MALNUTRITION

**Fig VI.12 Prevalence of Global Acute Malnutrition of refugees in selected countries, 2004-2006**
(dotted line indicates the GAM that is considered under control)

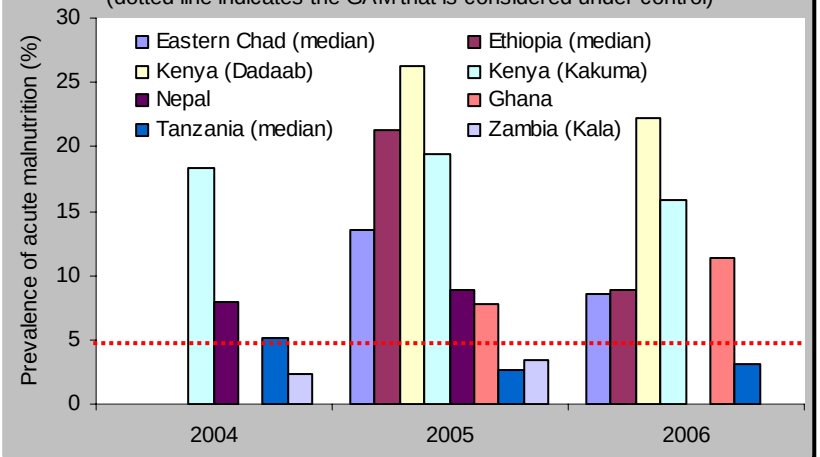


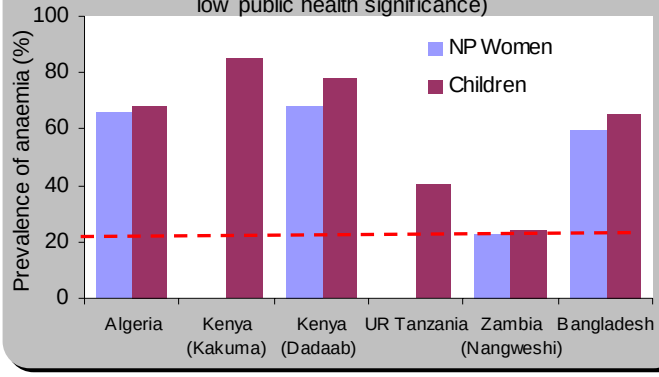

Figure VI.12 displays trends in prevalence of Global Acute Malnutrition (GAM) of refugees in selected countries over 2004-2006. It shows that the nutrition situation in terms of GAM, measured in z-scores[7], has slightly improved in 2006 in most of these selected refugee operations (Kenya, Ethiopia, United Republic of Tanzania, and Eastern Chad), yet remains above the benchmark of less than 5 per cent prevalence. This is in particular the case for Dadaab and Kakuma camps in Kenya where levels are three to four times higher than the acceptable standard. As such, the situation still needs close monitoring in those countries to maintain the momentum and further improve the gains achieved in recent years.

Strategies implemented to address the malnutrition in priority operations include the provision of adequate nutrition, food and public health services as well as proper assessments, in addition to improved technical capacity and coordination with partners. There are also other refugee operations, mainly protracted, where the nutrition situation is critical, calling for more integrated interventions and immediate actions to address the causes of poor nutrition.

## MICRONUTRIENTS

Micronutrient deficiencies (hidden hunger) are highly prevalent among refugees as illustrated in selected camps in Figure VI.13. Many refugee children and women, in some camps in Algeria, Bangladesh and Kenya reaching even values of more than 60 per cent, suffer from high levels of anaemia. Malnutrition including

**Fig VI.13 Prevalence of anaemia among non-pregant (NP) women and children, 2004-2006**
(dotted line indicates prevalence of aneamia that is of low public health significance)




[7] Z-score is the deviation of an individual's values from the mean value of a reference population taking into consideration the standard deviation of the reference distribution.

micronutrient deficiencies among women prior and during pregnancy limits the ability of the foetus to grow, leading to low birth weight, which is associated with increased mortality, impaired mental and physical development and increased susceptibility to diseases throughout the life cycle. Iron plays an important role in cognitive development during foetal development.

