CHAPTER VI
WELFARE AND LIVING CONDITIONS OF REFUGEES: CASE STUDIES

INTRODUCTION

UNHCR compiles statistics on the size, the distribution and the well-being of its population of concern. Size and distributional data come from monthly, quarterly and yearly reporting processes with standardized forms and guidelines which have been used for many years. All UNHCR offices provide total numbers and distribution of population of concern by various characteristics, using wherever possible UNHCR registration, NGOs or official government data. However, the quantification of protection needs, living conditions and welfare of refugees, was until recently less systematic and standardized. The provision of quantitative indicators was mainly based on ad-hoc surveys or reports from specific offices.

Since 2002, a consultative process both within UNHCR and with external partners resulted in a guidebook on what has been labelled UNHCR Standards and Indicators (S&I). Not only does this guidebook include a list of quantifiable indicators on different themes, but it also set standards to assess protection, living conditions and welfare of the populations of concern. In addition to being part of UNHCR's implementation of the Results-Based-Management (RBM) approach adopted in 1998, the S&I initiative ensures that information on protection, welfare and living conditions is reported in a consistent manner across UNHCR operations.

In 2003, the "Camp Indicator Report" (CIR) was introduced to capture and report data related to the situation of selected indicators in refugee camps. In 2004, a revised guidebook was published which recognized that the first edition did not provide an exhaustive list of indicators to measure the well-being of refugees. In 2005, UNHCR started considering non-camp based refugee situations, namely those related to urban and returnee areas and also introduced access-right data at the country level. This resulted in the production of an additional list of indicators. Through the new Standards & Indicators Report (SIR), UNHCR is now able to collect information on over 150 camps (with more than 2,500 persons); over 100 countries with urban refugees; and a sizeable number of reintegration country operations.

Other protection and welfare data sources include UNHCR's registration software "proGres" launched in 2004, the Health and Nutrition Information System (HNIS) currently being piloted in some 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 mechanisms.

Recently, internal and external requests for UNHCR statistics showed an increasing interest in welfare and living conditions of the population of concern. Within the organization, headquarters and field offices alike use S&I data for resource allocation and prioritization of their activities. Other UN agencies, donors, NGOs, the media and academia are interested in the welfare data primarily for assessing the effectiveness of interventions, for accountability, research activities or simply public information.

Data from different years, camps and countries are not fully comparable because of the different data collection activities and the various changes in the reporting instruments, methodologies used by implementing and operational partners as well

as indicators and standards over time. However, case studies on comparable methodologies and data can be used to illustrate some of the protection and assistance issues beneficiaries are facing. UNHCR is currently working on harmonizing methodologies in order to ensure data comparability across countries, locations and years.

Owing to the difficulty of ensuring data quality and geographic and time trend comparability, it is very difficult to provide a global quantitative and representative picture of UNHCR protection and assistance activities, beneficiaries' needs and gaps to meet the Office's standards. Therefore, this chapter presents case studies based on selected data sources and for a limited number of countries. The main objective of this chapter, which can be considered as a pilot undertaking, is 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 2005 Yearbook attempts to support the decision-making process. This is an addition compared to previous editions of the Statistical Yearbook which primarily analysed the levels and trends of UNHCR's main categories of population of concern.

Four main topics were selected to reflect the living conditions and welfare of refugees and other persons of concern to the Office: Protection, Nutrition, HIV/AIDS and Water/Sanitation. This chapter presents for each of the four topics outlined above:

- a short explanation of the topic's relevance;
- current and potential data sources;
- levels and trends in refugee or refugee-like situations, reflecting on information availability and gaps; and
- policy and operational implications of the findings.

VI.1 INTERNATIONAL PROTECTION

BACKGROUND AND DATA SOURCES

While the main responsibility for safeguarding the rights of refugees remains with States, UNHCR's statutory role is to assist governments to do so. UNHCR's international protection function has evolved greatly over the past five decades from offering a substitute for consular and diplomatic protection, to ensuring the basic rights of refugees, and increasingly their physical safety and security. In fulfilling its mandated responsibilities, UNHCR has had to contend with a rapidly changing and complex protection environment.

Protection function is multifaceted. In general terms, it entails: field protection interventions to ensure rights are respected and principles adhered to; development of international and national legal frameworks to put these rights in place; the promotion of resolute implementation of these frameworks of rights and principles; the building of civil society constituencies in support of protection; the training of all "users" on protection concepts; and the realisation of protection sensitive and lasting solutions.

Given the complexity of the political and operational environment, the availability and quality of protection cannot always be illustrated by quantitative indicators alone. However, statistics can provide valuable indications of protection gaps, demonstrate emerging trends and developments over time, and, more importantly, bring to the fore information on the impact of UNHCR activities. Through collection and analysis

of statistical data, UNHCR has access to 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 people of its concern.

UNHCR has access to a range of data sources relevant to protection, including the results-based management software, the proGres registration database, the Annual Protection Report which captures detailed information from all UNHCR operations and the Standards and Indicators initiative. Together with the availability of increasingly detailed demographic data, these tools provide UNHCR with a comprehensive global picture of the well-being of all persons of concern and the gaps which remain to be filled.

PROTECTION LEVELS FOR SELECTED INDICATORS

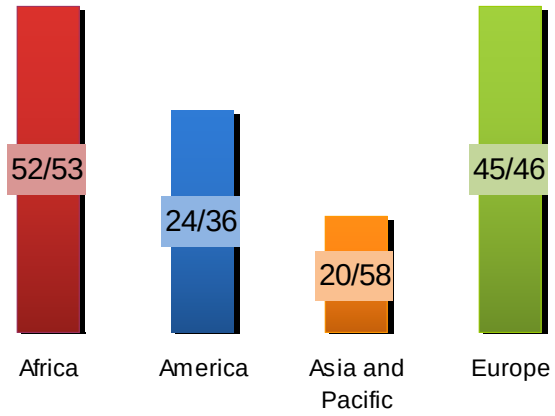
Drawing from the sources mentioned above, UNHCR has access to information on a broad range of indicators for measuring gaps and progress in protection. These include detailed global statistics on persons of concern to the Office, information relating to the development of the international legal regime, assessments of States' compliance with core protection principles, situation of girls, boys, women and men with special needs. Finally, UNHCR compiles detailed information on resources available for protection, be it in terms of staffing or required funding. The following paragraphs are illustrative of the type of information available to the Office.

