2014 – 2018

Ethiopia Refugee Program Strategic Plan Public Health Sector

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Public Health, HIV and Reproductive Health, Food Security and Nutrition, Water, Sanitation and Hygiene

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VISION

The United Nations High Commissioner for Refugees (UNHCR) working with Administration for Refugee and Returnee Affairs (ARRA) & their partners, aim to ensure that all refugees are able to fulfil their rights in accessing lifesaving and essential health care, HIV, reproductive health, food security and nutrition and water, sanitation and hygiene(WASH) services. UNHCR adopts a rights and community-based approach, ensuring that boys, girls, young people, women, men, the elderly and groups with special needs are engaged and participate in all stages of the design and implementation of programmes.

UNHCR's role in these four sectors is *to advocate* for, *facilitate* and *monitor* access to services, as well as to promote the best evidence-based standards.

These strategies guide operations throughout the displacement cycle, i.e. in emergency and post-emergency scenarios and longer-term or protracted refugee situations.

MISSION STATEMENT

UNHCR, in its effort to fulfil its mandate of leading and coordinating international protection of refugees and the resolution of refugee problems, works in partnership with governments, regional organizations; international and non-governmental organizations in order safeguard the rights and well-being of refugees. UNHCR coordinates and support access to standard and cost-effective public healthcare services in a comprehensive manner based on the principles of primary healthcare in timely manners during both emergency and stable situations.

It is committed to the principle of participation, believing that refugees and others who benefit from the organization's activities should be consulted over decisions which affect their lives.

OVERVIEW

This five-year strategy outlines the principles, impacts, objectives and strategic areas of focus for UNHCR Ethiopia's public health, HIV and reproductive health, food security and nutrition and WASH sector programmes for the period 2014-2018. Administration for Refugee and Returnee Affairs (ARRA) is a key government counterpart and main health partner in implementation of this strategy.

UNHCR public health programmes operate in a wide variety of settings. These include in emergencies and in post-emergency, in rural and urban settings, in refugee camps and in out of camp programs. Programme targets vary slightly according to the scenario, setting and type of settlement.

The focus of this strategy is on refugees, but in some contexts may apply or be adapted to asylum-seekers, stateless persons, internally displaced persons and in returnee settings (when/where applicable). The proportion of these persons of concern and decisions on levels of assistance varies according to context.

ETHIOPIA COUNTRY PROFILE

Ethiopia is Africa's oldest independent country. It is the tenth largest country in Africa, covering 1,104,300 square kilometres (with 1 million sq. km land area and 104,300 sq. km water) and is the major constituent of the landmass known as the Horn of Africa. It is bordered on the north and northeast by Eritrea, on the east by Djibouti and Somalia, on the south by Kenya, and on the west and southwest by Sudan.

Ethiopia is a country with great geographical diversity and its topography shows a variety of contrasts ranging from high peaks of 4,550m above sea level to a low depression of 110m below sea level[1]. More than half of the country lies above 1,500 meters. The predominant climate type is tropical monsoon, with temperate climate on the plateau and hot in the lowlands. There are topographic-induced climatic variations broadly categorized into three: the "Kolla", or hot lowlands, below approximately 1,500 meters, the "Wayna Degas" at 1,500-2,400 meters and the "Dega" or cool temperate highlands above 2,400 meters.

Ethiopia has a tiered government system consisting of a federal government overseeing ethnically based regional states, zones, districts (woredas) and neighbourhoods (kebele).

At present Ethiopia is administratively structured into nine regional states—Tigray, Afar, Amhara, Oromiya, Somali, Beneshangul-Gumuz, Southern Nations Nationalities and Peoples (SNNP), Gambella, and Harari—and two city administrations, that is, Addis Ababa and Dire Dawa Administration Councils[2].

ETHIOPIA NATIONAL HEALTH POLICY

Ethiopia had no health policy until the early 1960s, when a health policy initiated by the World Health Organization (WHO) was adopted. In the mid-1970s, during the Derg regime, a health policy was formulated with emphasis on disease prevention and control. This policy gave priority to rural areas and advocated community involvement[3]. The current health policy, promulgated by the Transitional Government, takes into account broader issues such as population dynamics, food availability, acceptable living conditions, and other essentials of better health[4].

To realize the objectives of the health policy, the government established the Health Sector Development Programme (HSDP), which is a 20-year health development strategy implemented through a series of four consecutive 5-year investment programmes[5]. The first phase (HSDP I) was initiated in 1996/97. The core elements of the HSDP include: democratisation and decentralisation of the health care system; development of the preventive and curative components of health care; ensuring accessibility of health care for all segments of the population; and, promotion of private sector and NGO participation in the health sector. The HSDP prioritizes maternal and new-born care, and child health, and aims to halt and reverse the spread of major communicable disease such as HIV/AIDS, TB, and malaria. The Health Extension Programme (HEP) serves as the primary vehicle for prevention, health promotion, behavioural change communication, and basic curative care. The HEP is an innovative health service delivery program that aims at universal coverage of primary health care. The programme is based on expanding physical health infrastructure and developing Health Extension Workers (HEWs) who provide basic preventive and curative health services in the rural community.

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[1] Central Statistical Agency (CSA) [Ethiopia]. 2009. Statistical Abstract of Ethiopia. Addis Ababa, Ethiopia: Central Statistical Agency.

[2] Central Statistical Agency [Ethiopia] and ICF International. 2012. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International

[3] Transitional Government of Ethiopia (TGE). 1993a. *National Population Policy of Ethiopia*. Addis Ababa, Ethiopia: Transitional Government of Ethiopia.

[4] Transitional Government of Ethiopia (TGE). 1993b. *Health Policy of the Transitional Government of Ethiopia.* Addis Ababa, Ethiopia: Transitional Government of Ethiopia.

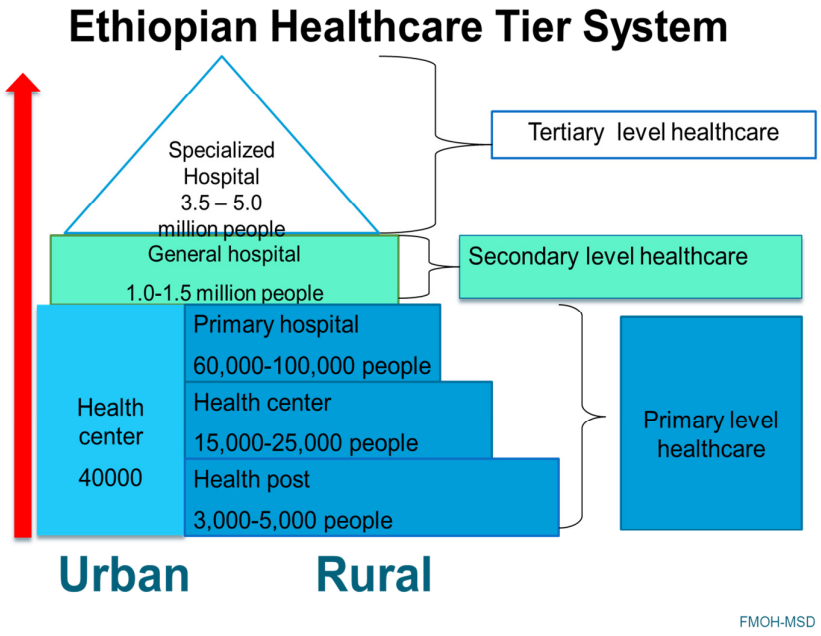
[5] Ministry of Health (MoH) [Ethiopia]. November 2010. *Health Sector Development Programme IV, 2010/11-2014/15.* Addis Ababa, Ethiopia: Ministry of Health.

The first phase (HSDP I) was initiated in 1996/97.Thus far, the country has implemented the HSDP in three cycles and is currently extending it into the forth programme, HSDP IV (2010/11 – 2014/15). Assessment of HSDP III shows remarkable achievements in the expansion and construction of health facilities, and improvement in the quality of health service provision. The assessment also shows that in the last five years the distribution of insecticide treated nets (ITN) were successful in reaching targeted areas of the country including areas that are hard to reach, placing Ethiopia as the third largest distributor of ITNs in Sub Saharan Africa.

HSDP IV is designed to provide massive training of health workers to improve the provision of quality health services and the development of a community health insurance strategy for the country. In addition, HSDP IV will prioritize maternal and new-born care, and child health, and aim to halt and reverse the spread of major communicable disease such as HIV/AIDS, TB and Malaria. In line with the government's current five-year national plan, the health sector continues to emphasize primary health care and preventive services; with focus on extending services to those who have not yet been reached and on improving the effectiveness of services, especially addressing difficulties in staffing and the flow of drugs.

According to the HSDP IV, the Ethiopian Healthcare is based on three tier system to ensure access and continuum of care

FIGURE 1: ETHIOPIA HEALTHCARE TIER SYSTEM



UNHCR ETHIOPIA STRATEGIC FRAMEWORK[6]

In its now over 45 years of presence in Ethiopia (since 1966), UNHCR has carried out a dual mission - undertaking complex diplomatic negotiations geared to influence Africa's policies on refugees on the one hand and undertaking protection and assistance activities for refugees in Ethiopia.

[6] UNHCR Ethiopia Country operation plan for 2014-2015

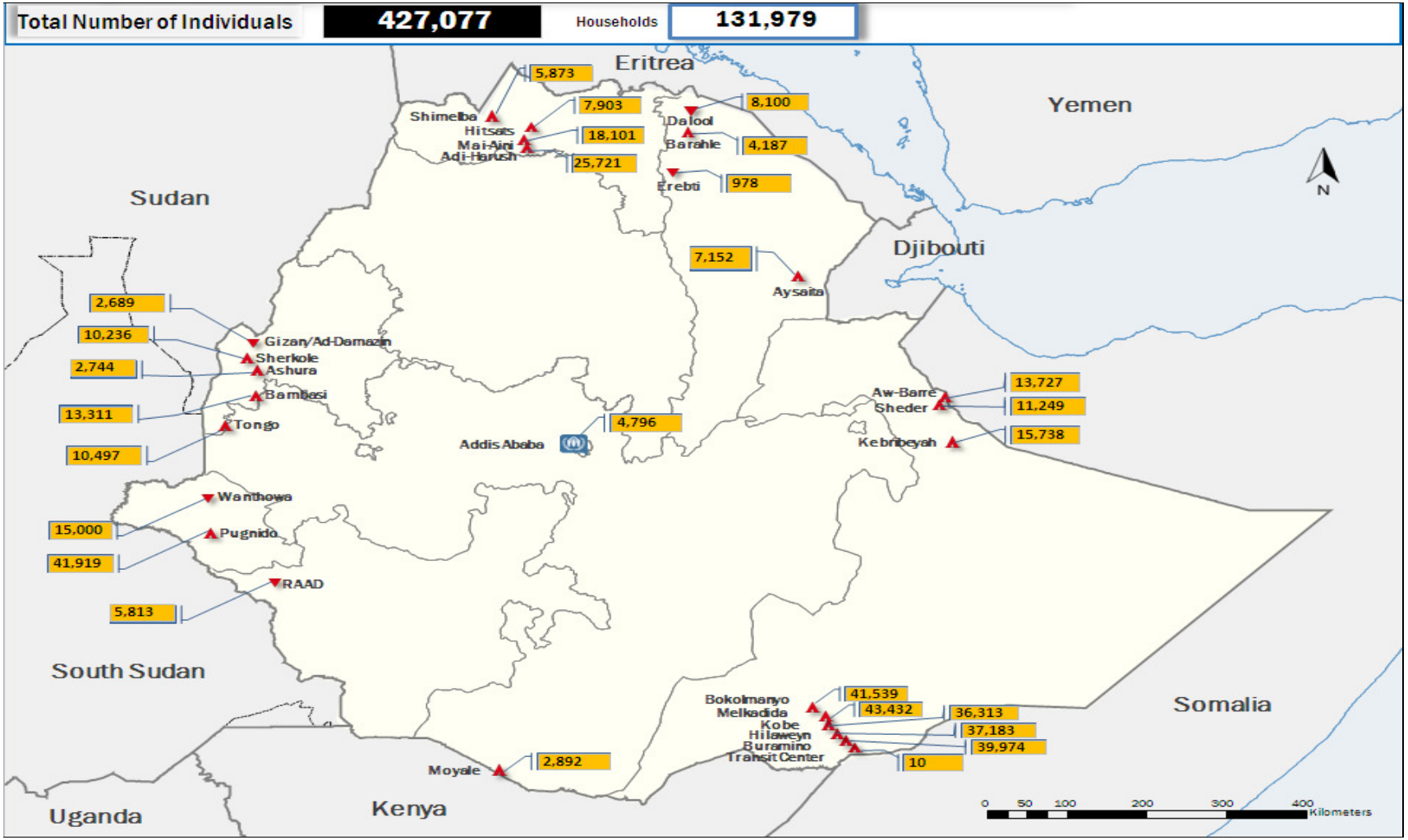
Ethiopia is now host to over 425,000 refugees, with the biggest population groups comprising Somali (58% of the population), Eritrean (18% of the population), South Sudanese, (16% of the population) and Sudanese (7% of the population). In addition there are persons of concern from Kenya who reside in the Moyale region, and urban refugees from several other countries, including the Democratic Republic of Congo (DRC), Yemen, Burundi, Djibouti, Rwanda and Uganda. The Ethiopia country operation has a total of 20 camps, 2 settlements, 4 temporary settlements, 4 transit/reception centres.

Much of UNHCR Ethiopia's focus in 2012 and 2013 included stabilising the emergency phases of its operations which were implemented to respond to the influxes of Sudanese and Somali refugees in 2011, during which over 130,000 new arrivals entered Ethiopia (including 100,995 new arrivals from Somalia, 19,861 from Sudan and 11,026 from Eritrea). After the emergency phase of 2011, many achievements were reached in 2012, despite on-going new arrivals from several neighbouring countries (including 35,823 new arrivals from Somalia, 35,238 new arrivals from South Sudan, 12,466 from Sudan and 10,731 from Eritrea). In 2013, UNHCR Ethiopia has continued to improve and consolidate its operations.

UNHCR, on the basis of its Statute of 1950, the 1951 United Nations Convention relating to the Status of Refugees, and subsequent United Nations General Assembly resolutions, is mandated to provide international protection to refugees and other categories of persons of concern and to search for solutions for them. Therefore, UNHCR and ARRA have leadership role with regard to all refugee issues in Ethiopia. UNHCR is committed to the proactive facilitation of the responses to refugee operations and will establish and maintain joint systems which can benefit both its implementing and operational partners.

Ethiopia's geographical position and several environmental and geo-political developments in the region mean that it is likely to continue to receive new arrivals from nearly all its neighbours during 2013 and into 2014.

FIGURE 2: ETHIOPIA REFUGEE AND ASYLUM SEEKER STATISTICAL MAP, 30TH NOVEMBER 2013



THE PROTECTION OF REFUGEES

UNHCR is the UN body mandated to lead and coordinate international action to protect refugees and resolve refugee problems worldwide. Its primary purpose is to safeguard the rights and well-being of refugees, ensuring access to services, including to health services, nutrient-rich food and safe water and sanitation.

UNHCR public health activities are underpinned by universal human rights concerns and principles. The 1951 Refugee Convention states that refugees should enjoy access to health services equivalent to that of the host population (Article 23, Refugee Convention of 1951). These rights to health, nutrition and water are also outlined in the Universal Declaration of Human Rights, 1948, Article 25: "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family", and Articles 11 and 12 of the International Covenant on Economic, Social and Cultural Rights (CESCR) which reinforce the right to food, health and living conditions, further highlighting these in the General Comments on the right 'to adequate food' (No. 12) and to the 'highest attainable standard of health' (No. 14). General Comment 15 on the right to water (2002) urges state parties to ensure that "Refugees ... have access to adequate drinking water whether they stay in camps or in urban areas. They should be granted the right to water in the same conditions as nationals."

Ethiopia is a party to the 1951 Convention Relating to the Status of Refugees and its 1967 Protocol, the 1969 Organization of African Unity (OAU) Convention on Governing the Specific Aspects of Refugee Problems in Africa particularly pertaining to the refugees and asylum seekers which thus paved the way for the adoption of Ethiopia's 2004 Refugee Proclamation. Additionally, the country is a party to a number of international and regional human rights instruments including ICCPR, ICESCR and ICEFRD, CEDAW, CAT, CRC (its two optional protocols), and the 1990 African Charter on the Rights and Welfare of the Child.

The Refugee Proclamation's refugee definition conforms to Article 1 (A) of the 1951 Convention and includes the extended definition contained in Article 1(2) of the 1969 OAU Convention. The Ethiopian government determines the criteria for asylum and protection based on these provisions and the Proclamation outlines the asylum legal framework within the country, wherein key protection principles on asylum are included and respected. In accordance with the 2004 Refugee Proclamation, the then NIS (National Immigration Service) is the designated administrative body dealing with refugees. NIS has in the meantime been replaced by ARRA (Administration for Refugee and Returnee Affairs), the de facto responsible body for the protection of refugees, including registration, refugee status determination, camp management, security and protection.

During the strategic period of 2014-2018, it is expected that the treatment of asylum seekers and refugees in Ethiopia will continue to be in accordance with the country's obligation, mainly discharged through maintaining an open door policy to the increasing number of refugees expected to arrive in Ethiopia. Also it is anticipated that the GOE will continue to readmit refugees expelled from third countries due to secondary movements, as well as allowing more refugees to benefit from the out of camp scheme and increased education, vocational training, livelihoods opportunities for refugees.