## WATER AND SANITATION

Water and sanitation provision in UNHCR refugee operations (2003 to 2006) was reviewed to identify gaps in current service provision. Inadequate water and sanitation services will increase transmission of water-borne diseases and compound malnutrition problems. Indeed, malnourished individuals have compromised immunity and are not only more likely to contract many communicable diseases, but also suffer from more frequent, severe, and prolonged episodes of these diseases.

Several sources were used, including data from the Standards and Indicators Report, and are summarised in Tables VI.c and VI.d. These tables demonstrate the overall median and average values for water supply and median values for latrine coverage across UNHCR refugee operations (20 litres of water/person/day and 1 latrine per less than 20 persons). The analysis shows that for large numbers of camps, the average water supply and number of latrines available is inadequate according to UNHCR standards. In fact, the numbers of camps with insufficient water supply was over 40 per cent in each of the three years. Over a quarter of the camps have access to fewer latrines than needed according to UNHCR standards. It is, however, estimated that many more camps have problems of poor maintenance and low user rates of latrines.

**Tab.VI.c Results from S&I: per capita water availability (litres/ person/day, 2003-2006), annual averages per camp**

| | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|
| No. of camps with data available | 92 | 73 | 93 | 125 |
| Median | 20.2 | 22.0 | 20.1 | 18.3 |
| Average | 23.1 | 35.0 | 31.3 | 35.8 |
| % of these camps meeting UNHCR 20L/day standard | 54 | 59 | 53 | 46 |
| Average % of population in camps meeting the UNHCR 200m access distance standard | 86 | 72 | 77 | 84 |

**Tab.VI.d Results from S&I: excreta disposal availability (persons / latrine, 2003 to 2006)**

| | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|
| No. of camps with data available | 89 | 81 | 90 | 81 |
| Median | 10.9 | 11.0 | 6.4* | 10* |
| Average | 27.7 | 36.0 | 26.9 | 17.0 |
| % of these camps meeting UNHCR excreta disposal standards | 74 | 67 | 83 | 70 |

**based on family latrine coverage figures assuming 5 people per family on average*

Issues in temporal and spatial differences in access to services across camps cannot be dealt with by single annual average indicators as provided in the tables above. Therefore, detailed household surveys were conducted to gain more information on the camp-level water and sanitation services. The results from three household surveys carried out to assess the level of water and sanitation provision in typical refugee camps within a range of settings are presented in Table VI.e below. These highlight the key parameters associated with water and sanitation services and have been grouped into results related to background, access, usage, sanitation and hygiene.

The average water quantities and distance to the source mirror the values provided by the Standards and Indicators Reports and comply with the UNHCR standards of 20 litres/person/day and a maximum of 200 meters to the water source respectively.

The fact that women and children are charged with water collection in the vast majority of cases has negative impact on child education, especially girl's. Monthly or more frequent interruptions in water availability are widely reported with the main coping strategies in the three camps being to use less water, buy or borrow water or walk further in search of water, the latter increasing the risk of attack. Disputes at water points are also commonly reported. Such points highlight the need to adequate WatSan service provision and conducting surveys like the ones analysed above help map the gaps and the way forward.