ACCESSIONS TO THE 1951 CONVENTION RELATING TO THE STATUS OF REFUGEES AND ITS 1967 PROTOCOL

During the elaboration of the 1951 Convention, 26 countries sat at the negotiation table. By 2005, 146 States had signed the Convention and/or its Protocol. Over the last few years, however, the accession of new States has stagnated. The accession of Afghanistan, both to the Convention and the Protocol, is the most recent, dating back to 30 August 2005. UNHCR continues its promotional efforts to increase the number of States Parties. Even though adequate protection is granted in many countries which are not signatories, the 2001 Declaration of States Parties to the Convention encouraged all States that have not yet done so to accede to the 1951 Convention and/or its 1967 Protocol, as far as possible without reservation. Fig.VI.1 illustrates that quite a significant number of States, particularly in Asia and in the Americas, have not yet acceded.

Fig.VI.1 Comparison of Accessions to the 1951 Convention by continent

(accessions vs. no. of countries per continent)



As of January 2006, of the 146 States signatories to the Convention, 102 had adopted national asylum procedures. UNHCR works in various ways with States to ensure national and administrative frameworks are in place to guarantee protection responsibilities can be met. This includes assisting States to enact or revise

Tab.VI.a UNHCR input to development of national legislation, 2005

No. of countries in the process of drafting/amending legislation	26
No. of countries where comments on draft legislation have been provided by UNHCR in 2005	21
No. of countries adopting/amending legislation in 2005 with previous UNHCR input	17

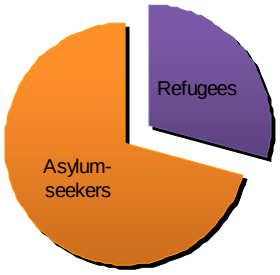
national refugee legislation and regulations, including administrative instructions and operational guidelines that are consistent with international protection principles. It also involves work with States to help ensure that the provisions of other laws and policies that have a bearing on refugee protection are consistent, and that the lines of responsibility between different government institutions in this regard are clear. Tab.VI.a shows the level of UNHCR involvement in national legislative processes during 2005.

THE PRINCIPLE OF *NON-REFOULEMENT*

One key challenge of international protection is to secure admission, asylum, and respect by States for basic human rights, including the principle of *non-refoulement*. The collection, analysis, and dissemination of statistical data gives UNHCR an important tool for the promotion of adherence to the international protection regime.

In 2005, *refoulement* concerns, or concerns relating to potential violations of the principle of *non-refoulement*, were reported by half of UNHCR's country offices. As indicated in Fig.VI.2, most of these reports related to implemented or planned *refoulement* or non-admission of asylum-seekers arriving at the border. A significant number of cases involving recognised refugees were also reported. According to the same UNHCR offices, some 75 per cent of the States that were in (possible) breach of the *non-refoulement* principle are signatories of the 1951 Convention, the 1967 Protocol or both.

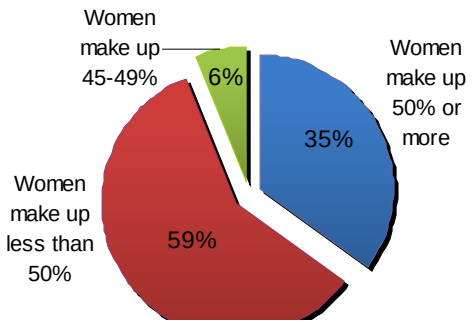
Fig.VI.2 UNHCR offices reporting *refoulement* concerns during 2005



AGE, GENDER AND DIVERSITY MAINSTREAMING

Mainstreaming age, gender and diversity means that the meaningful participation of refugee girls, boys, women and men of all ages and background is integral to the design, implementation, monitoring and evaluation of all UNHCR policies and operations. The overall goals are gender equality and the enjoyment of rights of all refugees of all ages and backgrounds. UNHCR has a two-pronged approach of gender equality mainstreaming and targeted action for women's empowerment. The Office's efforts are centered on five clear commitments to refugee women. These commitments were crafted in response to issues raised by refugee women. For example, one of these commitments relates to ensuring participation of refugee women in camp management and leadership positions. Available data from 2005 reveal that UNHCR's goal of ensuring gender parity in camp leadership has not yet been achieved in most refugee camps. Efforts continue to ensure that women's capacity and representation are actively promoted.

Fig.VI.3 Women's participation in management and leadership committees in refugee camps, 2005



Source: Standards and Indicators Report 2005

The High Commissioner's five commitments to refugee women

1. Participation of women in all management and leadership committees
2. Individual registration of all refugee women and men
3. Strategies to address sexual and gender-based violence
4. Women's participation in the distribution of food and non-food items
5. Provision of sanitary materials to all women and girls of concern

CONCLUSIONS AND IMPLICATIONS

The information presented above is merely illustrative and represents but a fraction of the protection data available to UNHCR. The organization is in the process of breaking new ground in its management of information relating to the protection function. The availability of more and better quality data with the new results-based management software, the revised Annual Protection Report format capturing detailed protection information, and a rapidly evolving Standards and Indicators database will support planning and management of UNHCR operations worldwide.

The value of data relating to persons of concern, protection needs or gaps, and activities to address them, available resources, and the impact of UNHCR activities lies primarily in how it is put to practical use. All available information and analysis as regards protection gaps and impact of activities is utilized to inform UNHCR planning processes and influence resource allocation and prioritization of activities.

