Syrian refugees at a distribution centre in Za'atri camp, Jordan

Providing for Essential Needs

Access to clean water, shelter, household energy, food and health care is something that many people take for granted. Yet, it has been a daily struggle for most refugees caught up in multiple crises in 2013. Despite the remarkable support and solidarity provided by the international community, UNHCR and partners sometimes find their capacity to provide for even the most essential needs of displaced populations stretched beyond the limit.

In 2013, UNHCR took a new look at how to improve the ways in which it responds and provides essential needs for refugees and other displaced populations. This chapter describes the new strategies launched, looks at some of the key achievements and highlights areas that require particular ongoing attention.

UNHCR / J. KOHLER

NEW GLOBAL STRATEGIES DEVELOPED IN 2013

UNHCR developed new five-year strategies in 2013 to guide its programmes through to 2018. They cover public health, HIV and reproductive health, food security and nutrition, water and sanitation (WASH), settlement and shelter, livelihoods (see also chapter on *Encouraging Self-Reliance*), and safe access to fuel and energy. Each of the global strategies has a strong protection and solutions orientation, and all are shaped by a common set of guiding principles aimed at ensuring equity, access and community empowerment through an age, gender and diversity (AGD) approach.

The new strategies aim to ensure that UNHCR's programmatic interventions are appropriate and sustainable. They focus on communication and advocacy; partnership, coordination and capacity-building; and evidence-based decision-making, coupled with impact measurement. Their implementation builds upon achievements in 2013, examples of which are outlined in the matrix.

AREAS OF INTERVENTION	ACHIEVEMENTS IN 2013
Public Health	■ Developed a new five-year strategy for public health ■ Launched operational guidance on mental health and psychosocial support, community-based work forces, hepatitis E and the provision of medicines ■ Completed 31 balanced score card evaluations in nine countries and piloted the prospective surveillance tool in two urban settings ■ Provided technical support to operations in the Congo, the Democratic Republic of the Congo (DRC), Gabon, the Islamic Republic of Iran, Malaysia, the Russian Federation, Rwanda and Thailand on the inclusion of refugees in health insurance schemes
Water, Sanitation and Hygiene (WASH)	■ Developed a new five-year strategy for WASH ■ Successfully implemented the WASH monitoring system in 64 camps, allowing for real-time monitoring of the effectiveness of interventions ■ Strengthened WASH in emergencies through the deployment of qualified technical staff, the use of WASH emergency kits and the fielding of support missions ■ Implemented innovative solutions, including the use of satellites to monitor the quality of water and solar-powered water supply systems
Reproductive Health and HIV	■ Developed a new five-year strategy for reproductive health and HIV ■ Reviewed 37 adolescent sexual and reproductive health programmes with partners to inform future programming ■ Deployed HIV experts in the Central African Republic, the DRC, Mali and South Sudan ■ Conducted neonatal mortality surveys in Chad and the United Republic of Tanzania to inform operational guidance on the subject
Nutrition and Food Security	■ Developed a new five-year strategy for nutrition and food security ■ Conducted 83 nutritional surveys and provided technical support to survey teams in Botswana, Yemen and Zambia ■ Initiated a pilot project in Niger involving blanket supplementary feeding and nutrition surveillance, using mobile data collection ■ Conducted joint assessment missions with WFP in 10 countries
Environment and Energy	■ Developed a new five-year strategy for safe access to fuel and energy ■ Undertook baseline surveys in Chad, Ethiopia, Kenya and Uganda to assess the impact of energy technology, including lanterns, streetlights and stoves ■ Established a carbon-financing scheme to provide refugees in Rwanda with fuel-efficient stoves ■ Produced software that will enable UNHCR to estimate the energy needs of refugee camps
Settlement and Shelter	■ Developed a new five-year strategy for settlement and shelter ■ Deployed 32 settlement and shelter experts in 15 countries ■ Developed the "master plan approach", a more holistic and comprehensive approach to settlement planning ■ Field-tested three newly developed tent designs in Burkina Faso with the national Red Cross Society, ICRC, IFRC, and the Norwegian Refugee Council

PUBLIC HEALTH

"All refugees are able to satisfy their rights in accessing life-saving and essential health care; HIV prevention, protection and treatment; reproductive health services; food security and nutrition; and water, sanitation and hygiene services" – UNHCR's Global Strategy for Public Health 2014-2018.