In terms of self-reliance, the GOE will continue to increase the Out of Camp scheme in terms of beneficiaries as well as expanding the scheme to other nationalities and allowing more livelihoods activities for refugees in camps.

The majority of refugees in Ethiopia are recognized on a prima facie basis and individually registered at Level 3 registration, including the taking of fingerprints. The Ethiopia operation has rolled out issuance of ID cards to refugees above 14 years of age. In addition, as of 2014, the operation is gearing towards implementing continuous registration systems.

Birth registration is not undertaken by municipalities for refugees in camps. Rather, birth notifications are being issued 100% to the refugees by the health centres in the camps, mainly through ARRA. Birth notifications need to be translated into proper birth certificates. UNHCR will liaise with UNICEF to support the

issuance of birth certificates for refugees in camps in Ethiopia. In the urban setting, refugees access birth certificates from the government and private health facilities.

GUIDING PRINCIPLES

RIGHTS-BASED, COMMUNITY-BASED AND PARTICIPATORY APPROACHES

All UNHCR interventions, including those related to public health issues should prioritize the interest of the refugees and respect for their decisions, and be guided by principles of confidentiality, safety, security, respect, dignity and non-discrimination. Refugees should be empowered at all stages to participate in policy-making, programme planning and implementation and evaluation, thereby contributing to quality, accountability and sustainability of programmes. Gender equality and respecting the rights of all refugees of all ages and backgrounds are central to the work of UNHCR.

Three strongly interlinked approaches are applied in UNHCR operations worldwide:[7]

- A participatory approach that seeks to link refugee participation to programme design, and feedback.
- A community-based approach that recognizes the resilience, capacities, skills and resources of the refugees, and focuses on identifying and building on community capacities for self-protection.
- A rights-based approach that requires actively working towards the realization of human rights of refugees, seeking to redress discriminatory practices and unjust distributions of power that impede development progress and ensuring that plans, policies and processes of development are anchored in a system of rights and corresponding obligations established by international law.

Effective communication mechanisms are in place to improve access to essential services, to ensure information accessibility and to improve the health status of refugees. Communication strategies ensure that refugees and key services providers are aware of their rights and obligations, as well as opportunities and services that are available to them. Refugees can become effective health workers, hygiene promoters and translators amongst their own communities.

ACCESS

UNHCR will support refugee access to inclusive services in similar ways and at similar or lower costs to those of nationals.

Access will be secured according to need and not according to gender, age, race, religion, sexual orientation, HIV status and physical disability. Access includes the promotion of an effective legal environment, but also to physical and economic access. Special measures will continue to be taken to ensure inclusiveness and accessibility, measures are taken to ensure that women and girls access services as effectively as men and boys, the elderly, the young, and that access is facilitated for those with disabilities (physical and economic access). Different financing options will be considered to support refugees who have to pay user fees to access health, nutrition and WASH services.

EQUITY

UNHCR seeks to ensure that all refugees can access quality health, HIV, reproductive health, food, nutrition and water and sanitation services, while prioritizing assistance to those most in need.
Special assistance, including cash assistance or waiving of fees, will be established for vulnerable refugees so that they can access services equitably. Efforts will be made to identify and lessen the effects of stigmatization and/or discrimination of any individual.

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[7]Executive Committee of the High Commissioner's Programme. *Age, Gender, and Diversity Mainstreaming Approach*. Standing Committee, 54th meeting. 5 June 2012. Available at: http://www.unhcr.org/500e570b9.html

INTEGRATION

UNHCR will ensure that public health, HIV, food security, nutrition and WASH services for refugees are integrated within national systems, whenever feasible, in order to ensure their sustainability.

UNHCR, ARRA and their partners, support relevant government ministries (health and water) and national AIDS control programme (Federal HIV/AIDS Prevention and Control Office, FHAPCO) to enable refugees and surrounding populations to access services. In addition, it relies on partners to provide services that complement government services where there are significant gaps in service provision, lack of capacity or need for temporary additional support to be provided to ensure refugee access to reproductive health, nutrition, HIV, mental health, specialist care programmes and other key health services, while advocating for and sometimes enabling the government of Ethiopia to provide such services.

PRIORITIZATION, RATIONALIZATION AND EFFICIENCY

UNHCR prioritizes the use of a package of quality, evidence-based public health, food security, nutrition and WASH services on the bases the strategic priorities of Ethiopia healthcare system to ensure access to healthcare which is provided from the smallest household units at community level to the level of highly specialized and rehabilitative services in a cost-effective and efficient manner

With UNHCR support, refugees are able to access a clearly defined package of essential, cost-effective primary and emergency health services, nutrition and WASH services. This includes emergency medical, surgical and trauma care, community-based prevention and management of acute malnutrition, reproductive health (RH) and services for infants and young children, food security and nutrition, communicable disease control (including HIV, TB and malaria), services for non-communicable diseases (NCDs) and mental health.

Essential health care packages take precedence over referral to more specialized medical care. Ethiopia follows a general practice model in which the majority of consultations are handled within primary health care (PHC) services, with referral for more complex problems (Refer to Standard Operating Procedures {SOP} for Medical Referral of Persons of Concern in Ethiopia). Increasingly, UNHCR takes value-for-money into consideration by comparing the costs of delivering similar services, but wherever national service delivery programmes are available; these are chosen in preference to setting up high-cost parallel services.

Refugees will continue to have access to a package of potable water and sanitation that meet minimum service provision standards close to their dwellings, and remain involved in designing the priority hygiene components of an integrated WASH package. Wastage will be minimized (e.g. during fetching of water) and cost comparisons estimated by comparing the value-for-money presented in the offers of different providers.

The rationalization of services is supported by identifying and supporting a select number of quality public health service providers and facilities for primary and emergency health, for nutrition, for specialist health care providers and for additional WASH services if the national infrastructure capacity is insufficient. Limiting the number of potential service providers and services enhances cost-efficiency and effectiveness, and allows more manageable monitoring, evaluation and quality control process.

APPROPRIATENESS AND RELIABILITY

Services should be appropriate to the context in which they are provided. This includes ensuring and facilitating access to minimum essential services in emergency contexts and different levels of comprehensive services. Refugees are consulted in the design and implementation of essential service packages to ensure that these services are appropriate and sustainable. Overall, services should be similar to those provided in the country of origin and host country. However, minimum essential services must be provided in all situations, regardless of availability in surrounding communities. If such minimum essential services are not available in the latter, UNHCR advocates for their provision and provides such services to the surrounding community within existing capacities and resources. Prioritization is essential in these circumstances, and wide scale availability of primary health care, including obstetric care and prevention services must be prioritized.

EVIDENCE-BASED DECISION-MAKING

Public health programmes are planned and evaluated based on the availability of quality data. Data is collected and interpreted in UNHCR's online global public health information toolkit, TWINE, as well as standardized expanded nutrition surveys (SENS), knowledge attitude and practices (KAP) surveys, and needs assessments. TWINE provides a diverse set of data tools for health, WASH, food security and nutrition, HIV and RH. UNHCR likewise promotes the use of national and international guidance, quality standards and practices, and contributes to the formulation of these standards, thus promoting quality of services. Both facility and community-based surveillance and surveys are employed to give a clearer picture of health status and needs, and how services are being accessed. Effective monitoring and evaluation and associated data collected and reported enables better technical planning and improved advocacy around clear objectives.

URBAN HEALTH PROGRAM GUIDING PRINCIPLES

These principles are derived from UNHCR's policy on refugee protection and solutions in urban areas and from PHHIV Section's Guiding Principles and Strategic Plans and Principles and Guidance for Referral Health Care for Refugees that have been adapted to the urban context.

1. **Access**. Ensure that refugees access services in similar ways and at similar or lower costs to that of nationals.
2. **Integration.** Advocate that public health services for refugees are made sustainable by being integrated within the national public system whenever feasible. UNHCR may draw on partners to temporarily provide services complimentary to government services where there are significant gaps in service provision or when services are of insufficient quality.
3. **Equity**. Establish special assistance arrangements for vulnerable refugees and individuals with specific needs so that they can access services equitably.
4. **Prioritisation**. Ensure refugees access essential primary health care (PHC) services and emergency care; these take precedence over referral to more specialised medical care.
5. **Rationalisation.** Support the rationalisation of health services by identifying and supporting a select number of quality health service providers and facilities.
6. **Partnerships.** Partner with a wide range of actors, especially governments, other UN agencies, international agencies, civil society, non-governmental organisations (NGOs), academic institutions and the private sector to ensure the availability of quality public health services for refugees.
7. **Participation.** Promote the capabilities of refugees who participate in meeting health challenges in their communities to allow these principles to be fully realised.
8. **Communication.** Establish effective communication mechanisms to improve access to priority primary health care (PHC) services and to improve health status of refugees.
9. **Evidence-based decision-making.** Promote the establishment and utilisation of information systems to improve health policies and to increase the prioritisation and impact of programmes.

GLOBAL STRATEGIC PRIORITIES

The strategic impact objectives (goals) reflect the results of key inputs and outputs in the four sub-sectors successfully working together. Key improvements in health status, as measured by morbidity and mortality, come about when different determinants of a person's health are addressed. These goals appear as global strategic priorities (GSP) under basic needs and services in UNHCR's annual global reporting exercise. The GSP highlights areas of special focus for global operations, namely:

- Preventive lead focusing on CHWs & refugee health committee
- Addressing major causes of morbidity and mortality;
- Providing adequate HIV and reproductive health care;
- Reducing malnutrition and anaemia; and
- Meeting international WASH standards.

STRATEGIC AREAS

UNHCR's public health principles lay the foundation of a holistic approach that prioritizes equitable access to appropriate quality services, which are monitored for effectiveness. The strategy is implemented by UNHCR, ARRA and their partners working in Ethiopia, supported by UNHCR technical staff in Headquarters and at the regional level. The six strategic areas are:

EFFECTIVE RESPONSE IN EMERGENCIES AND BEYOND

The year 2011 and to some extent 2012 saw a huge influx of refugees from Somalia into the Dollo Ado camps and from Sudan into the Beneshangul-Gumuz camps in Ethiopia. An influx of the magnitude experienced in these two years brought enormous challenges in terms of meeting the many basic needs of newly arriving refugees which has required the attention of all the key stakeholders.

UNHCR prioritizes rapid and effective response in emergencies. This requires effective financing and coordination, technical capacities, physical infrastructure and supplies and streamlined data collection. Collectively, this ensures a quality response and that core indicators are kept below emergency thresholds. UNHCR continues representing the rights and needs of refugees until durable solutions are found.

PARTNERSHIPS AND COORDINATION

UNHCR together with its government counterpart, ARRA lead coordination mechanisms with relevant government ministries on public health, nutrition services and WASH programmes, and ensures that contingency plans are in place for potential large-scale influxes of refugees. UNHCR aims for monthly national refugee health coordination meetings with these ministries, and wants to ensure that operational health and nutrition and WASH coordination meetings are conducted with all agencies and partners working on refugee health at country level and at decentralized (zonal and/or camp) level.

UNHCR also collaborates with a wide range of other state and non-state actors within their mandates and expertise to ensure the availability of quality public health services for refugees. These partners include other UN agencies (WFP, UNICEF, WHO, UNFPA), international agencies, civil society, non-governmental organisations, academic institutions, multilateral institutions, donors and the private sector.

UNHCR's partnership with the World Food Programme (WFP) is a cornerstone for the organization's operation and directly contributes to the health and nutritional well-being and food security of refugees and has broader positive impacts in other areas, e.g. education and livelihoods. UNHCR and WFP both follow a Joint Plan of Action (JPA) that is reviewed every two years in line with Joint Assessment Mission (JAM) recommendations to address food security in refugee operations in Ethiopia.

Based on the LOU signed between the two agencies and mandate of child protection, UNICEF shall work closely with UNHCR in the sectors like child education, emergency public health and nutrition, immunization and WASH.

The World Health Organization collaborates in the areas of disease surveillance, epidemic and preparedness and response, emergency public health intervention and capacity building.

UNHCR as a UNAIDS co-sponsor and co-lead of the Interagency Task Force to address HIV in humanitarian situations is at the forefront of the response to HIV among conflict-affected and displaced populations. HIV prevention, care and treatment, including access to antiretroviral treatment (ART), are central to the overall protection of refugees and other persons of concern to UNHCR.

UNHCR Ethiopia also has developed a joint framework of collaboration with UNFPA in Reproductive health (RH), particularly, in ensuring access to Minimum Initial Service Packages (MISP) in RH during emergency.

As public health interventions that exclude refugees are not effective, UNHCR works closely with the federal, regional and woreda ministry health structures in order to ensure that the services are provided in line with the national standards. UNHCR shall advocate with the ministry of Health to ensure that refugees have access to national programmes like immunization, tuberculosis prevention and control, HIV and Other national disease prevention activities.

UNHCR closely works with the Ethiopian Health and Nutrition Research Institute (EHNRI) and the regional laboratories to ensure the effective response to epidemic, strengthen the capacity of refugee laboratories, quality assurance and capacity building.

UNHCR works closely with the Ethiopia Food, Medicine and Health Care Administration and Control Authority (FMHACA) for ensuring t refugee have access to standard, safe and quality medicines and medical supplies

FINANCING

In light of growing scarcity of resources, UNHCR will continue to enhance global advocacy efforts by providing high quality evidences on the efficiency and effectiveness of services provided to save the lives of refugees. UNHCR aims to increase the funding available for refugee programmes, as well as improve its sustainability and effectiveness. By working with the government of Ethiopia on its commitments under international conventions, UNHCR promotes the access of refugees to free or cost-effective public health and WASH services that are available to nationals.

Annual spending on public health, nutrition and WASH programmes for refugees have increased and need to increase further in real terms to meet the strategic objectives. To this end, UNHCR is seeking to increase contributions from donors (governments, private foundations and individuals), while improving accountability, efficiency and value-for-money of programmes, as well as working to ensure that refugees can make contributions to healthcare costs. This is dependent on effective livelihood strategies that improve refugees' access to economic opportunities.

INNOVATION

As UNHCR responds to the changing nature of forced displacement, with more and more refugees living in urban areas, it has to become as effective in responding to the needs of scattered urban and/or out of camp refugee populations as well as those in camps. With the organization's new focus on refugee protection and solutions in urban areas, operational guidance has been prepared on ensuring access to health care in urban areas; this guidance outlines ways of achieving greater integration into government systems and combining humanitarian programming successes with a more sustainable services approach. This will be mainstreamed in Ethiopia urban refugee program in the period of the strategic plan.

UNHCR's technical response in urban areas is being facilitated by the use of new technology. To improve the collection of public health, nutrition and WASH data, UNHCR Ethiopia has introduced the use of smart phones for field surveys in both camp and out-of-camp settings. The use of smart phones offers advantages over conventional paper-based survey methodologies, including the quality and accuracy of data and speed of analysis. UNHCR Ethiopia is also piloting use of computer tablets to support the balanced score card, HIS evaluation and laboratory assessment tools in TWINE; this enables mobile data collection and the consolidation and rapid review of results with all partners. Solar-powered netbooks will increasingly be used to collect data for the health information system in health facilities with pilot phase to start in Dollo Ado refugee camps.

UNHCR will continue to strengthen technical innovation and quality by establishing links with academic institutions and the private sector and foundations.

ASSESSMENT AND MEASUREMENT

Public health programmes are planned and evaluated on the basis of available quality health information. All public health programmes collect and interpret data in UNHCR's streamlined global health information toolkit, TWINE. UNHCR's health information system (HIS) is currently available in two versions – one for camps and the other for urban settings – and is used to collect health consultation information from partners caring for refugees and compiling mortality data in camps. These standardized tools make it possible to design, monitor and evaluate public health, nutrition and HIV programmes and provide evidence-based information that is used for programme evaluation, planning and policy formulation. All indicators for this strategy are found either in the HIS, in other reports in UNHCR's TWINE online toolkit of reports and databases or from survey and assessment data. TWINE data is compared between camps and different settings, as well as between countries and regions. (http://twine.unhcr.org/app/public.php). Other TWINE reports include prospective health surveillance that monitors access in urban settings, a balanced score card to assess quality of health facilities, a WASH report card, a disease outbreak report, a food aid report and a nutrition survey database. HIS evaluations are regularly conducted on UNHCR programmes using the HIS to measure reporting performance.

UNHCR has developed and introduced important improvements to the quality of assessment and monitoring in the area of nutrition through standardized expanded nutrition surveys (SENS) and accompanying guidelines (http://www.sens.unhcr.org). The SENS guidelines ensure a broader and more integrated approach to nutrition surveys and include modules on anthropometric data, anaemia, infant and young child feeding, food security, WASH and malaria. A standardized knowledge attitude and practices (KAP) survey has been developed for use as a standard tool for measuring hygiene behaviour in refugee camp settings and to improve WASH programmes accordingly. UNHCR has also developed a new WASH monitoring system (WMS) to streamline data collection and reporting on WASH indicators

Using these tools, UNHCR builds up the evidence base for all its public health activities and promoting quality standards in its different operational areas. In addition, these tools are used to feed information to the UNHCR Focus planning and budgeting tools to ensure integration in the wider UNHCR programming system.