Of primary importance here are UNHCR's Global Strategic Objectives (GSO) which define the strategic priorities for the organisation and establish priority performance targets on an annual basis. The GSO are articulated on the basis of strategic priorities, such as those articulated in the Agenda for Protection, identified protection gaps, as well as a review of results achieved across the board in the organisation. Collection and analysis of global protection data relating to persons of concern to UNHCR can contribute significantly to the development of Global Strategic Objectives and hence facilitate decision-making in the organisation on the basis of concrete knowledge about protection gaps, field realities and developing trends. As an example, through analysis of available data from its operations worldwide, UNHCR has found that the number of refugee children not attending schools remains disconcertingly high. In part as a result of this finding, the organisation's aim to ensure the right of education features prominently in UNHCR's Global Strategic Objectives for 2007-2009.

With the aim of illustrating, primarily by numbers, prevailing protection gaps, the resources that are available to address them, and, to the extent possible, the impact of protection activities, UNHCR launched in 2005 a new protection report labelled *Measuring Protection by Numbers*. It is hoped that, as the aforementioned information tools evolve, UNHCR will in the near future be in a position to plan its operations on the basis of more comprehensive and detailed statistical information on all aspects of the protection function, including on the results achieved.

VI.2 NUTRITION: A KEY ASPECT OF PROTECTION AND DEVELOPMENT

INTRODUCTION

Nutrition is fundamental to human well-being and important in achieving the Millennium Development Goals (MDGs) related to the reduction of child mortality; the eradication of poverty; education; gender equality; maternal heath; and HIV and AIDS. Not only is under-nutrition the underlying cause of 60 per cent of child deaths but malnutrition[1] has an enormous impact on children's capacity to learn, develop and work. The prevalence of acute malnutrition is one of the most widely used indicators of severity of humanitarian crises, and this indicator is endorsed by a wide

[1] The term malnutrition as used in the 2005 Yearbook refers to the various forms of malnutrition: notably global acute malnutrition (GAM), i.e. wasting plus nutritional oedema, expressed in Z-scores; chronic malnutrition (stunting); and micronutrient deficiencies (hidden hunger).

array of UN organizations, donors, national governments and international agencies.

Ensuring adequate nutrition is an essential part of protection for people of concern to UNHCR, in particular for refugee children and women. UNHCR is concerned that humanitarian standards in relation to nutrition, food security and public health have not always been met, particularly in some protracted refugee situations. In this respect, prevention of malnutrition was included under the Global Strategic Objectives for 2007-2009. The related performance measurable target clearly stated that "in operations receiving food aid and recording high malnutrition rates, steps will be taken in collaboration with the World Food Programme (WFP) to reduce the acute malnutrition rate to less than 10 per cent".

DATA SOURCES AND INDICATORS

Sources of nutrition data in UNHCR include the Standard and Indicators database, the nutrition information in crises situations (NICS) database and selected nutrition surveillance and monitoring systems. In addition, joint assessment missions with WFP provide a wider picture of the situation in relation to food, nutrition and related programme aspects. UNHCR has also introduced the Health Information System (HIS) that includes various indicators and will provide improved data leading in the future to better analysis. The HIS will also facilitate quicker intervention responses following faster recognition of increases in morbidity levels and standardized case definitions. The HIS is currently being tested in three countries.

The programming and implementation of activities have been supported by regular assessments and monitoring of malnutrition. In this respect, various nutrition surveys have taken place recently, in Bangladesh, Chad, Ethiopia, Kenya, and the United Rep. of Tanzania. Some operations, such as Nepal, are planning a comprehensive nutrition survey to be led by the Centers for Disease Control (CDC). Other countries are planning food security and household surveys. Moreover, the Health Information System which is currently being piloted in the United Rep. of Tanzania, Kenya and Ethiopia includes various nutrition indicators. Decisions regarding food assistance, related programme aspects and provision of non-food items are usually made through joint assessment missions by UNHCR and WFP. Such missions have taken place in more than 15 countries, including Chad, Gambia, Ghana, Bangladesh, the Islamic Rep. of Iran and Nepal. Some joint UNHCR-WFP nutrition reviews have led to the modification of general food rations.

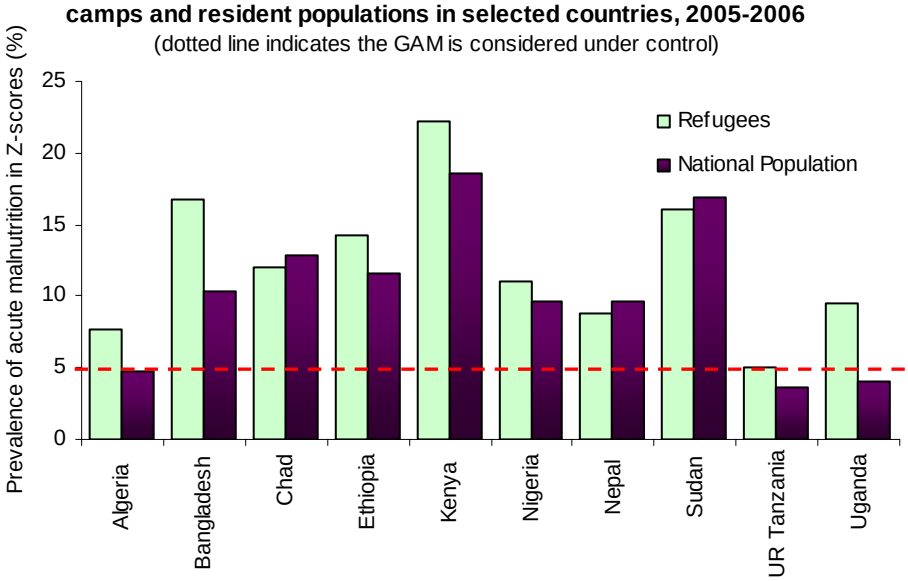
Adequate assessment of malnutrition is fundamental in guiding appropriate actions to address malnutrition and its underlying causes. Acute malnutrition is classified in two degrees of severity, according to the severity of wasting (moderate or severe) and presence of oedema (always considered as severe). Wasting is assessed by the weight-for-height index, which compares the weight of a child with a reference population of well-nourished and healthy children.