The lives of many refugees continue to be affected by disease, a lack of clean water and proper sanitation, malnutrition, and a dearth of child, HIV and reproductive health services. The new public health strategy provides a comprehensive response to these challenges and is relevant inside and outside camps, in low, middle and high income countries.

UNHCR will promote sustainable service delivery through the integration of refugees into national health care systems and by enrolling refugees in special health insurance programmes. Meeting and maintaining minimum humanitarian standards, ensuring access to life-saving services and averting abnormal mortality and morbidity levels will remain the goals of UNHCR's public health activities.

The public health strategy seeks to create synergies among health-related sectors – for example, between water and sanitation and the treatment of communicable diseases – and with other areas covered by the other Global Strategies, such as between mental health and sexual and gender-based violence (SGBV), and nutrition and livelihoods. Implementation will be driven by data and evidence, making full use of *Twine*, UNHCR's online health information platform which manages and analyses public health data collected in refugee operations. The platform was expanded in 2013 to include primary data collection tools in both camp and out-of-camp settings.

On *Twine*, more than 1,500 registered users regularly upload reports with key performance and impact indicators collected in the field. In 2013 alone, 44 country operations and 216 reporting sites contributed indicator data used in the Public Health Section's annual reports. The use of mobile devices for data collection was expanded for the completion of 88 standardized expanded nutrition surveys (SENS).

One example of the impact of UNHCR's investment in this work on health-related issues could be seen in Burkina Faso. Data collected using SENS in February 2013 detected

● *Bringing specialized mental health care to refugees in Dadaab, Kenya*

The launch of operational guidance on *Mental Health and Psychosocial Support Programming for Refugee Operations*, developed together with WHO, has provided a helpful tool for UNHCR staff and partners working in field operations. One example of how this is being put into practice is in Dadaab, Kenya.

Refugees with severe mental disorders in the Dadaab refugee camps are now being cared for by certified psychiatric nurses. Meanwhile, teams of trained refugee workers help in identifying people with mental disorders in the community and providing support at home for their families. Regular visits by a mental-health specialist from Nairobi also support the programme. June 2014 will see the start of training for refugee workers using the operational guidance. ■

Eradicating polio from the Horn of Africa

Poliomyelitis is a highly infectious viral disease affecting young children. Although easy to prevent, polio re-emerged among Somali refugees in Kenya in 2013 due to population movements and incomplete immunization coverage. In response to the outbreak, the Kenyan Ministry of Health, WHO, UNHCR and UNICEF implemented a series of short-interval mass immunization campaigns. Two kinds of vaccines were used to enhance immunity. The campaign was a success, as more than 90 per cent of refugees were immunized against the disease. The success was due in part to effective logistics management and community mobilization, which allowed UNHCR to provide fixed, mobile and household vaccination services. The last case of acute flaccid paralysis, the most common sign of acute polio, was seen in July 2013. ■

excessive levels of anaemia in all camps in Burkina Faso and a high incidence of acute malnutrition in Goudebou Camp. In response to these findings, the Office began blanket feeding in Goudebou with *Super Cereal Plus*, a nutritious, porridge-like corn and soya blend, for children aged between 6 and 59 months. UNHCR will also use the micronutrient powder *Nutromix* in all its blanket-feeding programmes.

SETTLEMENT AND SHELTER

"All refugees are able to satisfy their settlement and shelter needs in a safe, dignified and sustainable manner wherever they live, be it in urban or rural settings" – UNHCR's Global Strategy for Settlement and Shelter 2014-2018.