CAPACITY BUILDING

In collaboration with the Ministry of Health, UNHCR will give emphasis to capacity of the healthcare workers to provide up-to-date and quality service. The training will focus both on the national and the refugee healthcare staff. The capacity building training shall include training of relevant staff on new guidelines, protocols and tools in the form of in-service and on-the-job training. UNHCR in collaboration with the implementing partners will ensure that the trained staff is retained, appropriately assigned and provided the required support following the training.

In line with this, UNHCR will work closely with ARRA and other partners and involving various managers and program colleagues to develop a strategy on staff retention, continuous medical education (CME) and improvement of living and working conditions of staff so as to ensure

THE STRATEGY BY SECTOR:

In the following sections, brief descriptions are presented of the five sectors (urban health, public health, HIV and reproductive health, food security and nutrition and WASH) and followed by activities (enabling actions) that will guide the implementation of the strategy. Alongside this strategic document, separate operational workpans have been developed for the country strategy and per region/sub-office.

URBAN HEALTH PROGRAM

The public health role of UNHCR is more complex and less well defined in non-camp settings. There are multiple health service providers in cities including state, private and local and international non-governmental organisations (NGOs). UNHCR's aim in urban settings is for refugees to access quality health services at a level similar to that of nationals. UNHCR's major role in urban settings is to advocate for and facilitate quality health services to be available to and accessed by refugees. While working with government and city authorities, UNHCR engages with a wide range of actors promoting shared responsibility, and advocates for an appropriate resource base to enable the needs of refugees to be met.

The UNHCR global policy on refugee protection and solutions in urban areas elaborates a three pronged approach - advocacy, support, and monitoring & evaluation. UNHCR and ARRA will continue advocating on behalf of refugees and working closely with authorities to continue the current practice of making public services including health services available at similar costs to that of nationals or subsidized where necessary. UNHCR supports and facilitates integration into and strengthening of the national public health system. This may include direct funding or indirect support via partners. UNHCR, ARRA and FMOH will assess, monitor, and evaluate the health, nutritional, educational and economic status of refugees, ensuring needs are met in line with accepted standards and that quality services are available and accessible.

The health status of refugees will not be improved by health services alone; the underlying determinants of health must also be addressed by improving livelihoods and income, food security and nutrition, housing, education and access to water and sanitation services. UNHCR staff also engages in multi-sector, multi-agency mechanisms that address the underlying causes of vulnerability and ill health of the urban poor including refugees. Specific safety nets may need to be supported by UNHCR to support refugees most in need and to improve their economic potential.

The principle objective of the urban health program is to advocate for and facilitate access to (and when necessary provide and/or support) quality public health services for refugees equivalent to those available to the national population. UNHCR has developed a guidance note[8] that provides operational details for the urban health program and, that will need to be adapted to Ethiopia context.

Strategic indicators for monitoring the urban program are listed in the monitoring tales under each technical sector below.

[8] UN High Commissioner for Refugees (UNHCR), *Ensuring Access to Health Care: Operational Guidance on Refugee Protection and Solutions in Urban Areas*, 2011, available at: http://www.refworld.org/docid/4e27d8622.html [accessed 8 December 2013]

PUBLIC HEALTH

The principal objective of the public health programme is to minimize mortality and morbidity and improve quality of life of refugees and other Persons of Concern to UNHCR.

The objectives of Public Health sector are to:

Strengthen disease prevention & health promotion activities

Improve access to quality primary health care programmes

Improve childhood survival

Facilitate access to integrated prevention and control of NCDs, including mental health services

Improve access to specialist care and access to national health systems

Ensure an effective public health response in emergencies

OVERVIEW

Crises caused by armed conflict and natural disasters resulting in forced population displacements usually result in high rates of excess morbidity and mortality from communicable diseases. Refugees and internally displaced persons (IDPs) have experienced high mortality rates during the period immediately following their migration. In Africa, crude mortality rates (CMR) have reached levels that are 80 times as high as baseline rates. During the 2011 refugee crisis in Dollo Ado, mortality rates during the peak of the influx have been as high as 14 times above the standard. The most common causes of death have been diarrhoeal diseases, measles, acute respiratory infections, and malaria. High prevalence of acute malnutrition has contributed to high case fatality rates.[9]

UNHCR's public health assistance to refugees is anchored on the same primary health care (PHC) principles as contained in the Alma Ata Declaration which defines PHC as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination".[10]

In practice, PHC components vary according to context but should be available at first-contact with the health system and on a continuous basis. PHC incorporates the tasks of medical diagnosis and treatment, psychological assessment and management, personal support, communication of information about illness, prevention, and health maintenance. Depending on the setting, PHC may be provided by a medical doctor/ physician, health officer, nurse, or other type of health worker.

Health Information System (HIS) reports and nutrition surveys indicate that mortality rates in Ethiopia refugee camps have been trending downwards, as reflected in the following table representing trends of crude mortality rates (CMR), under-five mortality rates (U5MR) and neonatal mortality rates (NNMR) among

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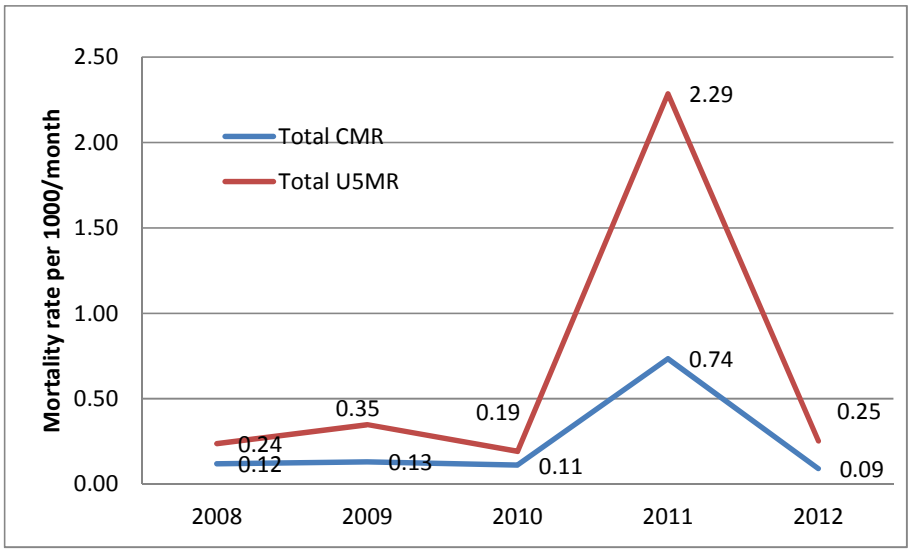
[9] MJ Toole and RJ Waldmann. The public health aspects of complex emergencies and refugee situations. *Annu. Rev. Public Health;* 18:283–312, 1997.

[10] Declaration of Alma Ata. International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978. Available at: http://www.who.int/publications/almaata_declaration_en.pdf

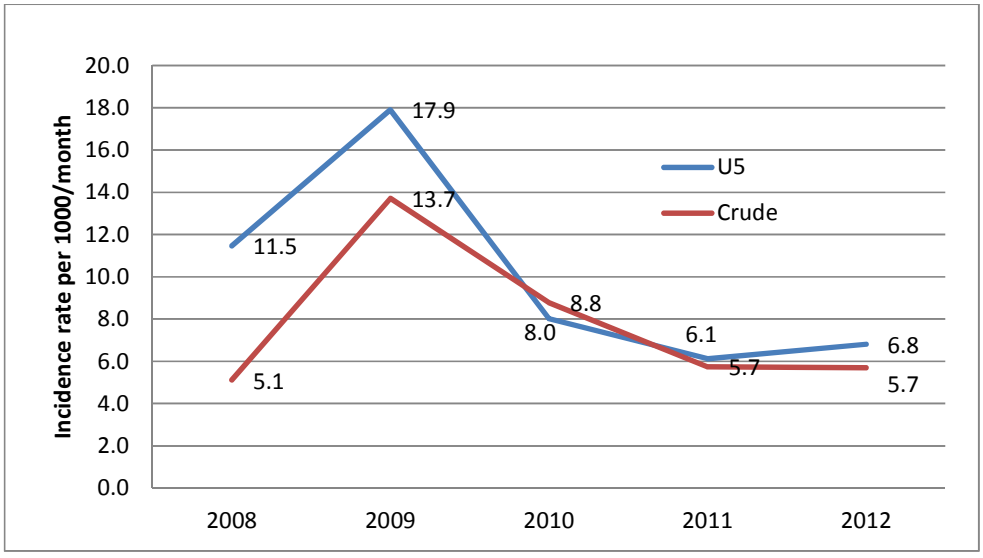
refugees over the period of 2008-2012. However, the highest mortality rates were reported in 2011 as a result of large influx of Somalia refugees in to Dollo Ado following the large scale draught in the region.

FIGURE 3: CRUDE AND U5 MORTALITY RATES FROM 2008 - 2012, ETHIOPIA



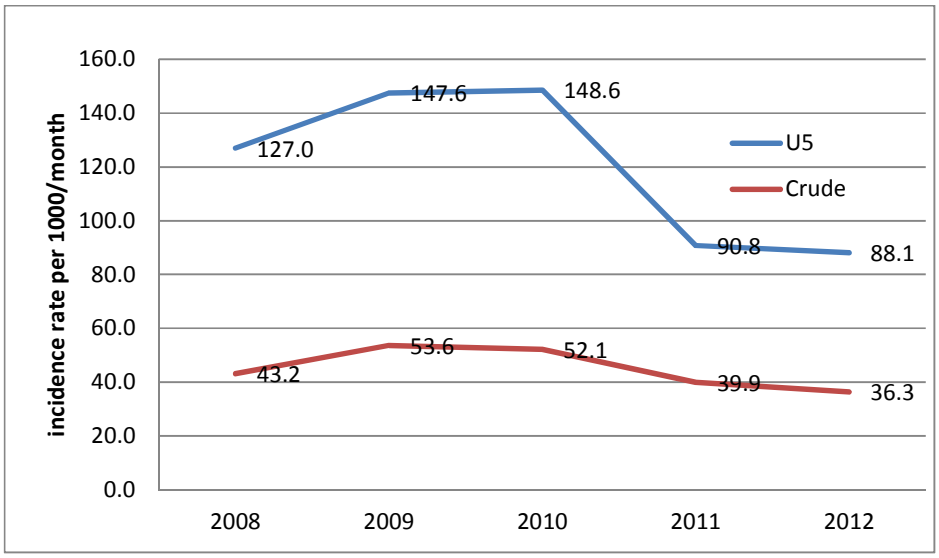
In the period 2008 to 2012, overall crude malaria-related morbidity among refugees in Ethiopia ranged from 11.5 per 1000/month in 2008 to 6.8 per 1000 per month in 2012.

FIGURE 4: CRUDE AND U5 INCIDENCE RATE OF MALARIA FROM 2008 - 2012, ETHIOPIA



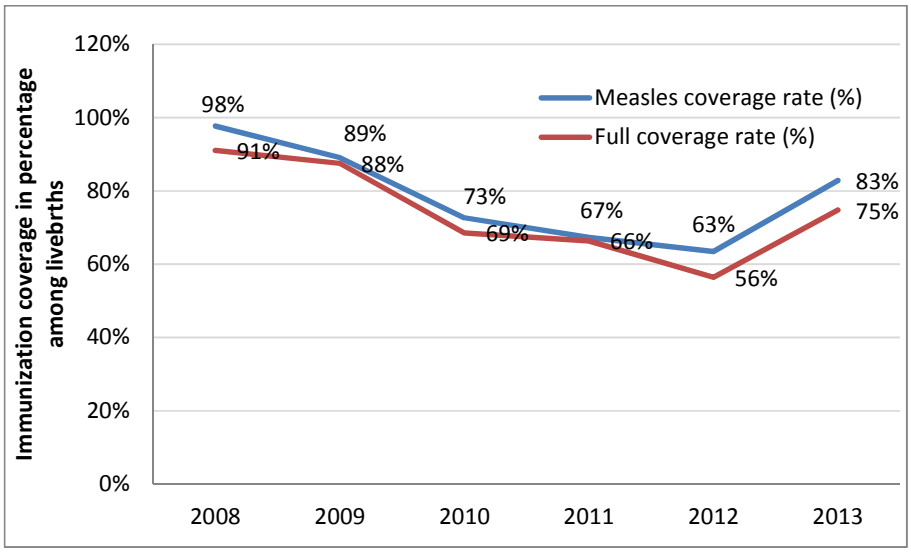
Acute respiratory infection (ARI) is the leading cause of morbidity and mortality representing almost half of the outpatient consultations and a fifth of all causes of death. Since 2008, acute respiratory infections (ARI) showed a decreasing trend in both total and under five populations. The drop was particularly significant in the under-five population which is from 127.0 per 1000/month in 2008 to 88.1 per 1000/month in 2012. The improvement may be related to improved shelter, provision of clean energy supplies and better outreach healthcare services.

FIGURE 5: CRUDE AND U5 INCIDENCE RATE OF ARI FROM 2008 - 2012, ETHIOPIA



The expanded programme on immunization (EPI) is considered to be the most cost-efficient preventive intervention to reduce childhood morbidity and mortality. Refugee children often miss their vaccination in their country of origin due to conflict and disruption of services. In the asylum country, giving full EPI coverage to refugees often takes time, leaving children unprotected for longer period. UNHCR and its main health partner, ARRA along with FMOH, UNICEF and WHO and other operational and implementing partners are striving to bring refugee children under coverage of the national EPI and supplementary immunization activities (SIA) programs. Newly arriving refugees will also receive vaccination targeting extended age groups of up to 15 years or 30 years (based on epidemiological analysis) at reception or transit sites. UNHCR will seek to place renewed emphasis on this important public health activity in its 2014-2018 strategic plan and ensure that immunization coverage is kept at above 90% for routine and supplementary immunization activities targeting women and children. UNHCR shall ensure that the refugees have access to all nationally recommended vaccination types.

FIGURE 6: IMMUNIZATION COVERAGE, ETHIOPIA



Tuberculosis control programmes are invariably disrupted in conflict situations because of the unavailability of services, delayed treatment-seeking and discontinuation of treatment. A recent analysis of data from several refugee situations has demonstrated high TB burdens in refugee camps.[11] In Ethiopia, with the emergence of Multi Drug Resistance (MDR) TB, particularly among Eritreans, where more than 10 cases are reported from 2011 – 2013,the strategic plan would thus place renewed emphasis on TB control among refugee population to help improve capacity for new case detection. Healthcare workers will receive adequate training that helps them undertake proper case detection, treatment and follow up. The strategy will also focus on improving outreach activities and screening for TB during the initial registration at reception and transit centres. Creation of demand for TB services through health education, social mobilization and awareness creation via trained community volunteers will also be enhanced. The capacity of laboratory to make correct diagnoses will be improved by providing the required laboratory supplies, equipment and expertise. All nationally recommended ant-TB drugs will be available to the refugee health facility through the Ministry of Health. Referral linkage between refugee and nearby health facilities will also be strengthened. Refugees will also have access to MDR-TB treatment within the existing system on referral to MDR-TB treatment site and sample transportation for MDR-TB Diagnostic services to the nearby culture and DST centre of Xpert MTB/RIF centre and other referral facilities.

Refugees often suffer from various mental health problems due to atrocities faced before or during displacement, including violence, separation, torture, killing, massive destruction, sexual and gender-based violence (SGBV)and child soldiering. Mental illnesses represent around 2% of all outpatient consultations in the refugee camps in Ethiopia. This trauma is often compounded by a generalized sense of hopelessness among refugees, absence of employment opportunities, and social dysfunction in refugee situations. Refugees are also frequently diagnosed with symptoms of post-traumatic stress disorder (PTSD), depression, psychosomatic complaints and anxiety. Addressing these mental health concerns and ensuring an adequate response is often problematic due to the very difficult geographical and political situations in which refugees find themselves, as well as lack of resources to mount an adequate response. UNHCR Ethiopia and partners will seek more effective and efficient ways to respond to these mental health concerns by strengthening both community and facility based programs

Non-communicable diseases (NCDs) are the leading causes of death and disability worldwide, but remain an area of neglect so far. Non-communicable diseases represent 2 – 3% of all outpatient consultations in the refugee camps in Ethiopia. Much of the disability and mortality attributed to NCDs is preventable, but the '25 by 25' goal[12] will not be met without a major focusing of resources and political commitment to addressing NCDs. Morbidities from these conditions are accelerating globally and advancing in every region and refugee populations have not been spared. Data from refugee camps in Africa show that the NCD burden and unknown conditions ranges between 34 and 62 per cent in these often remote locations. Cardiovascular, digestive, respiratory and musculoskeletal disorders are among the major NCDs that have been reported. The reported burden is higher in females. In Ethiopia refugee camps, chronic and non-communicable diseases account for a significant proportion of referral burden which is estimated at more than 90%. This strategic plan will ensure cost effective access to prevention and treatment of non-communicable diseases.

Proper monitoring of the health situation and access to healthcare of the refugee population remains amongst the highest priorities. The UNHCR integrated online public health information platform (TWINE) will centralize wider public health information of refugees in Ethiopia to inform public health decision-making.

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[11] Kinbrough W et al. The burden of tuberculosis in crisis-affected populations: a systematic review. *Lancet Inf Dis*;12:950-65, 2012.

[12] The commitment by the UN high-level meeting on NCDs to reducing relative mortality by 25 per cent by 2025.