NUTRITIONAL STATUS IN SELECTED UNHCR OPERATIONS

The prevalence of malnutrition, including micronutrient deficiencies, is in many cases higher among refugees than among local populations. Many refugee children and women in camps suffer high levels of anaemia as a result of various factors including (a) poor access to adequate food, (b) illness or (c) inequity of food allocation at household level. By using field data for 2005-2006 from selected UNHCR operations, Figure VI.4 below demonstrates clearly that Global Acute Malnutrition (GAM) is still prevalent in a wide range of UNHCR operations. A prevalence of five per cent or

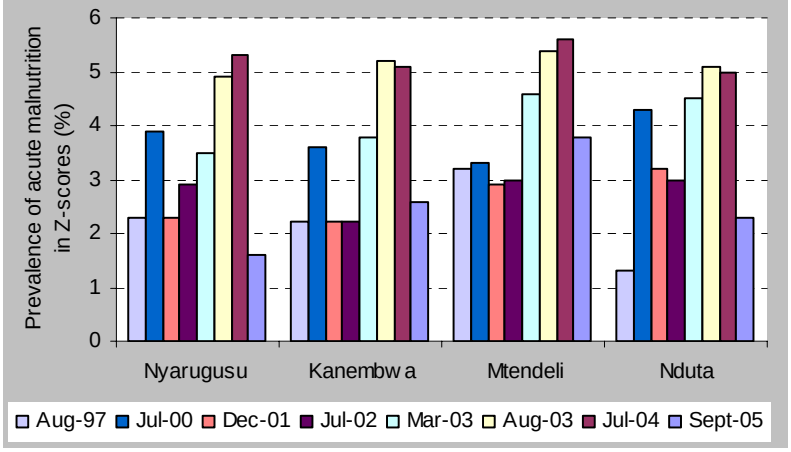
lower is regarded by UNHCR and the World Health Organization (WHO) as acceptable in a stable environment. Only refugee camps in the United Rep. of Tanzania show a prevalence rate near this value. All the other camps show higher rates of acute malnutrition. The highest rates of acute malnutrition, which can be considered as critical, are seen in Kenya, Ethiopia, eastern Sudan, some camps in Chad and Bangladesh.

Fig.VI.4 Prevalence of Global Acute Malnutrition of refugees in camps and resident populations in selected countries, 2005-2006
(dotted line indicates the GAM is considered under control)



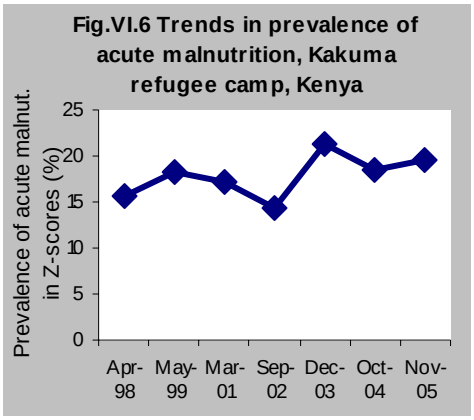
Contrasting situations in levels of acute malnutrition can be seen across UNHCR country operations. For example, prevalence of acute malnutrition in the United Rep. of Tanzania has remained low over the last years (see Figure VI.5). This might be explained by several factors related to nutrition interventions to address underlying causes of malnutrition. These interventions demonstrate that along with adequate food, other related programme elements implemented in an integrated fashion are essential in stabilizing the nutrition situation. However, even with relatively low acute malnutrition rates, the situation still remains precarious regarding anaemia and stunting which might compromise overall well-being of refugees in some situations including the United Rep. of Tanzania. Constraints to reach an optimal nutrition status include frequent breaks in the food pipeline due to resource shortages and inadequate coping mechanisms due to restriction of movement for refugees.

Fig.VI.5 Trends in prevalence of Global Acute Malnutrition in selected Tanzanian refugee camps

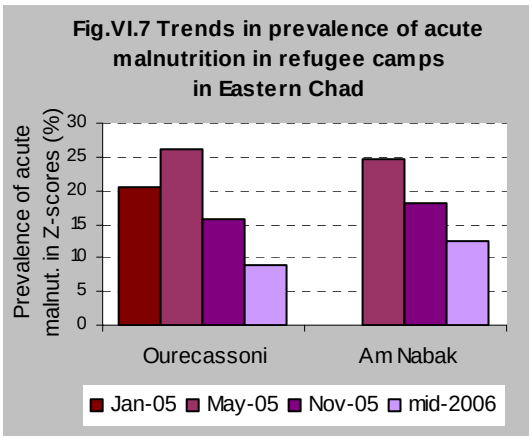


On the other hand, the nutrition situation in Kenya and Ethiopia has remained precarious for years. In Kakuma camp (Kenya), a number of surveys and assessment missions have shown that acute malnutrition levels remain very high

(see Figure VI.6). Similarly, in Ethiopia, although malnutrition levels have decreased in some camps recently, the general situation shows high levels of acute malnutrition at emergency level in 2005, which still remain a matter of concern. Underlying factors of acute malnutrition in Kenya include the (a) harsh environment, (b) the sale of food items in exchange of non-food items and payment of milling of cereals and (c) poor infant feeding practices. At field level, several strategies to address some of these causes of malnutrition have been put in place.



In contrast, regular nutrition surveys conducted in camps in eastern Chad since the beginning of operations in 2004 show a progressive and significant decrease of global acute malnutrition amongst Sudanese refugees. The example of Ourecassoni and Am Nabak camps shows that prevalence of acute malnutrition has significantly decreased in 2006, compared to the beginning of the crisis in 2004 (see Fig.VI.7). Several factors have contributed to the improvement of the nutrition situation in these camps including (a) regular monthly nutrition screening, (b) training of community health workers in nutrition and Integrated Management of Childhood Illness, (c) better management of acute malnutrition at the community level, (d) inclusion of fortified food in the general food rations and in maternal and child heath programmes, as well as supplementation of Vitamin A, zinc and de-worming programmes.