**Tab.VI.e Results from three household (HH) surveys carried out in refugee camps**

| | Parameter | Budumburam (Ghana) | Dadaab (Kenya) | Nakivale (Uganda) |
|---|---|---|---|---|
| | Date of survey | 12/2005 | 06/2006 | 02/2007 |
| *Back-* | Camp population | 10,000 | 50,000 | 23,000 |
| *ground* | No. of households interviewed | 840 | 285 | 395 |
| | Median household size | 6 | 6 | 5 |
| | % of respondees female | 79 | 64 | 67 |
| | Average time spent on water collection (minutes) | 35 | 99 | 92 |
| | Average distance to main source of water (m) | 153 | 163 | 1825 |
| *Water* | % of HH where no women or children are involved | 11 | 6 | 21.5 |
| *access* | in water collection (i.e. adult males only) | | | |
| *issues* | % of HH where school-going children collect water | 59 | 59 | 72 |
| | if yes, % arrive in school late | 29 | 39 | 60 |
| | % fail to do homework | 20 | 27 | 55 |
| | % reporting monthly or more frequent interruptions in water supply | 55 | 79 | 90 |
| | Average water usage (litres/person/day)[1] | 40 | 20.5 | 15.2 |
| *Water* | Usage breakdown %: | | | |
| *Usage* | Bathing & Laundry | 66 | 31 | 52 |
| | Cooking & Drinking | 26 | 23 | 36 |
| | Cleaning, Gardening etc. | 8 | 46 | 12 |
| | % with separate drinking water container | 88 | 93 | 67 |
| | Frequency of cleaning of this container[2] | 67% daily | 64% daily | 38 daily |
| | % with a designated latrine | 11 | 95 | 69 |
| | Average distance from shelter to latrine (m) | 6 | 15 | 15 |
| *Sanitation* | % of HHs disposing of child excreta in latrine | 31 | 87 | 90 |
| *and* | % of HH who received hygiene training | 23 | 32 | 50 |
| *Hygiene* | % of HH with access to a mosquito net | 8.2 | 74.6 | 53 |

1 = All of the Dadaab camp supply is chlorinated and distributed via tap stands; much of this figure of Budumburam supply is from unprotected sources and is used for washing and cleaning while one sixth of respondees state they use some form of household treatment. The Uganda supply is from a mixture of treated water and untreated lake water.
2 = The proportion of containers assessed as clean (inside and outside) was approximately 75 per cent in all camps.

## IMPLICATIONS AND RECOMMENDATIONS

The data and key results outlined above illustrate that although many gaps and unmet needs remain, advances towards reaching UNHCR's and international standards in key technical sectors have been achieved. Yet, these achievements are not sufficiently consistent nor are they yet sustainable. While many of the 'impact' public health indicators were found to be within acceptable ranges and below the set standards for the majority of UNHCR's operations, compounding aspects such as nutrition, water and sanitation have fallen short of significant benchmarks, regardless of the overall improvements in the health of the populations compared to previous years.

The improved data collection and reliability in data analysis has helped UNHCR and its partners to better understand operational gaps and strengthen technical competencies. The operational integration of the HIS has heavily contributed to the quality and consistency of programme monitoring. The effect of this evolutionary process is seen in improved reactions to health needs on the ground as well as to the contribution to formulating evidence-based policy and decision making.

Dealing with the health, nutrition, HIV and WatSan sectors in relative isolation does not maximize the potential overall benefits of the programmes and may even hinder progress in other sectors (UNHCR, 2006).[8] To reach a consensus on priority strategies for health, HIV, nutrition/food security and WatSan, joint consultations and integrated plans of action are needed across these sectors as well as numerous other sectors, such as protection, gender, education, and community services.

Operationally, the key recommendation is to continue to improve the consistency and quality of public health data collection in a sustainable manner. The Health Information System is a tested and proven means to achieving this goal. It should thus be distributed, shared and implemented beyond refugee camp situations. Furthermore, a strong effort must be taken to integrate the HIS also into existing data management systems in UNHCR. Thus, the flow of information between operational partners and UNHCR on the implementing side, and UNHCR field, regional and HQ offices on the institutional side, must further be streamlined and integrated within the overall institutional information management.

[8] UNHCR (2006), Standing Committee Paper on Nutrition, Executive Committee of the High Commissioners' Program, 36th meeting of the Standing Committee (EC/57/SC/CRP.17), June 2006.