ACTIONS TO BE TAKEN TO ACHIEVE OBJECTIVES

OBJECTIVE 1: IMPROVE ACCESS TO QUALITY PRIMARY HEALTH CARE PROGRAMMES

UNHCR supports the Federal Ministry of Health to ensure that refugees have access to curative and preventative healthcare services, regardless whether they are living in refugee camps or out-of-camp situations.

Fees for accessing health services depend upon the context, but UNHCR advocates that they should not be higher than the fees paid by Ethiopian nationals. Furthermore, vulnerable refugees should be identified and a suitable safety net provided for them to ensure access to preventative and curative health services. Certain essential services, such as childhood vaccinations, antenatal and delivery care, communicable disease control and care for acute life-threatening emergency conditions should be provided free of charge. In situations where these are not provided as part of minimum healthcare package and where feasible, they should either be offered or paid for by UNHCR partners.

Distance to health facilities will be a factor to consider in design and construction of health facilities. Refugees should be within 5km of a health facility. Where this is not the case, effort will be made to construct decentralised health posts and/or provide mobile health services to enhance access to health services.

For out-of-camp refugees, UNHCR will continue to monitor PHC access in these contexts through the use and further development of the urban prospective surveillance, and also by developing a simple set of tools to understand how these health services are being used, as well as an urban health information system for UNHCR-supported clinics.

In refugee camps, public health programmes will continue to emphasize the quality of these programmes. This will focus on ensuring that universal precautions are met; essential quality medicines are available; national clinical protocols are adhered to and that laboratories are functioning and providing quality services; and that qualified staff are trained and retrained. The balanced scorecard and laboratory quality assurance tool will be used to assess quality. Additional easy-to-use quality monitoring tools for services at the primary health care level will be developed, and will support UNHCR and partners to continue to monitor and adjust programmes to meet these standards and adapt to the needs of the refugee population.

In the period 2014-2018, UNHCR will expand the vital role that the community-based health workforce plays in all phases of emergency risk management (prevention, preparedness, response and recovery); and promote the scale-up of community-based health workforces by recognizing all those who make up this workforce, and training and equipping them for interventions. A review of innovative initiatives in the domain and an operational guidance for the Ethiopia refugee program will be developed to improve community-based health programming. Linkages with hygiene promotion, RH/ HIV and nutrition will be crucial.

UNHCR will continue advocating with partners to recruit new health staff from the local community who also speak the respective refugee language, where applicable. Staff retention strategies which entice them to have a minimum contract period (eg 2 years) will be explored. Involvement of the Regional Health Bureaus and Woreda Health departments in identifying potential candidates for recruitment will help in minimizing high staff turnover and bringing on board local language speaking staff.

In addition to internal quality assurance system, UNHCR and its partners will collaborate with Ministry of Health in ensuring quality of services by establishing network for quality assurance tests in Tuberculosis, HIV and others as found appropriate.

OBJECTIVE 2: DECREASE MORBIDITY FROM COMMUNICABLE DISEASES AND EPIDEMICS

Communicable diseases are the major cause of mortality and morbidity among refugees, especially during the emergency phase. The main causes of morbidity and mortality in emergencies are diarrhoeal diseases,

including cholera and shigellosis, acute respiratory infections, measles and malaria in areas where it is endemic.

During the period of the strategic plan, UNHCR Ethiopia will further build upon a systematic approach to the control of communicable diseases. As an effective response will depend on adequate level of preparedness, renewed emphasis will be placed on epidemic preparedness and response. Measures will be taken to ensure that all refugee camps have updated outbreak preparedness and response plans in place so that immediate alerts are embedded in national early warning systems for outbreaks and effective multi-sectoral preventative and response programmes are established, ensuring strong linkages to the WASH sector.

Malaria prevention and control is the major priority program that has enjoyed over the years, utmost government commitment and considerable attention from the health policy makers in Ethiopia since the beginning of HSDP I. The overall strategies to substantially reduce the overall burden of morbidity and case fatality rates remained: comprehensive approach to vector control, early diagnosis and prompt treatment and, surveillance, prevention and rapid management of malaria epidemics when and where it occurs. Comprehensive malaria control programmes, including appropriate preventive interventions and a treatment policy based on national protocols and latest efficacy models, remain an operational priority in this strategic plan period. UNHCR Ethiopia and its partners will continue to coordinate with the national malaria control programmes, as well as support from donors, such as the UN Foundation, for the preventative elements of the malaria control programme. Monitoring of the utilization of long- lasting insecticide treated nets (LLITNs) is included as a module in the SENS survey.

Acute respiratory infections (ARIs) are the leading cause of mortality and morbidity among refugee children aged under 5. Control programme with community sensitization, early case finding and proper case management will therefore be strengthened. Cross-sectoral preventive activities will be promoted, including the provision of adequate shelter and blanket; drainage of stagnant water; and reduction of residual smoke through proper cooking energy provision.

While overall mortality levels have fallen for tuberculosis (TB), the TB burden remains enormous. Tuberculosis has remained one of the major global public health problems. Ethiopia ranks seventh among the world's 22 high-burden tuberculosis (TB) countries[13]. Refugees may be at increased risk of TB or inadequate detection and treatment due to health service disruption caused by conflict in their country of origin and subsequent displacement. Refugees, in general, can be enrolled in well-established national TB treatment programmes. During the strategic plan period, UNHCR will work strongly to ensure an early response during emergency phases and continue to advocate for access to treatment; improved screening, including linkages to the HIV programmes; and advocate for access to treatment for MDR-TB.

OBJECTIVE 3: IMPROVE CHILDHOOD SURVIVAL

Across the world, millions of children in resource-poor settings continue to die needlessly from common preventable infectious diseases, such as diarrhoea, pneumonia and malaria. Refugee children bear a disproportionately higher risk than all other age groups. Ensuring a healthy growth and development of refugee children is of prime concern to UNHCR. Studies have shown that rapid and sustained progress can be made in reducing neonatal and under-five mortality with effective public health measures.

The statistics contained in the Ethiopian September 2013 progress report compiled by UNICEF, WHO and the World Bank Group, showed Ethiopia has reduced child deaths by more than two thirds over the past 20 years. In 1990, an estimated 204 children in every 1,000 in Ethiopia died before the age of five. The latest data shows that by 2012 the rate had dropped to 68, a massive 67% fall in the under-five mortality rate. UNHCR

[13] USAID, Tuberculosis profile, Ethiopia, 2009

works in close collaboration with the government of Ethiopia adopting the local experiences in community mobilization and awareness raising.

In this strategic plan period there will be a strong focus on ensuring that all refugee children have access to full expanded programme on immunization (EPI) and improved diagnosis and treatment of childhood infections; this will be achieved through the use of updated clinical protocol, the establishment of linkages with national integrated management of childhood illness (IMCI) approaches, as well as strengthened linkages to nutrition and RH programmes. UNHCR Ethiopia together with its partners will continue to emphasize the critical role of community-based health interventions in addressing childhood illnesses.

Integrated management of childhood illness (IMCI) is an approach to child health that focuses on the well-being of the whole child. This approach aims to reduce death, illness and disability, and to promote improved growth and development among children of age 5 and below. It includes both preventive and curative elements that are implemented by families and communities, as well as by health facilities. The IMCI strategy seeks to improve case management skills of healthcare staff; overall health systems; and family and community health practices.

In health facilities, the IMCI strategy promotes the accurate identification of childhood illnesses in outpatient settings; ensures appropriate combined treatment of all major illnesses; strengthens the counselling of caretakers; and speeds up the referral of severely ill children. In the home setting, it promotes appropriate care-seeking behaviours; improved nutrition and preventative care; and the correct implementation of prescribed care.

Linkage to nutrition and RH programmes are critical for infant survival. UNHCR Ethiopia and its partners will therefore seek to ensure that all children receiving nutritional treatment can also benefit from interventions that improve general health, such as completing the EPI. Sick children that are not yet malnourished (e.g. they have diarrhoea), such as the siblings of malnourished children, can benefit from a nutrition follow-up, as well as health preventative and curative interventions and that children that go to a health facility are screened for undernutrition and referred as appropriate (particularly to CMAM).

OBJECTIVE 4: ENSURE ACCESS TO INTEGRATED PREVENTION AND CONTROL OF NCDS, INCLUDING MENTAL HEALTH SERVICES

Non-communicable diseases (NCDs) are major global causes of mortality and morbidity but have so far remained relatively neglected. Disability and mortality attributed to NCDs are largely preventable. Among these are people with mental illness that do not receive the first-line supportive therapy and treatment they need to be stabilized or healed.

During the strategic plan period, UNHCR will further strengthen its mental health programmes, with the roll-out for a model of interventions for mental health and psychosocial support programmes, focusing on the primary health care level and establishing multi-sectoral referral mechanism to ensure that the needs of different stakeholders are promoted in a balanced manner and within a coherent resource use framework.

UNHCR and several partners in Ethiopia are implementing psychosocial support activities in many camps. In a mental health and psychosocial support (MHPSS) assessment done in 2012 in Assosa and Dollo Ado, there were gaps identified such as the lack of access to mental health services and individual psychological counselling, lack of quality clinical care for severe mental disorders and the absence of community based mental health services. The needs in terms of mental health and psychosocial support are significant, taking into account the high number of psychologically distressed individuals identified during the assessment and the relatively few relief actors present in the area. The priority actions recommended include implementing a multi-layered community based mental health programme, that the quality of clinical services at the primary health care level be enhanced, setting up livelihood, informal education and recreational activities and a psychoeducation campaign on the risks of alcohol and substance abuse.

UNHCR will further support the development of an integrated approach that will target all major common risk factors of cardiovascular diseases (CVD), diabetes mellitus (DM), and chronic respiratory diseases as the most cost-effective way to prevent and control them. This integrated approach will focus on treating chronic diseases at primary health care level – a strong preventative component to reduce referral to costly secondary and tertiary health care systems.

OBJECTIVE 5: IMPROVE ACCESS TO SPECIALIST CARE AND ACCESS TO NATIONAL HEALTH SYSTEMS

Medical referral care is an essential part of health services. While the primary health care strategy is the core of all interventions, access to secondary health care is equally important. UNHCR Ethiopia has established country-specific standard operating procedures (SOPs) for medical referral care that stipulate UNHCR access and coverage conditions.

According to Ethiopian legislation, refugees have free access to national programmes and are charged only in cases where fees are charged to nationals as well. Cost, availability and quality of service, as well as timely access to treatment, will be the factors considered when deciding whether to refer to private or public health institutions.

Secondary Health Care is generally provided to refugees in zonal and regional hospitals, while Tertiary Health Care is generally provided in Addis Ababa. In-patient and out-patient care should be provided in public hospitals and in a select number of private health facilities.

Select specialists will be sent to the camps to provide on-site health care so as to enhance objective decision making, treatment and capacity building at field level and hence reduce the number of referrals to secondary and tertiary health care facilities

OBJECTIVE 6: ENSURE AN EFFECTIVE PUBLIC HEALTH RESPONSE IN EMERGENCIES

A timely, adequate and effective public health response is part of UNHCR's renewed emphasis on improving emergency response to refugee emergencies and assuming its mandated coordination responsibility. An emergency response can only be effective when it is predicted and prepared for. Public health is incorporated in UNHCR Ethiopia's multi-sectoral contingency plans. Public health coordinators will form part of the core emergency response team from the onset of the response in medium to large-scale emergencies.

During the strategic plan period (2014-2018), UNHCR Ethiopia and ARRA will work closely with its operational and implementing partners to ensure a predictable response to public health in emergencies focusing on the regular data collection and reporting from the onset of the emergency, adapted to the context, to determine needs and trends, which will lead to cost effective public health programming. UNHCR and ARRA will continue to work with partners with proven experience and capacity to mobilize own resources in shortest time for emergency response like MSF among others. Plans of action with operational partners like UNICEF and WHO will be further improved/ developed to ensure effective response drawing on comparative advantages and resource capacity to achieve better outcomes for refugees and other affected populations. Early intervention will focus on:

- Ensuring vaccination coverage for measles and polio and a rapid establishment and enrolment of refugee children in EPI programmes;
- Preventing and controlling disease outbreaks;
- Creating referral links for life-threatening health emergencies;
- Ensuring continuity of treatment of chronic diseases, e.g. TB and HIV;
- Establishing and supporting a strong community-based health programming;
- Adapting public health interventions to meet the need of the most vulnerable part of the population through decentralization of services, including mobile health and nutrition activities in large camps or settlements.

- Ensuring well-coordinated, timely and appropriate information sharing

UNHCR will also ensure that Ethiopia national health systems are supported to the fullest extent possible during new and emerging refugee crises and that refugees have access to these health systems free of charge or at reduced fees at the first stages of emergencies, depending on the context.

OBJECTIVE 7: ADOPT & IMPLEMENT ETHIOPIA'S HEALTH EXTENSION PROGRAM IN REFUGEE CONTEXT

Improving outreach activity has been one of the priority and strategic focus for UNHCR and ARRA in Ethiopia. The current UNHCR/ARRA standard that recommends one outreach worker to manage outreach healthcare service for 50 houses-holds has not been effectively implemented because of lack of availability of clear guidance on the requirements, roles and responsibilities of the outreach worker. The outreach workers lack well-defined service packages and resources that are needed to carry out the activities that are expected from them. Even, in most of the refugee camps, this standard that is recommended has not yet been attained despite the availability of the diverse community outreach work forces that are recruited by different implementing partners to undertake limited and specific tasks. Therefore, UNHCR and ARRA will establish a model community outreach programme by adopting from the national health extension programme. In order to ensure effective use of the pool of community outreach workers per camp/site, the programme will be coordinated by one lead agency which collaborates with other agencies in the same camp/site to address their specific community healthcare needs.

TABLE 1: MONITORING- PUBLIC HEALTH

Objective	Output objective	Indicator	Unit	Emergency indicator	Post-emergency indicator	Refuge camp	Urban/ Out-of-camp
Improve access to quality primary health care programmes	Increased access to primary care	Health facility utilization rate	New visits/person/year	1 to 4	1 to 4	✓	✓
		Number of health facilities per population	Proportion of health facilities per camp	1:10,000	1:10,000	✓	✓
	Improved community-based health programming	Proportion of community-based health workforce	Number	1:<1,000	1:<1,000	✓	✓
	Improved quality of diagnosis	Percentage of laboratories meeting the laboratory evaluation standard	Percentage of laboratories achieving >60% score	N/A	100%	✓	✓
	Improved quality of care	Percentage of health facilities meeting the balanced scorecard assessment standard	Percentage of health facilities achieving >60% score	100%	N/A	✓	✓
		Percentage of health facilities meeting the balanced scorecard assessment standard	Percentage of health facilities achieving >90% score	N/A	100%	✓	✓
Decrease morbidity from communicable diseases	Improved outbreak response	Does the operation have an outbreak response plan	Yes/No	Yes	Yes	✓	✓
	Decreased malaria incidence	Number of long lasting insecticide treated nets distributed	Number	1 LLITN / 2 persons	1 LLITN / 2 persons	✓	X
	Decreased malaria incidence	Incidence of malaria among children aged under 5	Cases/1000/month	Yes	Yes	✓	X
		Proportional morbidity of malaria among children aged under 5	Cases/total <5 patients X 100	Yes	Yes	X	✓
	Decreased watery diarrhoea incidence	Incidence of watery diarrhoea among children aged under 5	Cases/1000/month	Yes	Yes	✓	X
		Proportional morbidity of watery diarrhoea among children aged under 5	Cases/total <5 patients X 100	Yes	Yes	X	1
	Decreased pneumonia incidence	Incidence of pneumonia among children	Cases/1000/month	Yes	Yes	✓	X

		aged under 5					
		Proportional morbidity of pneumonia among children aged under 5	Cases/total <5 patients X 100	Yes	Yes	X	✓
		Incidence of pneumonia > 5 years	Cases/1000/month	Yes	Yes	✓	X
		Proportional morbidity of pneumonia > 5 years	Cases/total >5 patients X 100	Yes	Yes	X	✓
	Improved TB treatment outcome	Tuberculosis success rate	%	Yes	Yes	✓	X

HIV AND REPRODUCTIVE HEALTH

The objective of this sector is to provide universal access to HIV protection, prevention, care, treatment services and comprehensive integrated reproductive, maternal, new-born health services in order to prevent morbidity and mortality due to HIV and reproductive health (RH) problems.

The objectives of HIV and Reproductive Health sector are to:

- Reduce transmission of HIV using a protection and rights-based approach;
- Facilitate universal access to antiretroviral therapy (ART)
- Facilitate the elimination of vertical transmission of HIV;
- Improve access to comprehensive reproductive, maternal and new-born health services;
- Make progress in use of innovative and appropriate technologies in women's health;
- Ensure an effective minimum HIV and RH response in emergencies.

OVERVIEW

The Ethiopia Health Sector strategy in general and the HIV and Reproductive Health strategy (2014-2018) in particular is a consequent adoption of the UNHCR Global Health strategy and the Ethiopian Strategic Plan II for Intensifying Multisectoral HIV and AIDS Response.

The Ethiopia Refugee program HIV and Reproductive Health sector strategy is targeted to prevent and control HIV/AIDS epidemic and mitigate its impacts by creating universal access to HIV prevention, treatment, care and support services and improve access to quality comprehensive reproductive, maternal and new-born health services through enhanced partnership with the government of Ethiopia and line ministries at Federal and regional levels.