However, careful monitoring of the situation is still required due to the changing nature of the situation, including problems with security and access, increasing influxes of internally displaced persons in areas hosting refugee camps and potential new influxes of refugees.

By and large, assessments and in-depth reviews of selected refugee operations have revealed that the causes of malnutrition in refugee situations are multi-factorial with inadequate food intake and morbidity being the main direct factors. Contributing factors to the high malnutrition prevalence in refugee camps include (a) an inadequate general food ration, (b) the absence of livelihood strategies outside relief assistance, (c) security issues, (d) water and sanitation below the minimum standards, (e) poor infant and young child feeding practices, (f) poor access to health services and (g) limited coverage of the selective feeding programme. At the same time, the situation in some camps has improved because of better coverage of the selective feeding programme; regular monitoring and coordination between partners; sustainable general food rations; and increased refugee community participation in health and nutrition activities. Activities such as active health and nutrition surveillance by community health workers, targeted feeding programmes, nutritional support to people living with HIV/AIDS (PLWHA), and the provision of micronutrients also contributed to the reduction of malnutrition levels. A number of solutions to respond to these trends were designed and reflected in various UNHCR documents (see UNHCR's nutrition website).

PARTNERSHIP AND POLICY IMPLICATIONS

UNHCR recently became a member of the partnership framework and institutional management structure of the Ending Child Hunger and Undernutrition Initiative lead by UNICEF and WFP. The High Commissioner has accepted to become the Chair of the Global Partners Group, a key forum for action and decision-making for all stakeholders, for a two-year term starting in 2007. The Initiative will provide UNHCR with a platform to promote the inclusion of refugees and others of concern into national policies and action plans. In addition, UNHCR is working with a range of relevant partners on nutrition and associated new developments through memoranda of understanding and other arrangements.

At the operational level, UNHCR and WFP have taken various strategic steps to prevent malnutrition. These include joint in-depth nutrition reviews in different countries as well as the development of a joint global nutrition strategy emphasising the importance of understanding malnutrition and the development of appropriate solutions in an integrated manner. Accordingly, some UNHCR operations such as Chad, Bangladesh, Ethiopia and the United Rep. of Tanzania have developed joint plans of action with WFP at the field level. Based on the Standards and Indicators and other available information concerning nutrition, food, health, water and sanitation, some 11 operations were identified as a priority for action. This was shared with the concerned operations in order to prioritize actions.

The main challenges UNHCR faces to remedy high malnutrition prevalence are inadequate technical capacity in nutrition at both headquarters and field levels, and resource limitations to address the observed gaps. The involvement of beneficiaries in the implementation of recommended strategies is also a key element for reduction of the observed high malnutrition prevalence in some UNHCR operations. Below are additional elements listed which can form the basis for UNHCR's future success in preventing malnutrition.

- Application of programming instructions on nutrition and other priority areas put in place in order to achieve the Global Strategic Objectives;
- Promotion of integrated approach and essential package to prevent malnutrition by strengthening linkages between sectors including health, water and sanitation, food, HIV/AIDS as well as protection, gender and community services;
- Enhancing nutrition monitoring systems through nutrition surveys, joint UNHCR-WFP critical mission reviews, Standards and Indicators and Health Information Systems;
- Enhancing the technical integrity and nutrition capacity through key regional nutrition posts, secondments, standby arrangements and junior professional officers.

VI.3 WATER AND SANITATION

BACKGROUND AND DATA SOURCES

Water is essential for survival and its availability and quality are important factors for all UNHCR assistance programmes. When water availability or quality is sub-standard, the problem created has direct serious consequences for the people of concern to UNHCR and their immediate protection is not granted anymore.

Four main data sources provide most of the information on Water and Sanitation (WATSAN). First, the Standards and Indicators programme which includes 11 indicators relating to the water and sanitation sectors. Second, since 2004, health coordinators provide annual reports which contain both health and WATSAN data. These reports provide information from over 20 countries, covering about 90 camps with a combined population of approximately three million refugees. Third, UNHCR and partners conduct selected surveys of WATSAN service provision in camps which provide a good overview of services available in camps. Despite the fact that these surveys are conducted once and thus provide only a snapshot of the situation, they nevertheless help to understand the real camp situation. Fourth, different camps and implementing partners employ different reporting mechanisms which complicate data consolidation across the sectors and because population changes in refugee camps are notoriously hard to monitor with new influxes or unreported deaths.

WATER AND SANITATION PROVISION IN REFUGEE CAMPS

Water and sanitation provision in UNHCR operations (2003 to 2005), as indicated by the Standards and Indicators data, are summarized in Tables VI.b and VI.c below. These tables show that while the overall median and average values for water supply and median values for latrine coverage across UNHCR's operations are above the set standards (20 litres/person/day and less than 20 persons/latrine), there are still large numbers of camps where the average water supply is inadequate and not enough latrines available for the population. In fact, according to the Standards and Indicators reports, the number of camps with less than 20 litres of water per person per day was over 40 per cent in each of the last three years. In other words, in four out of 10 camps, UNHCR's standard on water was not met. Interestingly, if the Sphere standard of 15 litres/person/day is used instead of the UNHCR one, the corresponding percentage ranges between 18 and 32 per cent for the years 2003-2005. Over one out of four camps have an insufficient number of latrines, i.e. there are on average more than 20 people per latrine.

