Strategic Guideline on Health, Nutrition and Food Response

Gambella Emergency Refugee Programs, Ethiopia

Joint UNHCR/WFP/UNICEF/ARRA/Humanitarian Partners Strategic Guideline

2014

Introduction

At the end of 2013, the number of refugees in Ethiopia had reached 431,648. With the influx over 95,000 new arrivals from South Sudan, this number has soared above a half million. Ethiopia is receiving large number of asylum seekers following the S. Sudan conflict which unfolded on 15 December 2013. The humanitarian community in Ethiopia is planning to receive a projected estimate of 170,000 asylum seekers from South Sudan into Gambella Regional State.

In January 2014, mid-upper arm circumference (MUAC) measurement screening of 2,407 newly arrived children (age 6 to 59 months) at the Pagak entry point has indicated that the level of malnutrition is well beyond the international emergency thresholds. In the established camps agencies are making every effort to maintain the mortality rates below emergency threshold. This health, nutrition and food security guiding framework include the following objectives:

- Ensure all camps in Ethiopia provide a harmonized package of health and nutrition services;
- Assure compliance of health and nutrition services to national and UNHCR/WFP standards;
- Provide clear guidance to partners on the coordination dynamics and expected package of activities/interventions by all the sectors;
- Provide clear performance indicators/benchmarks in each area of intervention; and
- Ensure the lessons learned from previous refugee response actions receive due consideration so that this emergency response is more effectively coordinated and managed.

The goal of the coordinated emergency response is to keep the core indicators below the emergency threshold of 1) Crude Mortality Rate (CMR) of 1/10,000/day and under 5 mortality rate (U5-MR) of 2/10,000/day; 2) Global Acute Malnutrition (GAM) below 10% and Severe Acute Malnutrition (SAM) below 1%; and 3) prevent the occurrence of disease outbreaks as well as malnutrition.

Guiding principles

Access

UNHCR will ensure refugees access the minimum level emergency services in similar ways or at lower costs than nationals according to the needs. Access includes physical, legal, and economic environment.

Integration and sustainability

UNHCR will ensure that the emergency public health; HIV; food security; nutrition; and water, sanitation and hygiene (WASH) responses are integrated within national systems. In addition, UNHCR will support the existing local health facilities by providing supplies, equipment, expanding services and conducting capacity building training.

Partnership and Coordination

UNHCR together with its government counterpart, the Administration for Refugee and Returnee Affairs (ARRA) lead coordination mechanisms with partners and the relevant government ministries on emergency public health, nutrition services and WASH programmes, and advocates that the refugees are integrated to the national plans in large-scale influxes of refugees. UNHCR aims for regular national, regional and camp-based refugee health coordination meetings with partners at a minimum on a weekly basis until further notice.

UNHCR will also collaborate 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 (see 3Ws matrix in Section VII below). These partners include other UN agencies (WFP, UNICEF, WHO, UNFPA), international agencies, civil society, non-governmental organizations, academic institutions, multilateral institutions, donors and the private sector.

Effective and Efficient Response during Emergency and Post-emergency

UNHCR prioritizes rapid and effective response in emergencies through financing and coordination, technical leadership, physical infrastructure and supplies and streamlined data collection, analysis and management. Comprehensive services will be planned and delivered during the emergency phases.

I. Health

Key Emergency Health Interventions

In the early phase of emergency response, the focus should be at preventing conditions that may cause excess morbidity and mortality. Services that are to be implemented during post-emergency should also be planned at this stage. Some of the essential services that should be implemented during emergency phase are shown below:

1. Measles and polio vaccination together with vitamin A supplementation;
2. Provision of essential medicines, emergency health kits;
3. Implementation of Minimum Initial Service Package(MISP) in Reproductive Health (RH);
4. 24/7 curative and emergency referral services including comprehensive emergency obstetric care (cEmOC);
5. Emergency laboratory investigation and confirmation of outbreaks;
6. Mental health and psychosocial support;
7. Community-based preventive and health promotion services;
8. Disease surveillance;
9. Continued support for the host community health programs and facilities; and
10. Emergency Health Information System (HIS).

Planning for services of the post-emergency phase should be undertaken during the emergency phases. Some of the services that should be implemented during post-emergency phase include:

1. Routine immunization programme;
2. Procurement of essential drugs based on the requirement;
3. Implementation of a comprehensive RH/HIV package;
4. Basic laboratory investigations and confirmation of outbreaks;
5. Mental health and psychosocial support, community-based mental health programme;
6. Setting up of referral system to [government] secondary/tertiary health care facilities for life-saving interventions;
7. Tuberculosis (TB) and leprosy programme;
8. Chronic disease clinics integrated into the Out-patient Department (OPD); and
9. HIS.