The strategy will be used as a guide for all RH and HIV programming in all the refugee camps in Ethiopia through effective coordination mechanisms and integration with the national system to produce important HIV and RH related outcomes.

As per the demographic health survey (DHS) of 2011, the HIV prevalence in Ethiopia is now at 1.5%. However, since there has not been any sero-prevalence study conducted in the refugee camps in Ethiopia and no national study in the past included the refugee camps, the HIV prevalence data for all the different nationalities in camps in the country is unknown. The impact of stigma and the complexity of the HIV in emergency settings are also some of the obvious limitations in fully understanding the epidemic in the absence of recent sero-prevalence data.

In Ethiopia, the epidemic which started in the mid-1980's, expanded rapidly reaching a plateau around the mid-1990s. Although the epidemic is on the decline in major urban settings and stabilizing in rural areas, there is significant variation in the epidemic among geographic areas and population groups. Over the years, the national HIV and AIDS response has improved to be more comprehensive in the services it provides to some marginalized groups of people including refugees. In the past, however, the responses were not adequately targeted to refugees and there is a huge gap in baseline information regarding HIV in the refugee camps. Monitoring the HIV epidemic and assessing the impact of HIV prevention interventions is an intrinsically complex and multi-faceted process. This is because of the dynamics of the epidemic, the nature of interventions necessary to reduce its spread, and the inherent limitations of measuring the impact of multiple, mutually reinforcing interventions.

HIV sentinel surveillance, the traditional cornerstone of monitoring HIV trends, becomes less sensitive as an epidemic matures. This is because HIV prevalence changes very slowly in response to behavioural changes in populations due to the chronic nature of HIV infection. Thus, HIV prevalence data cannot indicate whether

prevention interventions are having their desired short-term effect of changing behaviours of people who live in the country for a limited period of time.

While data on HIV prevalence in refugee situations are scarce, the health centre data indicates that there is a similar prevalence with the Ethiopian regions the camps are located in. Though refugees and other displaced populations are at increased risk of contracting the virus during and after displacement due to poverty, disruption of family/social structures and health services, increase in sexual violence, and increase in socio-economic vulnerability, UNHCR together with the Ethiopian government combats the stereotypical perception that 'refugees bring AIDS with them to local communities", which may lead to discriminatory practices.

In Ethiopia, following the slow progress on Millennium Development Goal (MDG 5) on improving maternal health, an Accelerated Action Plan on Improving Maternal Health in Ethiopia was validated and endorsed in November 2013 by the Ministry of Health at a national conference in Addis Ababa.

The 2010/11 Demographic and Health Survey indicates that Ethiopia has made limited progress to reduce maternal deaths over the last decade. There is some concern that the trend might be reversing; The maternal mortality ratio declined from 871 deaths per 100,000 births in 2000 to 673 in 2005 , however, between 2005 and 2010, the maternal mortality ratio marginally increased to 676 per 100,000 live births in 2010.

The rate of achieving MDG 5 varies across geographic regions and socio-economic groups in the country. Similarly, children growing up in the nomadic communities of the Eritrean Afar refugees in Ethiopia face their own particular challenges. These communities often live in remote areas at great distance from essential services such as health care. Women and children are at greatest risk in the hours around childbirth. Mobile communities and uncoordinated service provision leaves pregnant women without antenatal care, For these refugees who live spread-out among the host community in these locations, there are no clear referral pathways if and when things go wrong, Lack of access to maternal and child health care means a high infant mortality rate, high maternal death rates, and poor health and nutrition for the surviving children. The spread of disease is more likely as people move across the country, and children are vulnerable to diarrhoea, measles, malaria and HIV/AIDS.

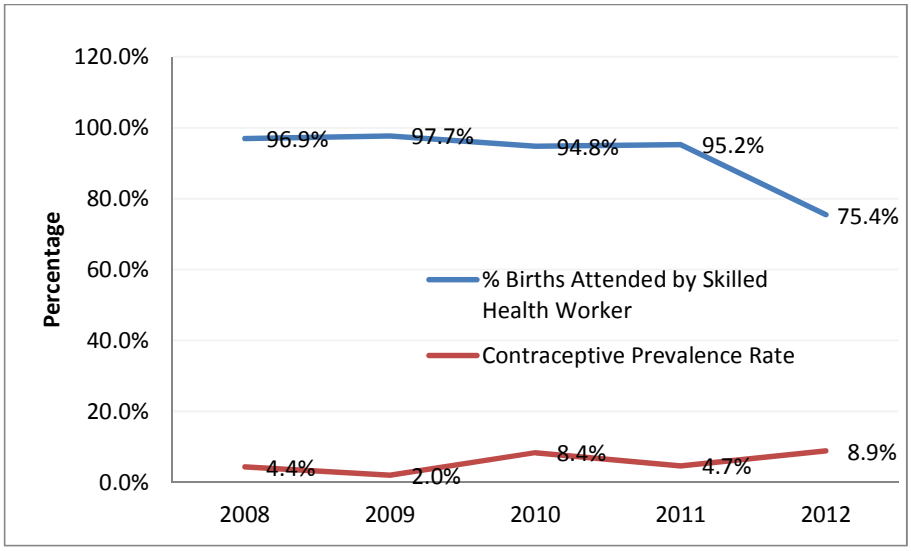
Advancing better health is a gateway to development progress, lifting economies and societies. Meeting a woman's need for sexual and reproductive health services will increase her chances of finishing her education, and breaking out of poverty, The UNHCR will work with the Ministry of health to identify and remove barriers to MDG achievement in and around the refugee camps in Ethiopia and for the effective implementation of the MDG Acceleration Framework (MAF) for reducing maternal mortality.

HIV, REPRODUCTIVE HEALTH AND REFUGEES

Significant progress has been made in improving access to comprehensive HIV and RH services for refugees. However, challenges remain. The components of the programme where standards have not been met become high priority areas for the 2014-2018 strategy.

UNHCR has been working with the Federal Ministry of Health and Regional Health Bureaus (RHB) as well as the FHAPCO and RHAPCO to ensure comprehensive Reproductive Health and HIV services in all the refugee camps in Ethiopia and impact-oriented multi-sectoral assistance through youth health education specifically awareness raising programmes on abstinence and/or being faithful and condom use. Reproductive health, gender-based violence/rape in relations with Post Exposure Prophylaxis (PEP), targeted programs on Orphan and Vulnerable Children (OVC), on maternal health as well as clinical care services were being provided in a comprehensive manner since 2008. UNHCR together with the host country government supported HIV programmes and continued to ensure the establishment of quality interventions as well as integration into the national HIV programme; Hence excellent level of ANC attendance was recorded with close to 100% PMTCT coverage and uptake in most long existed camps and contraceptive prevalence rose from less than 1 to 52% in highly conservative refugee communities; however, challenges remain with the newly opened refugee camps towards which UNHCR works to avert with partners.

FIGURE 7: REPRODUCTIVE HEALTH PERFORMANCE FOR SELECTED INDICATORS



ACTIONS TO BE TAKEN TO ACHIEVE OBJECTIVES

OBJECTIVE 1: REDUCE TRANSMISSION OF HIV USING A PROTECTION AND RIGHTS-BASED APPROACH

UNHCR will continue to anchor its HIV programme in UNHCR's protection and human rights principles. These involve public health approaches and focusing on the strong links between protection, education and livelihood activities.

UNHCR in addition to targeting most at risk populations, women and adolescents plans to target young people (10-24 years) in refugee camps as they have special HIV-related prevention and response needs. The HIV programme for young people will focus on evidence-informed combination prevention interventions prioritized to specific localities and contexts. The array of interventions will include raising their awareness on sexual and reproductive health and HIV through formal sexuality and life skills education in schools and in non-formal settings; this will be achieved through evidence-based peer-led approaches through school-based peer-education and awareness raising camp-based campaigns; universal access to male and female condoms; providing youth-friendly HIV prevention and response services in health centres; and empowering youth and youth-led organizations to champion HIV prevention in refugee camps.

In line with the UNAIDS investment framework and UNHCR experience of working on HIV in emergencies, the HIV prevention programme will scale up the targeting of most-at-risk populations (also referred to as key populations), notably sex workers. The ten-step approach foreseen in the UNHCR guidance note focuses on access to stigma-free health and protection services, and working to remove children from exploitative and abusive situations.

With newer models of improving uptake of HIV counselling and testing services, UNHCR will support the introduction of those models in refugee camps with limited counselling and testing coverage. Emphasis will continue to be placed on strengthening quality-assured counselling and testing services at multiple entry points in the health system, including but not restricted to provider-initiated testing and counselling (PITC), voluntary counselling and testing (VCT), ANC, STI and TB clinics. Family planning programs will also be used as entry points for counselling and testing services, sexually transmitted infection and HIV and reproductive cancer services and vice versa. Care is taken to ensure that the voluntary, confidential and privacy concerns are respected at all times.

Stigma and discrimination continue to undermine prevention, treatment and care of people living with the HIV and AIDS. It hinders prevention efforts from succeeding. Therefore UNHCR will continue to mobilize partners to strengthen the response to HIV stigma and discrimination and maximize investments in HIV prevention, treatment and care as well as coordinate and expand strategies for reducing HIV stigma and discrimination across the camps.

Further activities such as infection prevention, Behaviour Change Communication (BCC) and Voluntary Medical Male Circumcision (VMMC) and awareness raising programs focusing on Female Genital Mutilation (FGM) will be intensified to reduce the transmission of HIV in and around the refugee camps.

OBJECTIVE 2: FACILITATE UNIVERSAL ACCESS TO ANTIRETROVIRAL THERAPY

With the release of the 2013 WHO consolidated guidelines on the use of antiretroviral (ARV) drugs for treating and preventing HIV and its implications for national ART programmes, UNHCR will continue to advocate, work with and support Federal Ministry of Health and HIV/AIDS Prevention and Control Office (HAPCO) to ensure that refugees benefit from the newly adopted national protocols. When treatment and prevention programmes are well established, UNHCR will focus on scaling-up testing services, early detection of HIV and rapid enrolment in care and treatment.

Equal emphasis will be placed on ensuring adherence to treatment as much as access to treatment. This will entail developing simple evidence-informed guidance notes for promoting adherence in refugee settings and supporting effective adherence monitoring mechanisms. UNHCR together with the MOH and ARRA will create the demand for ART through sustained provision of ARV and continued community-based awareness raising on the benefits of adherence, training adherence support groups and ensuring increased donor commitments. Global experience and UNHCR's own experience suggests that loss to follow-up remains high among clients who are in the pre-ART phase. In addition to supporting adherence measures for ART clients, emphasis will be placed on retaining clients in the pre-ART phase until they become eligible for ART.

UNHCR will work closely with Federal Ministry of Health and HIV/AIDS Prevention and Control Office (HAPCO) and partners in promoting and expanding the use of point of care CD4 testing and other simplified platform for diagnosis and treatment monitoring. Furthermore, UNHCR will support government referral facilities with drugs and equipment on need base and availability of funds.

Equitable access to ART would be ensured for children, vulnerable groups among men and women with a particular focus on key populations. In order to increase access to quality and sustainable treatment, ART services will be provided in a decentralized manner and integrated with prevention and other health programmes. Efforts will likewise be put into further strengthening access to prophylaxis and treatment for opportunistic infections, with particular emphasis on TB/HIV co-infection.

Community systems, including networks of people living with HIV and AIDS, would be strengthened to actively engage in developing testing and counselling strategies, service design and delivery, adherence and provision of care and support, including nutrition support for the affected communities.

OBJECTIVE 3: FACILITATE THE ELIMINATION OF VERTICAL TRANSMISSION OF HIV

With the emergence of overwhelming evidence on the need to treat HIV-positive pregnant women to effectively prevent/eliminate mother to child transmission, UNHCR will continue working with Federal Ministry of Health and HIV/AIDS Prevention and Control Office (HAPCO) for the inclusion of refugees in the national roll-out plans. UNHCR will support capacity building of partners to be able to effectively provide appropriate elimination of mother to child transmission (EMTCT) regimens according to national protocols within the comprehensive PMTCT framework providing guidance on the four prongs of PMTCT intervention: (1) primary prevention, (2) family planning, (3) ART/ARV interventions, and (4) care, treatment, and follow-up.

UNHCR will work with partners and ensure that a full panoply of EMTCT services are provided, including universal access to counselling and testing for all pregnant women; access to appropriate ARV regimen for pregnant women and exposed babies, including adherence counselling; counselling on infant feeding practices; and early infant diagnosis and follow-up testing at 18months. The full range of EMTCT services will be firmly integrated within strengthened maternal and child health systems, including focused ANC and skilled birth attendance at delivery. In addition to integrating feeding programs with the MNCH, UNHCR together with ARRA and partners will ensure strong paediatric integration with maternal health services that offers infant vaccinations as a prime opportunity for follow-up.

OBJECTIVE 4: IMPROVE ACCESS TO COMPREHENSIVE REPRODUCTIVE, MATERNAL AND NEW-BORN HEALTH SERVICES

UNHCR recognizes that comprehensive reproductive, maternal and new-born services have an impact not just on individuals, but also on the family and the community at large. It will therefore continue to emphasize this area through a community-centred approach. The main components of such a programme would comprise:

A full scope of maternal and child health services, including focused antenatal care; access to supplementary feeding programmes including macro and micro-nutrients; delivery by skilled birth attendants in institutions with adequate facilities, including emergency referral; access to safe blood and C-sections; post-abortion care, post-natal care, including post-partum family planning counselling; and early new-born and neonatal care. All efforts would be made to minimize delays in access to maternal health services. In refugee camp settings, Traditional Birth Attendants (TBA) will be trained and incentivized as promoters of facility-based deliveries. In the event of a maternal death, the circumstances would be reviewed by a multi-sectorial group within 48 hours. UNHCR will support government referral facilities with drugs and equipment on need base and availability of funds. Furthermore, UNHCR, ARRA on conditions that the facilities exist, will provide CeMONC at camp level.

Child spacing/family planning measures will be introduced to meet current unmet needs. UNHCR will work with key stakeholders and use the widest spectrum of family planning methods in health centres to be provided with quality counselling and by trained healthcare workers. Various community mobilization strategies, including partnering with men, would be used to increase uptake of family planning services.

Evidence-informed adolescent sexual and reproductive health services which include quality, gender-sensitive youth-friendly information and services for young people (10-24 years) in both school and out-of-school settings will be provided. This will be achieved with full participation of young people and involvement of gatekeepers, including teachers, parents and community leaders. This approach aims to encourage the integration of youth centres with health centres. Evidence-informed peer approaches to promote behaviour change and increase uptake of services would also be supported in refugee situations.

Prevention and treatment of STIs will continue to be high strategic priority. A syndromic approach to managing STIs will be strengthened through awareness-raising, training, ensuring availability of drugs and supplies, display of protocols and carrying out prescription audits. Partner tracing, voluntary HIV counselling and testing for STI patients and their partners, venereal disease research laboratory (VDRL) and rapid plasma reagin (RPR) testing during ANC will be actively pursued. Presumptive treatment for high-risk groups will also be encouraged.

Sexual and gender-based violence remains both a protection and a public health challenge and combating it requires the adoption of an integrated approach involving health, protection and community-based protection. UNHCR will strengthen the referral systems and SOPs for clinical management of rape survivors. Clinical staff will be trained in clinical management of rape survivors and awareness of the population on early reporting, availability of services including the provision of Post Exposure prophylaxis and referral pathways would be improved. Harmful traditional practices, such as early marriage and female genital mutilation, have a

substantial impact on human rights and public health. There will be strong collaborative efforts involving health, protection, child protection and community based protection to address these issues through a long-term strategic approach. The plan will support capacity-building of partners with qualified agencies with a record of success in addressing these issues.

OBJECTIVE 5: MAKE PROGRESS IN THE USE OF INNOVATIVE AND APPROPRIATE TECHNOLOGIES IN WOMEN'S HEALTH

Global evidence suggests that a majority of maternal and child deaths could be prevented if women's rights are respected and if greater access to skilled care was available during pregnancy, childbirth and postpartum. Apart from the risk of maternal mortality, girls and women also pass through significant health challenges in their life cycle. Current tools and models of care for girls and women have not managed to address these challenges adequately.

In the last few years, new approaches to developing sustainable, scalable models for providing healthcare in countries where significant unmet needs have emerged including new solutions and innovative models that increase access to affordable and quality healthcare services for girls and women.

Preventing and managing fistula in refugee settings will be accorded high priority and addressed by improving skilled birth attendance at delivery, early detection of fistula and providing primary/secondary/tertiary care as needed for the woman.

During the period of the current strategic plan, Ethiopia will provide prevention and primary level care for gynaecologic conditions, such as cervical cancer and breast cancer, in line with national screening programmes/protocols and explore provision of affordable treatment where feasible. Screening for reproductive cancers would be promoted.

The Ethiopian government is piloting use of mobile technologies (mHealth) through the health extension workers (HEWs), who get a year of training before being assigned to a rural health centre. The program is expected to be an effective tool for advancing the government's key health initiatives, particularly community-based interventions that have women at their centre. UNHCR will explore the potential to roll-out the mHealth following the results of the pilot program in the national program and use the technology to share information and reminders on appointments for next clinic visit and others.