Tab.VI.b Results from Standards and Indicators Report: per capita water availability based on annual averages per camp

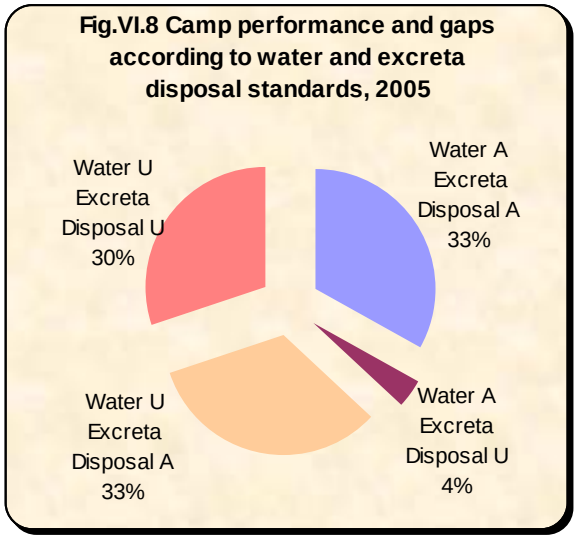
	2003	2004	2005
No. of camps with data available	92	73	93
Maximum (liters)	153	361	444
Minimum (litres)	2	7	6
Median (litres)	20	22	20
Average (litres)	23	35	31
% of these camps meeting UNHCR 20l/day standard	54	59	53
Average % of population in camps meeting the UNHCR 200m access distance standard	86	72	77

Tab.VI.c Results from Standards and Indicators Report: excreta disposal availability (persons per latrine)

	2003	2004	2005
No. of camps with data available	89	81	90
Maximum (persons/latrine)	793	802	1,124
Minimum (persons/latrine)	3	4	5
Median (persons/latrine)	11	11	6*
Average (persons/latrine)	28	36	27
% of these camps meeting UNHCR excreta disposal standards	74	67	83

* based on family latrine coverage figures assuming five persons per family.

Fig.VI.8 Camp performance and gaps according to water and excreta disposal standards, 2005



A = acceptable provision (Water > 20 Liters per person per day; Excreta Disposal < 20 persons per latrine); U = Unacceptable provision, i.e. indicators lower than the UNHCR minimum standards.

The annual UNHCR health coordinators country reports and Standards and Indicators data were further analyzed. Figure VI.8 presents the relationship between water and latrine provision across those operations for which data are available. Many operations fall outside the zone of acceptable provision and typically poor sanitation provision (i.e. high numbers of person per latrine) often corresponds to low per capita availability of water. The data refers to 28 refugee camps in Algeria, Bangladesh, Chad, the Dem. Rep. of the Congo, Ethiopia, Ghana, Kenya, Nepal, Pakistan, Sierra Leone, United Rep. of Tanzania, Uganda and Zambia in 2005. Only one third (33%) of the camps satisfied both water and excreta disposal standards. In about one camp out of three (30%), none of the two standards has been met.

Tab.VI.d Selected scorecards for refugee camps in Nepal, Rwanda and UR of Tanzania, 2005

Country	Camp name	Std. ≥ 20 18-19 < 18 Average quantity of water available per person per day (litres)	Std. = 100% 90%- 99% < 90% Percentage of families with latrines	Std. < 20 20-30 > 30 Average number of persons per drop-hole in communal latrine
Nepal	Beldangi 1	15	50%	161
Nepal	Beldangi 2	20	51%	116
Nepal	Beldangi 2 extension	20	50%	182
Nepal	Goldhap	20	51%	181
Nepal	Khudunabari	18	51%	108
Nepal	Sanischare	18	52%	189
Nepal	Timai	14	47%	171
Rwanda	Gihembe	10	0%	25
Rwanda	Kiziba	18	0%	23
Rwanda	Nyabiheke	15	0%	20
UR of Tanzania	Kane Mbwa	26	98%	78
UR of Tanzania	Lugufu	22	92%	67
UR of Tanzania	Lukole	27	72%	12
UR of Tanzania	Mkugwa	24	96%	62
UR of Tanzania	Mtabila 1	32	86%	38
UR of Tanzania	Mtabila 2	19	96%	9
UR of Tanzania	Mtendeli	22	89%	95
UR of Tanzania	Muyovosi	21	90%	80
UR of Tanzania	Nduta	25	99%	99
UR of Tanzania	Nyarugusu	16	93%	257

Country averages usually hide significant internal differences. UNHCR uses gap analysis methods to map the existing differences between levels of selected indicators and the standards. Camp differences are highlighted using the scorecard technique which shows the local differences in a country as well as those between

countries with regard to access to WATSAN and other services. Table VI.d above shows country and camp differences using Standards and Indicators data from Nepal, Rwanda and the United Rep. of Tanzania. Three different colours are used: green for camps having met the standard; blue for camps close to the standard (even though the standard is not met) and red for camps which are very far from meeting the standard. This type of information is crucial for identifying gaps, allocating resources and planning and prioritizing activities. For instance, from Table VI.d, it is possible to extract interesting information for decision-making, including the need for additional water taps or drop-hole communal latrines.

Inequalities in the provision of WATSAN services may be due to various factors, including the location of the water points, breakage or vandalism of water taps, existing control/influence systems in camps, or lack of storage facilities in the home. The latter is a serious concern due to the importance of adequate quantities of water for health. Proper water and sanitation provision are a vital tool in the control of morbidity of related diseases such as malaria and diarrhoea. Studies in different camps have shown that typically higher levels of morbidity of one infectious agent linked to the water and sanitation sector are also reflected across other morbidity levels. Malnourished individuals have compromised immunity and are not only more likely to contract communicable diseases, but also suffer from more frequent, severe, and prolonged episodes of these diseases.

CONSTRAINTS AND POLICY IMPLICATIONS

The statistical results presented above show that while overall average levels of water and sanitation provision are acceptable, many operations are still suffering from gaps in these sectors. The camp-level indicators, across the water, sanitation, health and nutrition sectors, also highlight their cross-cutting nature. Interventions to improve key indicators in any of these sectors rely not only on increased and sustained resources but also must adopt a sector-wide integrated approach to simultaneously tackle short-comings in all of these vital sectors. Dealing with water and sanitation, health and nutrition sectors in isolation will not maximize the potential overall benefits.