UNHCR's global strategy for settlement and shelter aims to improve the quality of life among both refugee and host communities and help achieve durable solutions. Poorly planned settlements and badly conceived shelter solutions have serious protection consequences. It is therefore essential to take into consideration sustainable and technically sound settlement and shelter strategies in contingency planning and during the earliest stages of an emergency response.

An important feature of the strategy is the "master plan" concept, which seeks to link refugee camps and settlements to surrounding communities in a more holistic and sustainable way, taking into account socio-economic dynamics, environmental considerations, local resources and services, and infrastructure. It has been developed with Stanford University and Ennead Architects.

In refugee settlements in Rwanda, UNHCR and its partners are currently testing a toolkit developed to support the master plan approach. The toolkit provides technical guidance, checklists, decision-making aids and good practice information. The master plan in Rwanda will reflect a consensus on the settlement response among the host communities, the affected population and the humanitarian and development actors. A new settlement in Mugombwa, Rwanda,

NUTRITION AND HEALTH

Thanks to sustained focus on acute malnutrition management measures undertaken in all camp health centres, the results of the nutritional survey conducted amongst Sudanese refugees in **eastern Chad** indicated that Global Acute Malnutrition fell from 11.6 per cent in 2011 to 10.1 per cent in 2013. Over 7,800 severely malnourished children were treated under the outpatient therapeutic programme (OTP) and some 16,600 moderately malnourished children were treated through supplementary feeding programmes (SFP) in 13 camps, including the new camp in Abgadam. Cured rates were satisfactory, at 84.8 per cent for OTP and 84.4 per cent for SFP. Since July 2013, all children aged 6-24 months in all 13 camps have been targeted with *Nutributter* interventions. *Nutributter* is a micronutrient-rich food supplement for the prevention of malnutrition and anaemia. Since July 2013, over 12,600 beneficiaries have received *Nutributter* supplements out of 13,600 registered (coverage of 93 per cent). The impact of this intervention will be measured through a nutritional survey in the second half of 2014.

In the Dollo Ado camps in **eastern Ethiopia**, the nutrition situation has also improved significantly from the critical levels registered during the 2011 emergency. However, the current prevalence of acute malnutrition remains at or above the WHO emergency threshold of 15 per cent in all camps. Persistent refugee influxes throughout 2013 affected efforts to maintain nutritional stability in the camps owing to the need to share resources with new arrivals. This kept the camps in emergency mode despite the measures already in place. Furthermore, the refugees were mainly dependent on general food rations, with limited access to other sources of fresh food or income.

Selling food rations and nutritional supplements was a common phenomenon as families struggled to cater for other basic needs. Although post-distribution monitoring showed that the refugees received almost 100 per cent of their entitlements in all five camps, the nutrition survey found that only 3 to 15 per cent of households reported that the ration lasted for the entire cycle. Monthly monitoring reports suggest that the general rations did not last because a portion was being sold to buy other preferred food products, basic items, firewood or to cover milling costs.

In response, UNHCR is introducing a pilot food assistance initiative under which delivery of a combination of cash and food will give the refugees more choices, for example to buy certain preferred food items or to pay for milling costs. Furthermore, a number of nutrition and food-security activities, such as treatment programmes for acute malnutrition, will be provided in 2014. Livelihood options will be increased and expanded, timely replacement of core relief items will be prioritized and alternative energy sources will be explored.

SHELTER

An estimated 40,000 people fled to **Burkina Faso** in 2012, following the turmoil in Mali. The housing situation was not satisfactory, with only 60 per of refugees living in adequate dwellings. By the end of 2013, all refugees were living in adequate dwellings, following the rehabilitation and construction of over 12,300 shelters. This success can be attributed to: effective partnerships between local and international entities with solid technical knowledge and capacity; the provision of rehabilitation kits which ensured that despite usual wear-and-tear as well as extreme weather conditions, the shelters continued to protect refugees; active participation of refugees in the construction of their respective shelters which they were able to adapt to their own individual needs; and consultations with upgrading of the current shelters based on extensive consultations with the refugee community on their preferred design and type of material prior to developing prototypes for an upgrading of the current shelters.