OBJECTIVE 6: ENSURE AN EFFECTIVE MINIMUM HIV AND RH RESPONSE IN EMERGENCIES

A timely, adequate and effective HIV and RH response is part of UNHCR's renewed assertion on improving an effective response to refugee emergencies and assuming its mandated coordination responsibility. During the strategic plan period (2014-2018), UNHCR Ethiopia will work closely with its operational and implementing partners to ensure a predictable response to HIV and RH in emergencies as part of the broader public health response focusing on the regular data collection and reporting from the onset of the emergency, adapted to the context, to determine needs and trends, which will lead to cost effective public health programming. Plans of action with operational partners like UNFPA will be further improved/ developed to ensure effective response drawing on comparative advantages and resource capacity to achieve better outcomes for refugees and other affected populations.

At the onset of a refugee emergency, programmes are expected to support minimum essential high impact interventions before comprehensive activities are initiated. The minimum initial service package (MISP) for reproductive health lists those priority interventions. As soon as the situation has stabilized and MISP components are in place, programmes will support the establishment of comprehensive RH and HIV programmes and target key populations at higher risk of HIV infection and high vulnerability.

Key interventions for addressing HIV during an emergency includes providing affected populations with continued access to ART; universal access to male and female condoms; provision of EMTCT services;

ensuring safe blood transfusion and universal precautions; and provision of consistent preventive messages. As the situation stabilizes a full scope of HIV prevention and response services is to be made available and accessible to the population.

As co-convener in the UNAIDS division of labour in addressing HIV in humanitarian crisis, UNHCR will increase its advocacy to other sectors and clusters involved in humanitarian response to build environments to mitigate the impact of HIV.

TABLE 2: MONITORING- HIV AND REPRODUCTIVE HEALTH

Objective	Output objective	Indicator	Unit	Emergency indicator	Post-emergency indicator	Refugee camp	Out-of-camp
Reduce transmission of HIV using a protection and rights-based approach	Reduced sexual transmission of HIV	Access of PoC to male and/or female condoms?	Yes/No	Yes	Yes	✓	✓
Facilitate universal access to antiretroviral therapy	Improved early detection of HIV	Equal access to VCT services as host nationals ensured?	Yes/No	N/A	Yes	✓	✓
		Do refugees have equal access to provider initiated testing & counselling (PITC)?	Yes/No	N/A	Yes	✓	✓
		Proportion of TB patients tested for HIV	%	N/A	>90%	✓	X
	Universal access to ART for those eligible for treatment	Equal access to ART services as host nationals ensured?	Yes/No	Yes	Yes	✓	✓
		Number of PoC receiving ART	number	N/A	Yes	✓	✓
Facilitate the elimination of vertical transmission of HIV	Scale-up and strengthen Elimination of mother to child transmission	PMTCT coverage	%	N/A	>90%	✓	X
		Equal access to maternal and newborn services as host nationals ensured?	Yes/No	Yes	Yes	✓	✓

		% of infants of HIV positive mothers who tested negative after 18 months	%	N/A	Yes	✓	X
Improve access to comprehensive reproductive, maternal and new-born health services	EmONC is available and accessible 24/7	Proportion of births attended by skilled personnel	%	80%	100%	✓	X
		Proportion of births conducted by caesarean section	%	5 to15%	5 to15%	✓	X
	Improved new-born care and survival	Are ambu bags for neonatal resuscitation available in all health facilities?	Yes/No	Yes	Yes	✓	X
	Investigation of all maternal deaths	Proportion of maternal deaths investigated within 48 hours	%	80%	100%	✓	X
	Improved preventive services for pregnant women, mothers and new-borns	Coverage of antenatal tetanus vaccination	%	N/A	100%	✓	X
		Antenatal care coverage	%	N/A	100%	✓	X
		Postnatal care coverage	%	N/A	100%	✓	X
	Rape survivors receive appropriate clinical care	Proportion of eligible rape survivors provided with PEP within 72 hours	%	80%	100%	✓	X
	Increased family Planning uptake	Contraceptive prevalence rate	%	N/A	Yes	✓	X
	Reduced sexually transmitted infections	Incidence of pelvic inflammatory disease	cases/1000/month	N/A	Yes	✓	X
		Incidence of genital ulcer disease	cases/1000/month	N/A	Yes	✓	X
	Adolescent sexual and reproductive health improved	% of deliveries to under 18s	%	N/A	Yes	✓	X

Make progress in the use of innovative and appropriate technologies in women's health	Reduce mortality caused by cervical cancer	Do refugee women have equal access to cervical cancer screening as host community	Yes/No	N/A	Yes	✓	✓
		Do girls < 16 years have access to HPV vaccination?	Yes/No	N/A	Yes	✓	✓

FOOD SECURITY AND NUTRITION

The goal of this sector is to improve the food security and nutrition situation of refugees, and to reduce the prevalence of undernutrition amongst refugees, especially women, young children and other vulnerable groups, including young people, the elderly and people with special needs.

The objectives of the food security and nutrition sector are to provide effective:

- Effective prevention of undernutrition and micronutrient deficiencies;
- Effective and timely identification and treatment of acute malnutrition; and
- Effective provision of up-to-date food security and nutrition information and analysis (to enable appropriate and needs-based programming);
- Effective food security and nutrition response including in emergencies

OVERVIEW/ SITUATIONAL ANALYSIS

FOOD INSECURITY AND UNDERNOURISHMENT GLOBALLY

Between 1990-1992 and 2010-2012 the number of undernourished people in developing countries fell from 980 million to 852 million and the proportion of the undernourished in the developing world fell from 23.2 to 14.9 per cent. However, one in eight people are undernourished in a world that has enough food to feed all.[14] Several factors help explain this, including the economic slowdown, higher level of food prices and food price volatility coupled with human and natural disasters affecting the production, livelihoods and household food economy. Food price volatility, in particular, affects the poorest consumers and producers.

Even though the number and proportion of undernourished people have decreased, hunger has still gone up in certain areas, mainly in Africa and in the Middle East clearly showing the link between conflict, potentially leading to displacement, and food insecurity and hunger.

FOOD INSECURITY, NUTRITION AND DISPLACEMENT

Displacement is a major shock for people and is often associated with a complete rupture of people's livelihoods, leading to undernutrition and food insecurity. In refugee operations, protection and food security and nutrition are closely intertwined. Forcibly displaced people need to acquire food and other basic items and services every day, but many aspects of refugee settings make this challenging and risky. Despite the policy of promoting livelihoods, host government policy to some extent makes it illegal for refugees to work or to own property or businesses. Encampment policies restrict freedom of movement of refugees, including access to markets. Livelihoods can be further restricted by a number of factors, thereby negatively affecting food security and nutrition. These include limited access to arable lands and natural resources, limited transportation facilities and situations of generalized poverty.

In such environments, refugees struggle to pursue livelihoods and become even further impoverished without them. Productive assets, such as cash savings or transportable goods, are rapidly eroded and access to some of the human and social capital is lost. Households and individuals that used to be 'better off' slip into poverty and the poor become more vulnerable, and risk facing acute food insecurity and malnutrition. Before arriving in their country of asylum, refugees often travel for days in precarious conditions, further compromising their physical health and safety and putting them at increased risk of disease, malnutrition and death.

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[14]Food and Agriculture Organization of the United Nations. *State of Food Insecurity in the World*, 2012

As a consequence, acute malnutrition is highly prevalent in many emergency and post-emergency refugee situations around the world, especially among young children. This is often exacerbated by challenging environmental, sanitation and shelter conditions at the onset of displacement.

WFP, UNHCR, and ARRA with the participation of NGO's and donor representatives undertook a Joint Assessment Mission (JAM) to several refugee camps in Ethiopia between 10th and 18th October 2012. The principal objective of the mission was to assess the current food security situation of refugees in the country and the extent to which the other needs of refugees such as Core Relief Items, water, health services, energy, shelter, etc. are being met. This assessment is an important tool for identifying gaps and help draw up remedial action plans for improving the assistance provided to refugees in Ethiopia.

This JAM, like others before it, reconfirmed the refugees' near total dependence on the general food rations for their daily sustenance. The food rations are seen not only as a source of sustenance, but as a source of income to help meet the refugees' many unmet needs through sale of a portion of their rations. Post Distribution Monitoring surveys undertaken in the Dollo Ado refugee camps as well as anecdotal information from other camps indicate that refugees sell between 25 and 50% of their wheat rations.

The selling of some ration is expected in order for refugees to achieve some dietary diversity, but when more than 30% of the cereal is sold it begins to appear that either the commodity is not the preferred one by the refugees, or that their economic needs are so great that they sell the one bulk item they receive each month. If the food is sold to diversify the diet, then perhaps the food basket itself could be strengthened through cash/vouchers, improved markets and the addition of complementary foods to enrich the micronutrient value of the ration. In this connection, the potential value of introducing a cash and voucher system for complementary foods and eventually for cereals has been recognized as an idea whose time has come for serious consideration and action.

The food distribution system in place in most of the camps needs also to be looked into and several identified gaps addressed. These gaps include lack of distribution chutes in some camps, the absence of shades and toilet facilities in waiting areas for refugees, inaccurate or improperly calibrated scooping materials, and complaints by refugee food scoopers about the low incentive payments they receive as well as lack of an effective monitoring system.

Provision of suitable sources of household energy for cooking food and light remains an enormous challenge for stakeholders not only in refugee assistance programmes but country wide. Wide spread cutting of trees in and around refugee camps has resulted and continues to do a negative impact to the environment. The issue has also become a source of conflict between refugees and local hosting communities in many camps. Inadequate distribution of kerosene and kerosene stoves and the general lack of alternative energy sources forces refugees to depend heavily on fire wood and charcoal for cooking food and lighting.

With the active participation of refugees, UNHCR introduced transitional (semi-permanent) shelters in most of the refugee camps. Nevertheless, due to shortage in funding, the issue of shelter remains a challenge. Appropriate designs taking into account the climatic conditions in the regions hosting the refugees need to be considered.

The year 2011 and to some extent 2012 saw a huge influx of refugees from Somalia into the Dollo Ado camps and from Sudan into the Beneshangul-Gumuz camps in Ethiopia. An influx of the magnitude experienced in these two years brought enormous challenges in terms of meeting the many basic needs of newly arriving refugees which required the attention of all the key stakeholders.

Much progress has been made in controlling the high levels of GAM and SAM at the time of the arrival of the refugees in Dollo Ado camps in 2011. There remains more to be done in the newest camp in the area, Bur Amino camp with new arrivals continuing to come in very poor nutritional and general health condition from Somalia; likewise in Aysaita camp in Afar Regional State where refugees are being relocated to the camp from hosting communities by the Government for security reasons; and Bambasi in Beneshangul-Gumuz

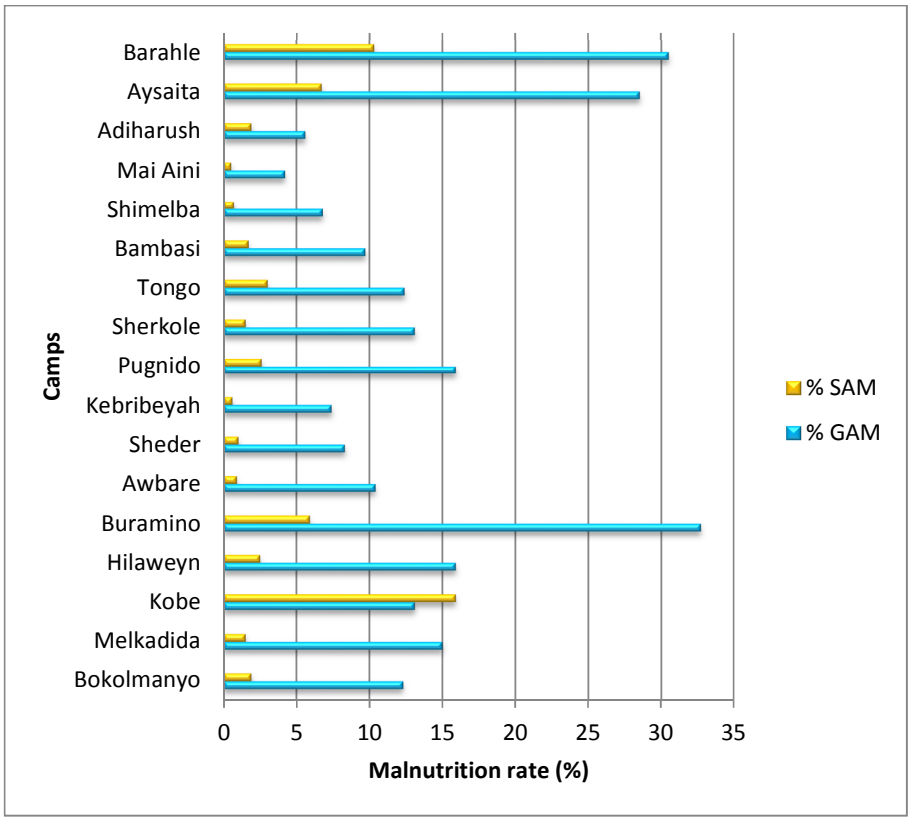
Regional State which is receiving new arrivals from war-torn Sudan's Blue Nile State in poor nutritional and general health state

In 2012/2013, the standardized expanded nutrition survey (SENS) found about 35% of camps in Ethiopia (Somali and Eritrean Afar camps) indicating above 15% of global acute malnutrition (GAM) rate as shown in the table and graph below:

TABLE 3: REFUGEE CAMPS IN ETHIOPIA WHICH RECORDED HIGH PREVALENCE OF MALNUTRITION (2012/13)

Camp	GAM%	SAM %
Aysaita	28.5	6.7
Barahle	30.5	10.3
Melkadida	15	1.5
Hilaweyn	15.9	2.5
Bur amino	32.7	5.9
Pugnido	15.9	2.6

FIGURE 8: MALNUTRITION RATES IN ETHIOPIA REFUGEE CAMPS, 2012/2013

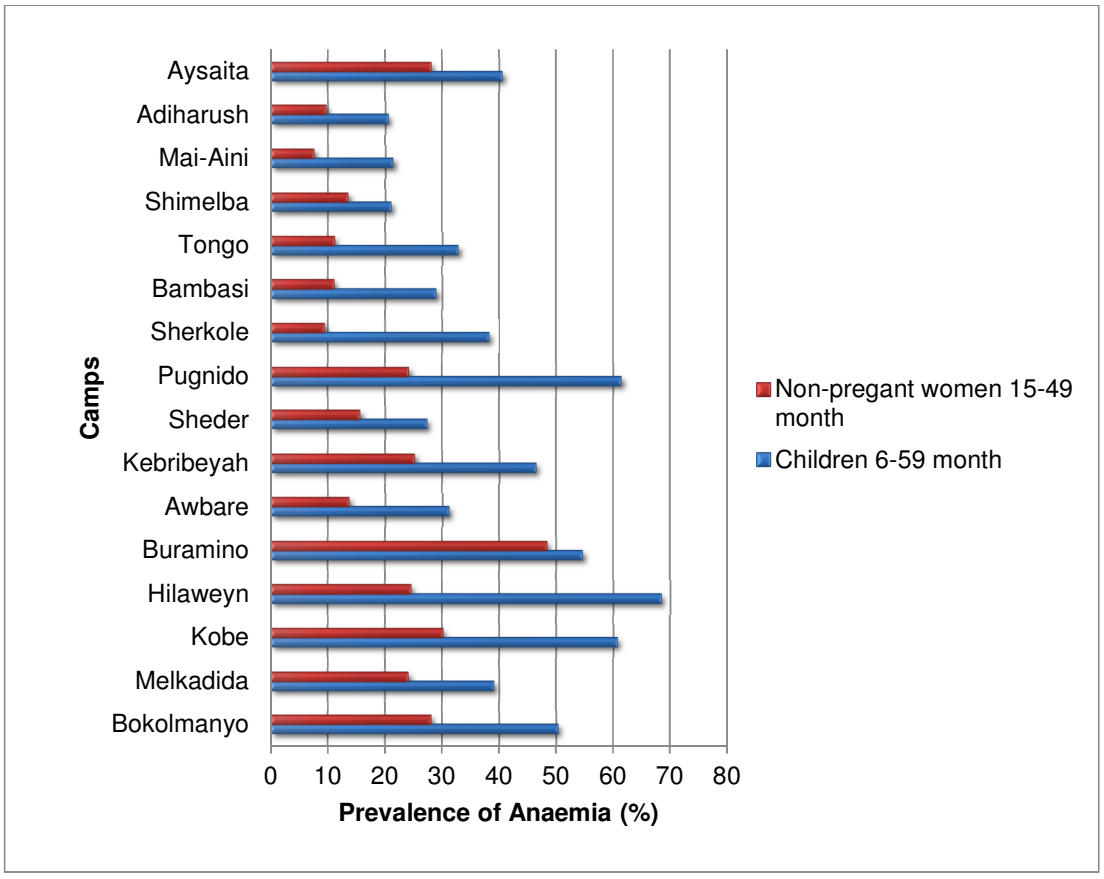


Acute malnutrition among children aged under five, together with mortality, is a main indicator for the overall health and nutrition situation of a population. The main causes for acute malnutrition are inadequate food intake and utilization, sub-optimal infant and young child feeding (IYCF) practices, and morbidity often linked to environmental, hygiene and shelter concerns. In addition, micronutrient deficiencies, notably anaemia, are common across refugee populations, including in post-emergency contexts, in large part because of inadequate food intake and communicable diseases, such as malaria. Malnutrition and micronutrient deficiencies can lead to death, irreversible developmental delays and stunting, and therefore impacts on short-term survival and long-term economic and productive capacity.