The existing data highlighted gaps that need dedicated allocation of resources and sustainable monitoring systems. Resources need to be adapted on a camp-by-camp basis as camps have distinct WATSAN systems and often very different operating costs. The Standards and Indicators are an important tool for WATSAN sectors, but are limited because of to their periodicity. In fact, as only yearly average values are provided by camp, more in-depth camp or country level comparisons on water or sanitation services are not possible. In addition, there are concerns about the quality of the collection and reporting of data received from some operations. Standards and Indicators data need to be complemented by more detailed monitoring systems that can show how differences (both geographic and temporal) in service provision occur on the ground and affect the refugees' well-being and dignity.

Concrete actions to scale up UNHCR interventions in these sectors include:

- Planning and implementing integrated approaches to tackle short-comings across all of these vital sectors, by also considering longer-term issues such as sufficient water for agriculture, food security, access to livelihoods, etc.
- These interventions must aim at improving service provision to at least the prescribed minimum standards in the water, sanitation, health and nutrition sectors. This will however also require increased and sustained resources. Gaps highlighted by the Standards and Indicators and other monitoring tools must be linked to programme planning.

- Continued improvement and expansion of the Health Information System to standardise and strengthen data collection and analysis across refugee operations. This will also strengthen cooperation between all actors working in these difficult settings.
- In acute emergencies, there is a special need to provide as much water as possible in the early critical phase though practicalities dictate that this is not always possible.

VI.4 HIV AND AIDS

BACKGROUND

HIV and AIDS prevention and response are essential components in the protection of refugees, IDPs, returnees and other persons of concern. UNHCR continues to provide guidance and support in response to reports of HIV-related human rights violations. The more serious gaps to be bridged include mandatory HIV testing, HIV-related stigma and discrimination as well as specific issues related to resettlement of refugees with HIV. There is also a common belief that conflict fuels the HIV and AIDS epidemic, and consequently, refugees and internally displaced persons fleeing humanitarian emergencies have a high HIV prevalence. This assumption has recently been questioned. Much of the data behind these claims have not been rigorously evaluated and appear to be based on anecdotal information or factors during conflict that tend to increase HIV transmission while ignoring those elements that may reduce transmission. A more subtle and context-specific picture is emerging on how the HIV epidemic is affected by conflict and forced displacement that depends upon numerous complex, interacting, and often countervailing factors.[2]

DATA AVAILABILITY AND SOURCES

In recent years, UNHCR has focused on gathering baseline data regarding HIV-related risks with the aim of informing and guiding the organization's interventions towards mitigating the spread of HIV in the refugee and surrounding communities, and dispelling some of the misconceptions regarding refugees and HIV. In addition to the Standards and Indicators reports, UNHCR and some partners have conducted HIV behavioural surveillance surveys (BSS) in various camps, targeting in particular refugee camps and surrounding communities.

BSS collect crucial HIV and AIDS data to inform local and national interventions, for programme monitoring and evaluation, and for the allocation of scarce resources. Scientifically sound studies with structured and detailed reports are needed. Most BSS are undertaken on a nationwide scale with large samples that require significant technical expertise and resources; this is often not possible in conflict and post-conflict situations. Furthermore, these situations are unique and require different information from other populations; this includes questions on displacement and interaction with surrounding host populations as well as sensitive questions on sexual exploitation and violence.

Recognizing this need, UNHCR, in collaboration with the World Bank and the Great Lakes Initiative on AIDS, is engaged in a process that has produced a BSS manual that serves as a generic tool for conflict-affected and displaced populations. This

[2] P. Spiegel, HIV among conflicted affected and displaced populations: dispelling myths and taking action (2004), Disasters, 28(3), 322-329

manual contains practical sections on methodology, analysis and results, indicators, report writing as well as sample questionnaires that contain modules on pre-displacement, displacement and post-displacement/interaction with the surrounding host community. Emphasis is placed on the latter as well as on the need to undertake such surveys among both the displaced populations and surrounding host communities. This effort will ultimately aid in the provision of integrated HIV and AIDS programmes for refugees and surrounding host populations. Such BSS have been undertaken in numerous countries among refugees and their surrounding host populations. Figures VI.9 and VI.10 below show such an example for Tanzania.

By the end of 2005, HIV and AIDS data were collected from 30 countries worldwide; in 35 urban areas and 228 camps.

TRENDS IN HIV PREVALENCE AND RISK BEHAVIOURS

HIV sentinel surveillance surveys among women in antenatal care (ANC) have been undertaken in numerous refugee settings throughout the world. For the most part, the HIV prevalence has been found to be lower or similar to the nearest national government's sentinel site for the host population (see Fig.VI.9).

Figure VI.9 shows that the HIV prevalence among refugees is lower than the surrounding rural population in the United Rep. of Tanzania. However, the risk of refugees being exposed to HIV in these circumstances can increase depending on several factors, one of which is the degree of interaction between the two populations.