At the end of 2013, **the Syrian Arab Republic** reported an alarmingly low percentage of households living in adequate dwellings. The current situation is compounded by the sheer magnitude of needs of the millions of internally displaced people (IDPs), and the volatile security situation across the country which limits the delivery of assistance in key locations. The Government's decision in September 2013 to relocate IDPs who were occupying schools led to people seeking refuge in unfinished, sub-standard buildings.

Despite these obstacles, UNHCR is working closely with the Ministry of Local Administration and partners to rehabilitate buildings and provide individual housing units as well as tents. Specific focus has been placed on improving buildings and conducting detailed technical assessments in various governorates to identify additional buildings to rehabilitate for IDPs. In collaboration with UN-Habitat, UNHCR is looking beyond emergency assistance and conducting in-depth shelter needs assessments, notably in Lattakia, as part of planning for more durable shelter solutions.

UNDER-5 MORTALITY RATE

Refugees from the Central African Republic fleeing to **southern Chad** often arrive in a precarious condition. Food insecurity resulted in high rates of malnutrition, and malaria and outbreaks of measles endangered the lives of children in particular. While measles vaccination coverage among children under five years in the camps was increased, reducing the risk of transmission, measles cases were observed among newly arriving children and adolescents. In this case, high-quality immunization campaigns are needed to reinstall population-level immunity. Malaria prevention remained a key means of reducing morbidity, mortality and continuous transmission of the disease. A combination of distribution and use of mosquito nets, in-door residual spraying, community participation and integrated management of disease is required to break the transmission.

In **Zambia's** Mayukwayukwa camp, the under-five mortality rate dropped from 1.6/1000/month in January to 0.5/1000/month at the end of 2013, which was a major success. Yet, despite intensified maternal and child health activities, measles immunization coverage fell back from 89 per cent in January to 68 per cent at the end of 2013. An assessment revealed problems with vaccine cold-chain equipment and continuous vaccine availability for routine immunization; an area that needs to be strengthened in 2014.

Malaria and diarrhoea, the main causes of child morbidity and mortality, were significantly reduced through two child health campaigns covering health education, child immunization, health screening for malnutrition and the provision of Vitamin A supplements and deworming medicines. Over 6,500 mosquito nets were distributed, resulting in a reduction in malaria morbidity from 71 per cent to 48 per cent.

WATER

Dadaab camp in **Kenya** made progress with regard to the water supply. Four years ago, the average water supply was 12 litres per person per day for a population of around 250,000 refugees. In 2013, some 408,000 refugees received on average 26 litres per person per day. Increased access to safe water has significantly reduced diarrhoea cases in the camps. In addition, the proximity of water collection points has reduced the risk of sexual harassment. To reach this level of service, the systems were reviewed using computer modelling, which helped identify areas that needed strengthening. As a result, five new high-yield boreholes were drilled, replacing low-yield boreholes. In addition, new storage tanks of 150 m3 each were constructed and a 24-kilometre pipeline was laid to ensure better distribution of the water across the camp, raising the water pressure and reducing waiting time at the tap stands.

The situation in **Kenya's** Kakuma camp deteriorated. Water supply decreased from 23 to 17 litres per person per day. One of the reasons was the considerable rise in the refugee population during the reporting period which stretched financial resources. The water system that was initially planned for 100,000 refugees could no longer meet the needs of the expanded camp population of 128,000 refugees. As a result, about 33 per cent of the refugee population had to walk more than the recommended distance of 200 metres to access the nearest water-tap point; and the number of people per usable tap increased from 79 in January to 102 by the end of December. The situation was further affected by official licensing restrictions on the drilling of new boreholes. ●

Funding for safe and eco-friendly cooking

In what is its first carbon-financing agreement, UNHCR has teamed up with *atmosfair*, a climate protection organization, to bring fuel-efficient stoves to refugees in Rwanda. The aim of the agreement is to increase refugees' access to energy while reducing environmental degradation. Ultimately, this new initiative will enhance the quality of life of refugees and members of host communities.