FIGURE 9: REFUGEE CAMPS IN ETHIOPIA WHICH RECORDED HIGH PREVALENCE OF ANAEMIA (2012/13)

Camp	Children 6-59 month	Non-pregnant women 15-49 month
Bokolmanyo	50.2	28
Melkadida	39	24
Kobe	60.6	30.1
Hilaweyn	68.3	24.5
Bur amino	54.5	48.3
Kebribeyah	46.3	25.1
Aysaita	40.4	28

FIGURE 10: ANAEMIA RATES IN ETHIOPIA REFUGEE CAMPS, 2012/2013



Food security and nutrition interventions aim to improve the immediate food security and nutritional well-being of refugees, mainly by tackling the immediate and underlying causes of malnutrition. This is done through: (a) effective prevention of undernutrition and micronutrient deficiencies through the provision of access to food, cash and/or vouchers to the general population, and special nutritional products for vulnerable groups, as well as the promotion of and support to adequate IYCF practices; (b) effective and timely identification and treatment of acute malnutrition ensuring quality treatment projects and sufficient coverage; (c) provision of up-to-date food security and nutrition information and analysis, thereby enabling appropriate and needs-based programming; and (d) effective food security and nutrition response in emergencies. The food security and nutrition sectors also work in close collaboration with livelihoods, to strengthen household food security, provide longer term solutions and to promote self-reliance among refugees.

ACTIONS TO BE TAKEN TO ACHIEVE OBJECTIVES

OBJECTIVE 1: EFFECTIVE PREVENTION OF UNDERNUTRITION AND MICRONUTRIENT DEFICIENCIES

Effective prevention of undernutrition and micronutrient deficiencies are optimally achieved through the provision of, and ensuring access to adequate foods which meets the daily micronutrient and energy requirements of an individual, as well as the promotion of adequate IYCF practices. Prevention is also assured through the improvement of community awareness , water, hygiene, sanitation (WASH) situation, as well as the promotion of adequate IYCF practices, and health conditions,

Access to adequate food is provided through a variety of means. Various food commodities are provided through the General food distribution (GFD) to the refugee population in collaboration with World Food programme (WFP). Food utilization will be maximized in collaboration with partners by reducing food drain due to selling to address unmet needs. Specific projects for the prevention of undernutrition and micronutrient deficiency diseases, such as blanket feeding for young children (6-23 months of age) and pregnant and lactating women using special nutritional products or fortified blended foods are put in place where the prevalence of acute malnutrition is high or where there are aggravating risk factors. Use of other micronutrient-rich products is initiated where micronutrient deficiencies, including anaemia and stunting, are high.

Increasingly, where markets are functional and refugees have free access to them, UNHCR in collaboration with WFP will promote the use of cash and/or vouchers among refugees in line with the guidelines contained in the position paper on cash-based interventions in UNHCR operations[15], to increase their purchasing power to access nutritious, diversified and culturally appropriate foods. Cash and vouchers also provide important protection dividends as they, among others, provide refugees with a choice and help to 'normalize' their life through economic empowerment and market inclusion. In addition, agriculture and homestead food production, including vegetable gardening and animal rearing, will be promoted wherever possible through provision of inputs and adapted training.

Promoting and supporting adequate IYCF and care practices play a key role in preventing malnutrition and micronutrient deficiencies. Sensitization, demonstrations and other interventions, such as baby and child-friendly spaces with appropriate services and community-based support networks, are put in place to promote and support feeding practices that maximize survival and reduce morbidity in children less than 24 months. These include: timely initiation of exclusive breastfeeding, exclusive breastfeeding for six months; continued

[15] An Introduction to Cash-Based Interventions in UNHCR Operations, October 2005

breastfeeding to 24 months and beyond; and timely introduction of safe, adequate and appropriate complementary foods at 6 months.

UNHCR will also increasingly look for local and culturally adapted solutions for the prevention of undernutrition. These include enhancing access to fresh milk among pastoral populations and promoting other traditional practices that may have positive nutritional outcomes, such as locally available foods such as canned porridge made from mixed cereals, pulses and milk, etc. Improvement of IYCF practices will also be a major focus over the strategy period. In collaboration with WFP, UNHCR will conduct pilot acceptability study for children 6-23 months blanket supplementary feeding in the three Dollo ado camps and Jigjiga camps. The study will comprise, provisions of micronutrient rich product (CSB ++), Lipid based Nutritional Supplement (Nutri-butter) and cash/voucher assistance to allow the mother to choose the most appropriate product and access fresh vegetables, fruits and milk.

OBJECTIVE 2: EFFECTIVE TREATMENT OF ACUTE MALNUTRITION

Treatment options for acute malnutrition are provided through services provided in refugee camps. Treatment of acute malnutrition in refugee situations should be managed using the principles of community-based management of acute malnutrition (CMAM), according to national CMAM treatment guidelines or WHO protocols where there are no recent CMAM treatment guidelines.

Treatment of severe acute malnutrition (SAM) will be provided through inpatient and outpatient platforms and, wherever possible, in collaboration with UNICEF in order to secure the supply of SAM treatment products and training. Treatment of moderate acute malnutrition (MAM) using outpatient modalities will be provided, with WFP normally providing the food products required for the treatment of MAM. Community involvement and awareness in the identification of malnourished individuals, and their inclusion and retention in the treatment of acute malnutrition is crucial in the success of this programme, as well as in obtaining effective coverage. Establishing and maintaining strong linkages between the different components of the CMAM programmes, as well as with health and preventative services are key features of any effective treatment programme.

UNHCR will continue to strengthen programmes to treat acute malnutrition, with particular focus on improving community activities and linkages with related services and seeking appropriate solutions for the management of acute malnutrition in refugees living in and out-of-camp situations.

OBJECTIVE 3: EFFECTIVE PROVISION OF UP-TO-DATE FOOD SECURITY AND NUTRITION INFORMATION AND ANALYSIS (TO ENABLE APPROPRIATE AND NEEDS-BASED PROGRAMMING)

UNHCR has developed a number of tools to provide information on the food security and nutrition status of refugees and implemented in most refugee operations worldwide. Analysis and information obtained through surveys, studies and monitoring feed directly into programming in order to ensure that food security and nutrition programmes are needs and evidence-based.

UNHCR will continue to promote the use of the standardized expanded nutrition survey (SENS)[16] in refugee operations on a regular basis, preferably annually. SENS is the reporting standard for UNHCR's global strategic priorities and is based on internationally accepted methods for anthropometric data collection at the population-level, and also includes information on health, anaemia, IYCF, food security, WASH and mosquito net coverage.

Monitoring of ongoing treatment programmes will be systematic, with documentation through an improved nutrition module in the health information system (HIS). Regular coverage surveys will be promoted, especially in high GAM situations.

[16] http://www.sens.unhcr.org

Measures will be taken to ensure that anthropometric screening and rapid joint assessment missions (rapid JAMs) are conducted systematically and in timely manner in all new emergencies. Measures will likewise be established to ensure that recommendations from assessments and surveys, including SENS and JAMs, are followed up. Monitoring of ongoing operations, e.g. through post-distribution monitoring (PDM) and food basket monitoring (FBM), will be formalized to allow for timely implementation changes, where required.

UNHCR-WFP guidance on JAMs[17] is a key tool for assessing the food security situation among refugees and is used systematically in areas in joint activities with WFP. Practical guidance was updated in 2013 and now also includes rapid JAM guidance, which provides a methodology for a rapid food security assessment in new refugee emergencies.

OBJECTIVE 4: EFFECTIVE FOOD SECURITY AND NUTRITION RESPONSE INCLUDING IN EMERGENCIES

UNHCR and ARRA will continue to improve the timeliness of food security and nutrition interventions in refugee emergencies in collaboration with WFP, UNICEF and other partners. Beginning with the provision of food rations or prepared meals, where needed, in the first days of displacement alongside collection and documentation of regular and meaningful data in order to determine needs and trends. This will lead to more timely and effective food security and nutrition programming. Providing adequate food assistance in the form of in-kind food aid or cash-based assistance during the first days of displacement is essential for ensuring the nutritional well-being of refugee populations during this critical period. Although in the initial stages of an emergency when registration of refugees is becoming organized, management of food assistance according to UNHCR norms may be challenging, these activities need to be appropriately organized as soon as possible. Timely and adequate coordination and organization of nutrition services will be assured during emergencies. Not doing so increases the risk of food insecurity and malnutrition and issues related to protection.

Access to adequate food will be provided through a variety of means. High energy biscuits (HEB) and/or BP5 will be provided to newly arriving refugees. In addition General food distribution (GFD) will be provided to the refugee population preferably at camp level in collaboration with World Food programme (WFP). Food utilization will be maximized in collaboration with partners by reducing food ration drain due to selling to address unmet needs (milling, fuel wood, NFI etc.). UNHCR will ensure relevant c

During the strategic plan period (2014-2018), UNHCR Ethiopia and ARRA will work closely with its operational and implementing partners to ensure a predictable response to food security and nutrition in emergencies as part of the broader public health response focusing on the regular data collection and reporting from the onset of the emergency, adapted to the context, to determine needs and trends, which will lead to cost effective public health programming. Plans of action with operational partners like WFP and UNICEF will be a reference point to ensure effective response drawing on comparative advantages and resource capacity to achieve better outcomes for refugees and other affected populations.

At the onset of an emergency, access to food is often provided through in-kind food aid distributions, in collaboration with the world food programme (WFP).

Protection and promotion of appropriate IYCF in emergencies (IYCF-E) at the initial stage of an emergency helps to save the lives of the most vulnerable infants and young children aged under 2 years. This will be the case even in situations where GAM is not of particular concern in the given emergency. In 2013, IYCF-E was rarely an early feature of emergency nutrition programming and is an action that needs to be strengthened.

[17] http://www.unhcr.org/521612d09.html

In emergency situations where GAM levels are high, it is important to ensure optimal organization and coordination of services among all partners, and maintain communications with and raise awareness among the refugee population.

TABLE 4: MONITORING- FOOD SECURITY AND NUTRITION

Objective	Output objective	Indicator	Unit	Emergency indicator	Post-emergency indicator	Refugee camp	Urban/ Out of camp
GOAL: Improve the food security and nutrition situation of refugees, and reduce the prevalence of undernutrition among refugees, especially women, young children and vulnerable people	Reduce prevalence of global acute malnutrition	Global acute malnutrition	Prevalence (%)	<10%	<10%	✓	✓
	Reduce prevalence of chronic malnutrition (stunting)	Stunting	Prevalence (%)	< 20%	< 20%	✓	✓
	Reduce prevalence of anaemia in infants and children aged between 6 - 59 months	Anaemia (children aged between 6 - 59 months)	Prevalence (%)	< 20%	< 20%	✓	✓
	Reduce prevalence of anaemia among non-pregnant women aged between 15 and 49 years	Anaemia among non-pregnant women aged between 15 and 49 years	Prevalence (%)	< 20%	< 20%	✓	✓
Effective prevention of undernutrition and micronutrient deficiencies	Improve adequate dietary diversity	Percentage of households not consuming any vegetables, fruit, meat, eggs, fish/seafood and milk/milk products	Proportion of households	<20%*	<10%*	✓	✓
	Improve access to adequate foods without resorting to negative coping strategies	Proportion of households not using negative coping strategies	Proportion of households	>50%*	>50%*	✓	✓
	Improve provision of continued and predictable food assistance	Occurrence of pipeline breaks during the past year	Yes/No	No	No	✓	X

	Improve coverage of special nutrition products for prevention of undernutrition in young children (LNS/MNP/FBF)	Coverage of special nutrition products for prevention of undernutrition in young children (LNS/MNP/FBF)	Coverage (%)	>70%	>70%	✓	✓
	Improve IYCF practices	Timely initiation of breastfeeding	Proportion of children 0-23 months who were put to the breast within one hour of birth	≥80%*	≥80%*	✓	✓
	Improve IYCF practices	Exclusive breastfeeding under 6 months	Proportion of infants0-5 months who received only breast milk during the previous day	≥70%*	≥70*	✓	✓
Effective treatment of acute malnutrition	Improve MAM treatment outcomes	MAM treatment programme recovery	Recovered (%)	>75%	>75%	✓	✓
	Improve SAM treatment outcomes	SAM treatment programme recovery	Recovered (%)	>75%	>75%	✓	✓
	Improve coverage of SAM treatment programmes	SAM treatment programme coverage	Coverage (%)	>90%	>90%	✓	X
Effective provision of up-to-date food security and nutrition information and analysis (to enable appropriate and needs-based programming)	Improve nutrition needs assessment and nutrition status monitoring	A population-based nutrition survey conducted during the last year?	Yes/No	Yes	Yes	✓	✓
	Improve food security needs assessment	JAM conducted according to recommended	Yes/No	Yes	Yes	✓	✓

		schedule?					
	Improve emergency nutrition needs assessment	Rapid MUAC screening of children aged under 5 has been conducted and report produced?	Yes/No	Yes	Yes	✓	✓
	Improve emergency food security needs assessment	Rapid food security needs assessment has been conducted and report produced?	Yes/No	Yes	Yes	✓	✓
	Improve PDM	Regular PDM has been conducted during the last year and report produced?	Yes/No	Yes	Yes	✓	✓
	Improve FBM (where in-kind food aid)	Regular FBM has been conducted during the last year and report produced?	Yes/No	Yes	Yes	✓	✓

WATER, SANITATION AND HYGIENE (WASH)

The WASH sector aims to ensure that refugees have safe access to water of sufficient quality and quantity and to improved hygiene and improved WASH in institutions.

All refugees are assured the basic right to WatSan facilities and hygiene promotion and practices in order to reduce morbidity and mortality, as well as enhance their protection, dignity and quality of life. The WASH sector promotes a demand-led approach that puts people rather than engineering at the heart of the interventions. In addition, the WASH sector addresses specific cultural and social needs to ensure that minimum standards are met, and that both the quality and quantity of water and sanitation are enhanced to reduce the likelihood of a negative impact on protection and health status.

OVERVIEW OF SECTOR

CONSEQUENCES OF POOR WASH

Inadequate and unsafe water, poor sanitation and unsafe hygiene practices are the main causes of diarrhoea, and at least 1.9 million children aged under five die every year from inadequate WASH services. Poor quality water and lack of sanitation and hygiene practices are underlying causes of malnutrition, disease, impaired growth and mortality. Children in resource-poor settings average four to five debilitating bouts of diarrhoea per year, which can cause and exacerbate acute malnutrition and result in long-term stunting.

Water, sanitation and hygiene are also linked to many other diseases that kill children or stunt their development, including helminthic infections, guinea worm, trachoma, cholera, and fluoride and arsenic poisoning. Children (and adults) living with HIV and AIDS, because of their weakened immune systems, are especially susceptible to the debilitating effects of persistent bouts of diarrhoea.

One substantial way to sustainably reduce this massive burden of disease is through the use of safe drinking water, improved sanitation and hygiene practices, in particular handwashing with soap (or any rubbing agent). There is also emerging evidence linking better handwashing practices with reduced incidence of acute respiratory infections.

The absence of WatSan services can also result in women and children spending hours to fetch water – time that could be spent in better care for the family or in school. There are also protection concerns in the form of increased exposure to gender-based violence fetching water in insecure areas; it also has economic implications and the cost of buying water or disposing of waste can replace other spending priorities, including spending on health care and education. Every US$1 invested in improving sanitation is estimated to result in an average return of US$9 value in terms of avoidable deaths, time and effort saved more productivity due to less down-time due to illness as well as saved health costs (Water Supply & Sanitation Collaborative Council).

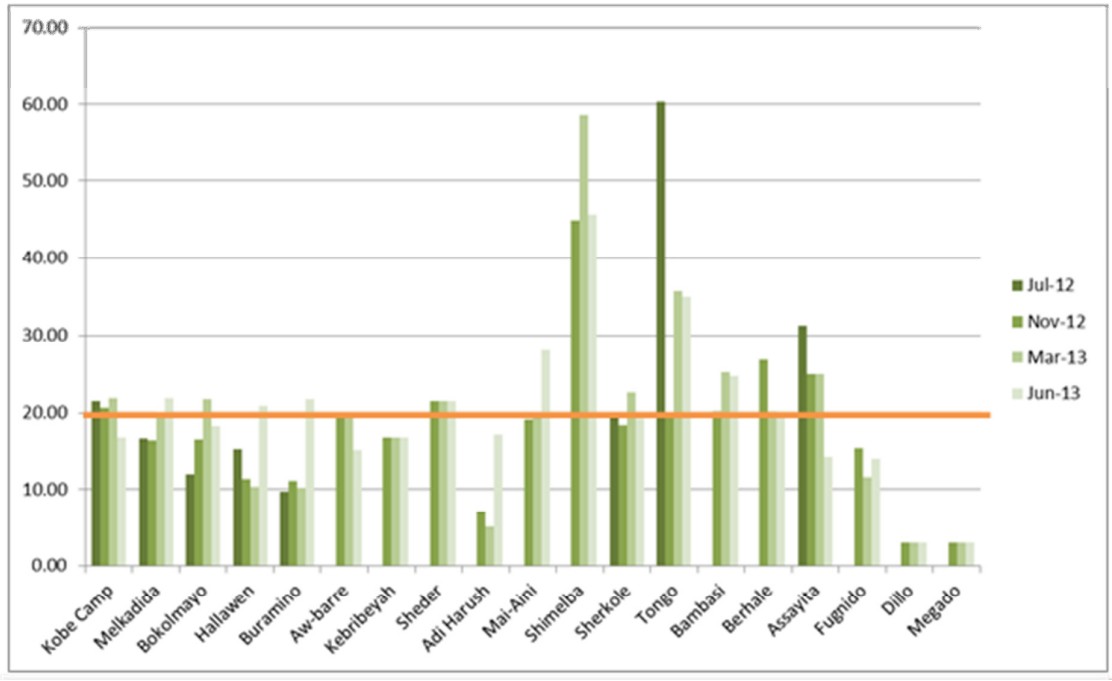
WASH AND REFUGEES

WASH activities have been increasingly prioritized by UNHCR, as the High Commissioner pointed out: "*Water is an essential tool for health and for protection. There is not enough awareness of the importance of water as a key instrument in development, both at a global level and at a local community level*."