Fig.VI.9 HIV prevalence among refugees and rural host populations in Tanzania

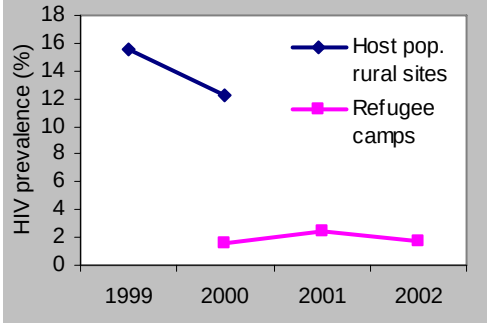


Fig.VI.10 Behavioural Surveillance Survey, Tanzania, 2005

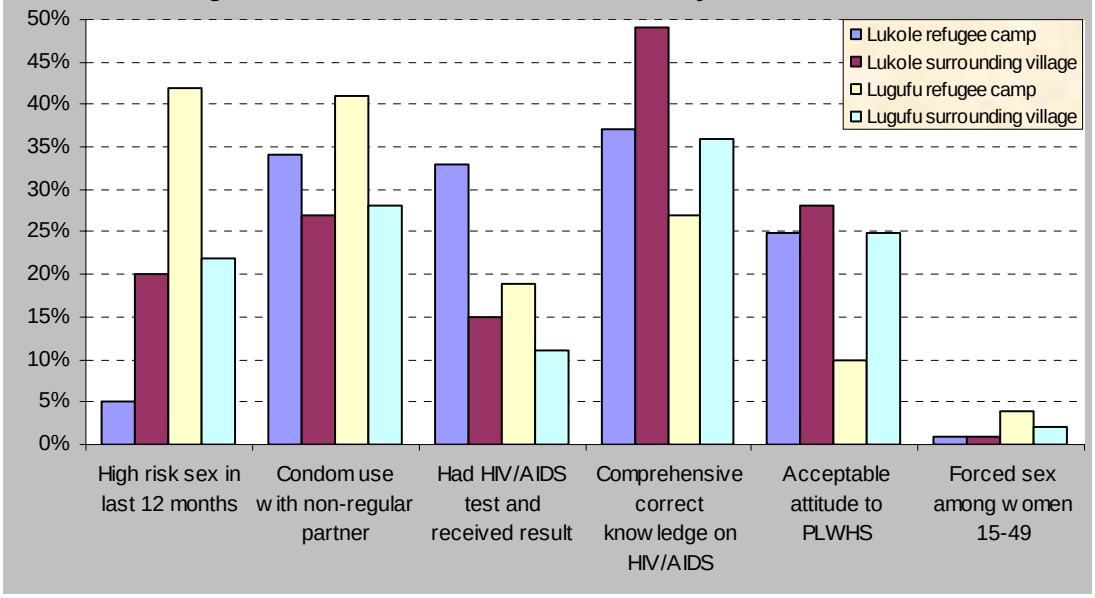


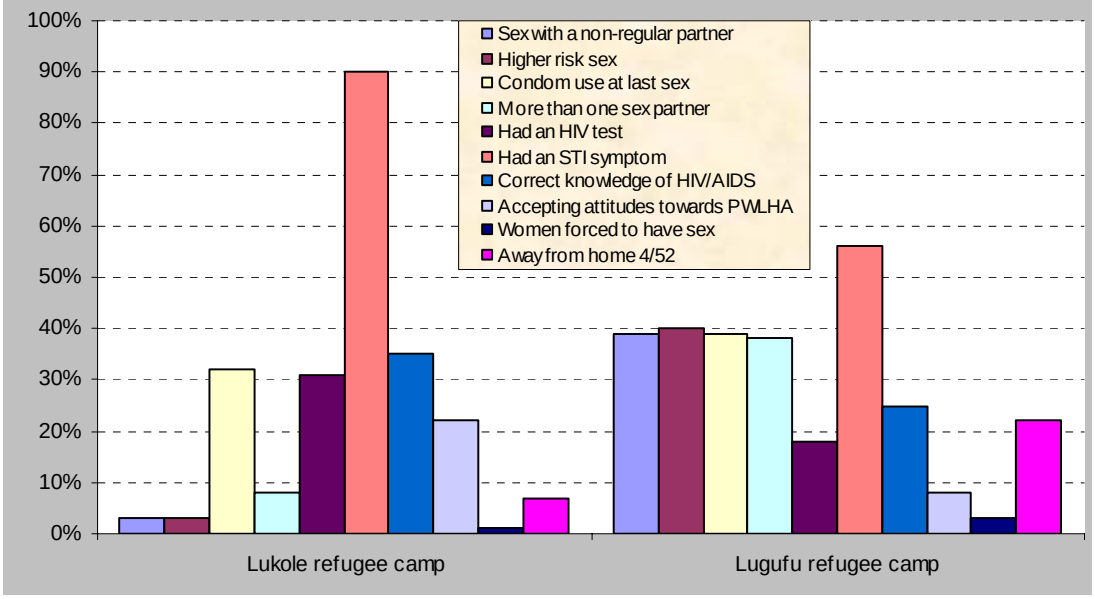
Figure VI.10 indicates varying trends. For example, the surrounding populations at Lukole and Lugufu have better comprehensive knowledge than the refugees in the camps. On the other hand, high risk sexual behaviour is more predominant among surrounding populations than in camps in Lukole. In contrast, such behaviours are

more predominant in Lugufu camps in comparison with surrounding populations. Probably due to sensitization campaigns and availability in camps, condom use and HIV testing are more frequent in both camps than in surrounding populations.

Underlying factors of the lower HIV prevalence in refugee camps include strong HIV and AIDS prevention programmes and related activities such as condom and food distribution, access to health services and better knowledge of HIV-related vulnerabilities. However, as camps and local populations are highly mobile and mix with each other on a daily basis, targeted prevention programmes should also include surrounding communities. In Kenya, BSS show that 85 per cent of local people surveyed reported having regularly visited Kakuma camp while 25 per cent of refugees said they visited the local community. It makes both practical and economic sense if refugees are integrated into national health and HIV programmes.

Comparison analyses showed that there are also distinct differences in HIV attitudes, vulnerabilities and risk behaviours between the refugee camps of the same country. In the United Rep. of Tanzania, as shown in Figure VI.11, more refugees at Lukole camp know their HIV status and have accepting attitudes towards a person living with HIV and AIDS than those in Lugufu.

Fig.VI.11 Behavioural Surveillance Survey, Tanzania, 2005



IMPLICATIONS

Data on HIV prevalence and related behaviours are important to inform policies, direct HIV and AIDS programmes, monitor their effectiveness and make informed decisions for effective interventions towards mitigating the spread of HIV in the refugee and surrounding communities. Following trends over time in HIV-related risk behaviours is also helpful to dispel some of the misconceptions regarding refugees and HIV and AIDS. UNHCR has established a strong and credible dataset in order to improve the Office's work, to help in its advocacy efforts to include displaced populations in the universal access to HIV prevention, treatment, care and support programmes, as well as to address the protection related HIV aspects among displaced populations. As a result of the development of such a competence and expertise in HIV and AIDS in conflict settings, UNHCR is now designated as the lead agency on HIV and AIDS for refugees and IDPs in the UNAIDS technical division of labour.