Carbon financing is an innovative funding tool that places a financial value on carbon emissions. It allows companies wishing to offset their own emissions to buy carbon credits earned from sustainable projects, such as those that bring sustainable energy solutions to people living in developing countries around the world – in this case, the displaced. UNHCR seeks to improve the living conditions of those it cares for by capitalizing on these efforts. ■

provides UNHCR with an excellent opportunity to test the master plan approach and monitor its impact on the lives of refugees and host communities. The ultimate goal is to ensure that all individuals benefit equally from adequate living conditions and protection, thereby promoting peaceful coexistence.

FUEL AND ENERGY

"All refugees are able to satisfy their energy needs for cooking and lighting in a safe and sustainable manner, without fear or risk to their health, well-being and personal security" – UNHCR's Global Strategy for Safe Access to Fuel and Energy 2014-2018.

The global strategy for safe access to fuel and energy (SAFE) supports the notion that safe and reliable access to energy for cooking, lighting and power is a basic need for everyone. For many refugees, cooking a meal or obtaining light at night is a daily struggle. Without light, refugees cannot move around safely and children are unable to study. The lack of sustainable energy sources also forces refugees to spend hours searching for firewood. This exposes them to protection risks, including SGBV, and prevents refugee children from going to school.

The unmanaged use of scarce fuel resources also damages the environment and brings refugees into conflict with host communities. The SAFE strategy seeks to ensure that domestic-energy programmes respond to protection concerns across sectors, ranging from health and nutrition to livelihoods, education and the environment. Energy interventions will be based upon technically-sound assessments and feasibility studies, as well as the use of sustainable technologies. The SAFE strategy also opens up new opportunities for partnerships and the use of creative funding mechanisms, such as carbon financing. ■

From supermarkets to refugee camps, bar-codes speed up the process of distributing food

This article is an adapted version of a UNHCR news story

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UNHCR / S. CANSIZOGLU

UNHCR staff at the Yida camp in South Sudan work on the monthly distribution of food rations for refugees. A new tool has cut the time it takes to complete the process from 10 days to four.

YIDA, South Sudan, July 2013 |
Bar-code technology more commonly seen in supermarkets is enabling the UN refugee agency to greatly improve the speed at which monthly rations of food and relief items are distributed to refugees living in camps in South Sudan.

During the distribution process, family members present their ration cards to staff who then scan them and retrieve photographs and registration information on all of the individuals recorded on the card. Previously, staff had to refer to a printed list of all families living in the camp, a lengthy process and one which inevitably led to mistakes. At the Yida settlement in South Sudan, which is home to more than 70,000 refugees, the bar-code tool has allowed UNHCR to cut the time it takes to complete the distribution from ten days to four.

The technology also reduces the risk of fraud. By being able to see the registration information and photographs of all of the family members listed on the card, staff can ensure that the rations only go to the right recipients, making it much more difficult for the cards to be used by individuals who are not registered with UNHCR. The technology also quickly generates valuable data on how many people are receiving the rations, their age, gender and other biometrics. If a card is determined to be invalid, its owner has the opportunity to argue his or her case at a desk set up to arbitrate disputes within the distribution centre.

Recently, the World Food Programme (WFP) requested that the tool be modified so that it could be used for the organization's milling voucher project, which allows refugees to access local services to mill the sorghum they receive as part of their monthly food rations.

Jabralla, a refugee who fled South Kordofan state in neighbouring Sudan in June 2011 with his family, appreciates the more streamlined process for the distributions. "The bar-codes have cut the time we need to wait in order receive our assistance, so it no longer takes days as it did before," he said.