Access to WASH services varies with each camp mainly as a result of contextual variables and socio-political factors that characterize each population of concern. By June 2013, water access in 50% of the camps is above 20litres per person per day, ratio of number of persons per useable tap stands at 1:120 whereas percentage of households living within 200m to a tapstand is approximately 82%. As presented in Figure 2 below, in the last 12months, there has been improvement in access to water in most camps. This was aided

by completion of permanent water systems for camps in Dollo Ado, Assosa, Aysaita and Shire which reduced reliance on water trucking by more than 95%.

FIGURE 11: ANNUAL WATER ACCESS TREND IN ETHIOPIA CAMPS JULY – JUNE 2013



Latrine coverage has also improved considerably in Dollo Ado and Assosa from a high of 1:75 persons per latrine to 1:18 persons per latrine in some camps. Only 3 camps have family latrine coverage of above 60%, while over 10,800 communal latrines spread in all camps continue to be used as the latrine implementation approach shifts towards households. Several designs contextually applicable to each camp setting exist. Overall, Sanitation challenges surmount particularly due to hard ground conditions, contextual variables that inhibit significant family contribution to household sanitation in virtually 75% of camps. Innovative approaches being piloted such as Urine Diversion Dry Toilet (UDDT) and composting, though nascent technologies that need further studies, have proven to be a favourite for refugees due to elimination of smell and flies. However, high initial capital outlay propagates dependency as households will need external support to implement.

Hygiene awareness raising is conducted in all camps, however, the implementation approach and methodology is left at the prerogative of the IP. A cocktail of curricula is applied from the standard PHAST and CTC approach to IP specific behavioural change communication guidelines developed over the years. As a result of sustained hygiene promotion, positive behaviour transformation has been observed and qualified by quantitate indicators arrived at through Knowledge, Practice & Coverage (KPC) surveys and formative assessments' conducted in various camps. Hygiene transformation support infrastructure and supplies, such as hand washing kits, washing basins, general hygiene kit is limited/lacking in most of the camps. IEC/BCC materials in use emanate from without the camps and mostly not responsive/instructive to the specific population of concern.

Overall, institutional WASH has received little attention as most schools and health clinics have poor access to water and sanitation facilities. Infrastructure development in schools and clinics has remained within

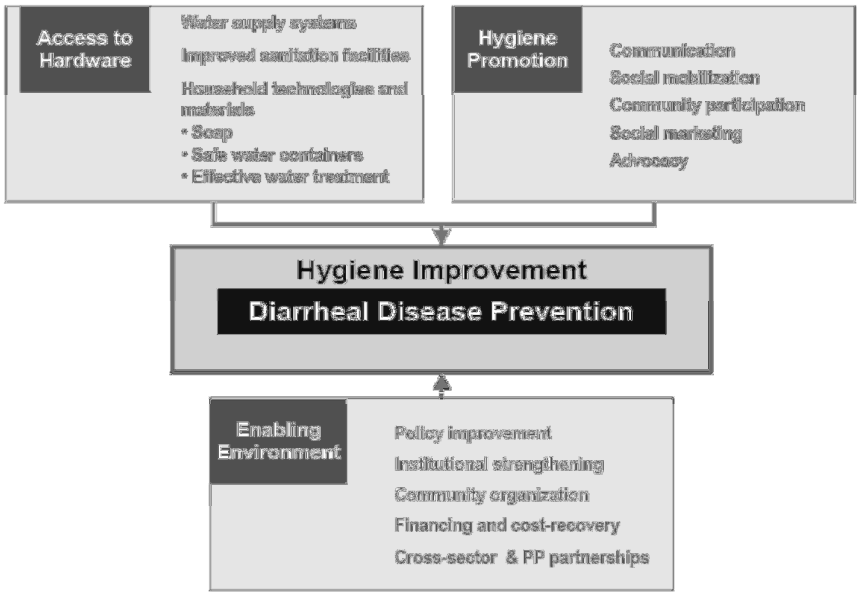
respective sectors of education and health without structural framework for WASH to intervene. Hygiene awareness in most schools is lacking and health facility hygiene activities are being conducted by health and Nutrition unit.

In refugee camps, as in most parts of the world, women and children primarily bear the burden of collecting water. Children that are sent to fetch water are often diverted from their school activities, which impacts their academic performance. Long walking distances and excessive queuing time at water points can have high social costs in the form of lost opportunities for productive work, adversely impacting health and exposing refugee women and children to potential harassment. Provision of accessible and adequate WASH interventions has positive effects across numerous sectors:

- *Protection*: Long distances to water points can put young girls and women at risk of sexual violence.
- *Nutrition*: A woman drawing 80 litres of water for her family from a well and carrying it to their home 200metres away (often uphill from the well) uses approximately 17 per cent of the standard ration of 2,100 Kcal/day only to accomplish this task.
- *Education*: Forty-two per cent of children attending school in one Ugandan refugee camp had their schooling interrupted due to water collection.
- *Food security and livelihoods*: Women who spend their time collecting water are missing opportunities to participate in more productive activities.
- *Environment*: non-sustainable usage of water resources can potentially overexploit groundwater resources.

UNHCR and partners use the hygiene improvement framework[18] to build effective WASH programmes (Figure 12). The hygiene improvement framework is a comprehensive framework developed on the basis of lessons learnt from USAID's Environmental Health Project, which aims to prevent childhood diarrhoea.

FIGURE 12: THE HYGIENE IMPROVEMENT FRAMEWORK



[18] Available at: http://www.ehproject.org/PDF/Joint_Publications/JP008-HIF.pdf

UNHCR hygiene promotion guidelines aim to strengthen effective hygiene promotion to maximize health benefits in the use of water and sanitation facilities.

ACTIONS TO BE TAKEN TO ACHIEVE OBJECTIVES

OBJECTIVE 1: REFUGEES HAVE SAFE ACCESS TO WATER OF SUFFICIENT QUALITY AND QUANTITY

Access to sufficient amount of potable water translates into several complementary actions, which include "hardware" and "software" components.

Mapping and modelling of water supply systems will constitute the baseline for potential future upgrading, enlargements, optimization and modernization of any water infrastructure. Water facilities should be designed so that sustainability issues (operation and maintenance) and long-term considerations are properly addressed – including back-up systems (alternative water sources, spare generators and pumps, etc.).

Often, one of the deteriorating factors in the water infrastructures is the poor and/or non-systematic operation and maintenance of the water facilities, mostly due to poor planning and/or budget constraints. O&M should be included in any operational plan and programme budget as first priority.

Monitoring of water systems production is another key aspect to reinforce, whereby water supply alert systems can be activated and the response to water production disruptions and water shortages avoided. The water alerting systems are an essential element of any water safety plan, whose preparation is required for any refugee camp with a population above 5,000.

As part of the UNHCR WASH strategy in the medium-long term, investments and researches are envisaged to calculate the cost of water in refugee settings. Such project will allow for early investment costs evaluation, better planning and enhanced effectiveness in technical operations.

Partnerships with Research Institutes/Universities/Private Companies for advanced and innovative designs of water infrastructures will be continuously expanded to strengthen UNHCR engagement in assessing and piloting innovative solutions in refugee contexts. This will include partnerships for groundwater monitoring (e.g. Merti Aquifer monitoring programme in Dadaab, Kenya), alternative solutions for water supply systems (i.e. partnership with VEOLIA Environmental Foundation for solar water pumping in Dollo Ado, Ethiopia), etc.

Regular water quality monitoring (bacteriological and chemical) at production and household level is also one of the crucial aspects to address, particularly in emergency settings. Water quality monitoring will include supply of adequate equipment to carry out water quality monitoring related tests for Free Residual Chlorine and Bacteriological and chemical analysis.

Capacity building in water supply, preventive operation and maintenance, water treatment and water quality monitoring will be promoted and implemented at regional and country level – including UNHCR WASH staff and WASH implementing partners.

Lastly, due to the increasing emergencies in urban areas, semi-urban areas, arid and semi-arid contexts, UNHCR engages in strengthening its water response in Sahel/semi-arid contexts adapted to nomadic populations, out of camps situations and urban settings, where ad-hoc water supply interventions are needed.

OBJECTIVE 2: REFUGEES HAVE SAFE ACCESS TO QUALITY SANITATION

Similar to Objective 1, improving safe access to quality sanitation, involves complementary hardware and software actions.

Enhancing safe access to sanitation translates into meeting the standards in terms of privacy, safety and locally/culturally acceptable sanitation infrastructures. In this framework, a more standardized design of sanitation facilities across similar refugees operations is envisaged to comply with the standards.
Additionally, equal access to sanitation will be strengthened through equal spatial distribution of sanitation infrastructures (using mapping/GIS tools) and proper monitoring.

For cost-effectiveness and self-reliance purposes, more sustainable sanitation infrastructures should be implemented, promoting use of local materials and family sanitation facilities in post-emergencies contexts.

Wastewater, solid waste management and drainage should be systematically part of the sanitation programme in all refugee camps, whereby wastewater evacuation system are handled by WASH actors/partners and the overall drainage component (runoff at cross roads) is developed in coordination with site planning. Where appropriate, work with livelihood on building business around solid waste (recycling& compost) and wastewater (biogas, gardening, water for livestock) should be encouraged and endorsed.

The software components will promote demand-led interventions putting people rather than engineering at the heart of the interventions. This entails involvement of refugees in all phases of sanitation infrastructures (i.e. planning, design, piloting, maintenance, etc.), and, where appropriate, roll out community-led total sanitation (CLTS) in locations with longstanding refugee settlements.

Similarly to Objective 1, UNHCR envisages to strengthen sanitation response in urban settings by developing specific guidelines based on field experience and lessons learnt from recent experiences and to expand partnerships with research institutes/universities and private companies for enhanced sanitation designs.

OBJECTIVE 3: REFUGEES HAVE IMPROVED HYGIENE

Community mobilization is key in addressing the determinants of poor hygiene. Therefore, particular emphasis will be placed on strengthening community mobilization for enhancing monitoring and use of water and sanitation facilities; strengthening the sense of ownership of water and sanitation infrastructures; and disseminating key messages.

Hygiene promotion in schools will also play a crucial role to promoting safe hygiene practices as part of an educational process. Coordination between health, education and WASH will be strengthened to enhance effectiveness in hygiene/public health promotion, and to enhance information-sharing and optimization of resources. Improved hygiene among refugees will also be achieved by enhancing expertise in hygiene promotion through capacity building measures and increasing the number of hygiene promotion officials.

Coordination with community services will be strengthened to ensure enhanced water storage capacity at the level of households through distribution of water containers and advocacy for persons of concern to have adequate quantities of soap and basic hygiene items (including handwashing devices such as tippy-taps, small jerrycans, hybricks) to maintain hygienic condition. This will also constitute a key action to improve hygiene and reach the HP objective for the sector.

In order to provide a baseline and monitoring tool for defining and adjusting the hygiene promotion strategy in each of the UNHCR's operational area, the roll out of a standardized knowledge, attitude, and practice (KAP) survey will be carried out in 20 countries by 2017.

OBJECTIVE 4: IMPROVED WASH IN INSTITUTIONS

As children are the main recipient for hygiene education, special focus needs to be given to WASH in schools and public institutions, such as hospitals, health centres and nutritional centres.

Among the main actions the WASH sector will emphasize include improved access for children to adequate number and adequate child friendly designed WASH facilities to enhance school attendance especially for girls. This includes enhanced access to water for drinking and handwashing.

Specific sessions and child-to-child hygiene promotion activities will be encouraged for children to become familiar with the importance of handwashing with soap and the linkages between poor hygiene and diseases, including drama, sketches, etc.).

Strengthened collaboration with health agencies/actors will also be encouraged to ensure minimum standards are met in term of WASH infrastructures in health centres, hospitals and nutritional centres and persons with specific needs have access to adapted sanitation facilities.

OBJECTIVE 5: COORDINATION, PARTNERSHIPS AND CAPACITY BUILDING OF WASH PARTNERS AND OFFICERS

For technical leadership and coordination purposes, UNHCR WASH officers and stand-by partners WASH staff deployed in UNHCR's operational areas will require specific technical expertise and skills. Therefore, capacity building both at regional and on-the-job level will be prioritized to achieve the objective.

Additional priority actions will include the regular reporting on key WASH indicators of at least 20 countries through the WASH monitoring system.

Innovative and contextualized options are key to providing good WASH quality services to persons of concern. Partnerships with research institutes, universities and private sector to support innovation will be strengthened and developed to achieve the objective together with continuous involvement in the WASH cluster for coordination, advocacy and improved emergency response capacity purpose. To improve emergency preparedness and response capacity, WASH contingency plans will be developed in camps and a strategy for urban settings will be developed in collaboration with UNICEF and other relevant partners.

TABLE 5: MONITORING- WASH

Sector Objective	Output objective	Indicator	Unit	Emergency (e.g. first 6 months of a newly installed camp, major influx of refugees, outbreaks)	Post-emergency, transitional phases (protracted crisis and long term situation)
1. Refugees have safe access to water of sufficient quality and quantity	Improved water quantity	Amount of water received per person per day	Litres per person per day	>15l/person/day	>20l/person/day
	Improved water quality	Coverage and rate of infrastructure development	Percentage	>=70% of HHs collecting drinking water from protected water sources only	>=95% of HHs collecting drinking water from protected water sources only
	Improved water quality at non-chlorinated water sources	Chemical, bacteriological & physical characteristic of water accessed by PoC	No of coliforms/ 100 ml of water, Turbidity in NTU, Contaminant level ppm against WHO standards	>=95% of tests with 0 faecal coliforms/100 ml of water	>=95% of tests with 0 faecal coliforms/100ml of water
	Improved water quality at chlorinated water collection locations	Residual chlorine in water after 30 minutes of contact time	FRC level in mg/l	>=95% of tests showing Free Residual Chlorine >= 0.1mg/l [19] and NTU<5	>=95% of tests showing Free Residual Chlorine >= 0.1mg/l and NTU<5
	Increased access to water	Queing time	Ratio	=< 250 persons per tap	= 80 persons per tap
	Increased access to water	Equity of distribution/ access to water	% above and below 15litres/person/ day	>=80% of HHs collecting >=15 litres/person/ day	>=80% of HHs collecting >=15 litres/person/day

[19] In case of outbreaks, the FRC at water collection locations can be raised up to 0.6-0.8 mg/l depending on the water specific characteristics and on the acceptability of the persons of concern.

	Increased access to water	Distance travelled to access water	Percentage coverage	=< 500m to tap	= 200m to tap
	Increased water storage	Storage capacity at household level	Percentage coverage	>=80% of HHs with sufficient daily water storage capacity (50 litres for a 5 members average)	>=80% of HHs with sufficient daily water storage capacity (50 litres for a 5 members average)
2.Refugees have safe access to quality sanitation	Increased safe disposal of human waste	Rate of infrastructure development	Ratio	=< 50 persons per communal latrine[20]	=< 20 persons per communal latrine aiming to 1 latrines / households
	Increased access to sanitation	Toilet use	Percentage	>=60% of HHs report defecating in a toilet	>=85% of HHs report defecating in a toilet
	Increased access to sanitation	Toilet coverage	Percentage	>80% of HHs have access to latrine	>80% of HHs have access to latrine
	Improved quality/standard of sanitation facilities	Compliance to UNHCR standard	Percentage	>80% of communal latrines compliant with UNHCR standards (cleanable slabs, privacy & structural safety)	>80% of communal latrines compliant with UNHCR standards (cleanable slabs, privacy & structural safety)
3.Refugees have improved hygiene	Improved hygiene	Soap distribution coverage	Percentage	>=90% of HHs with(any type of) soap present in the house (presented within 1 minute)	>=90% of HHs with(any type of) soap present in the house (presented within 1 minute)
		Knowledge levels on hygiene practises	Percentage	>=80% of HHs with knowledge of at least 3 of the 5 critical handwashing times	>=80% of HHs with knowledge of at least 3 of the 5 critical handwashing times

[20] This is the current Sphere standard, but UNHCR will aim to reduce this standard to 30 persons per latrine in the emergency phase during 2013-2017.

Improved WASH in institutions	Improved WASH in institutions	Coverage and Compliance to UNHCR standards	Percentage	>=90% of schools have WASH structures that are compliant with acceptable standards	>=90% of schools have WASH structures that are compliant with acceptable standards
		Compliance	Yes/No	Health and nutrition facilities hav e WASH structures that are compliant with acceptable standards	Health and nutrition facilities have WASH structures that are compliant with acceptable standards