Key Health Interventions at Reception Centres (Akobo and Pagak)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
Arrival measles vaccination	6 months to 15 years	The target for measles vaccination could be extended based on the proportion above 15 years affected by measles	Ongoing by the Gambella Regional Health Bureau (GRHB) with support from the United Nations Children's Fund (UNICEF)
Vitamin A supplementation	6 months to 5 years	Important to ensure there is at least an interval of four months between the doses	Ongoing by GRHB with support from UNICEF
Oral polio vaccine	0 to 15 years	Campaign conducted by GRHB	Campaign done; routine vaccination at entry points & in camp ongoing (GRHB)
De-worming	2 to 5 years	Ongoing	Ongoing by GRHB with support from UNHCR/ARRA
Emergency clinic	Pagak refugee and host community	Clinic (24 hour emergency treatment/referral)	Ongoing by Médecins sans frontières (MSF-F)
Ambulance service	Pagak refugee and surrounding community	24 hour emergency referral	Ongoing by MSF-F and ICRC in Pagak
Implementation of MISP	As per MISP guidelines	Planning for comprehensive RH/HIV should be started	Ongoing by GRHB in Akobo and MSF-F in Pagak with support from UNFPA, UNHCR
Identification of patients on previous treatment and ensure continuity of medication	HIV/TB patients, others	Ongoing	Ongoing by GRHB in Akobo and MSF-F in Pagak
Community health volunteers/workers	Pagak refugee and surrounding community	Move around Pagak to continuously identify vulnerable groups	ACF, MSF trained 23 locally recruited community outreach workers (CHWs)
Outbreak disease control and surveillance	Pagak refugee ad surrounding community	Ongoing measles outbreak; preparation/ prevention activities for any other outbreak	Ongoing by GRHB, UNHCR, ARRA, UNICEF, WHO, and MSF-F

Support Lare & Akobo health facilities with medicines, medical supplies/equipment	Local community	Local facilities have increased need for support due to increased target population needs	Medicines and supplies have been provided by UNICEF, UNHCR, ARRA, MSF-F & ICRC and will continue as needed

Upon arrival at reception center, refugees between the ages of 6 months and 15 years will be provided with measles and polio vaccination, Vitamin A supplementation and deworming. To the extent possible, the teams of vaccinators should be stationed at registration desks for this purpose.

Efforts have been made to ensure the emergency clinics are conveniently accessible to the refugees. The clinics should focus on basic health service provision and referral of the critically sick. The services should include triage, outpatient, referral, inpatient, dressing/injections); case definitions; standard treatment protocols, procedures for patient management including standard operating procedures (SOPs) for referrals. The clinics should enforce and fully adhere to standard universal precautions against infections. Referral services (including provision of ambulances) will continue to be provided at the reception sites.

The MISP for RH and HIV should be freely available. Awareness-raising among all staff on early referral of survivors of sexual violence to health services is crucial. The response should be coordinated between health, community, security and protection services.

UNHCR/UNFPA has provided clean delivery kits to all pregnant women and birth attendants. Health facilities and midwives should be provided with midwifery delivery kits. There is an established referral system to manage obstetrics emergencies and this should be closely monitored.

Key Health Interventions at Transit Center (Burubiey)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
Emergency clinic	All refugees in Burubiey	Daily clinic with 24 hour emergency treatment/referral	Ongoing by ARRA
Ambulance service	Patients needing referral	24 hour emergency referral	IOM on standby but there is need for additional ambulance
Arrival measles vaccination	6 months to 15 years	The target for measles vaccination could be extended based on the proportion above 15 years who have been affected by measles	Ongoing by GRHB with support from UNICEF
Vitamin A supplementation	6 months to 5 years	It is important to ensure that there is at least an interval of four months between the doses	Ongoing by GRHB with support from UNICEF
Oral polio vaccine	0 to 15 years	Ongoing	Ongoing by GRHB with support from UNICEF

De-worming	2 to 5 years	Ongoing	Ongoing by GRHB with support from UNICEF

The service at the medical clinic should include triage, outpatient, referral, dressing/injection; case definitions; standard treatment protocols, procedures for patient management including SOPs for referrals should be provided.

Refugees in transit from Akobo will spend one night at Burubiey before proceeding to Leitchuor Camp on the following day. IOM will ensure medical escort for all refugees is provided. ARRA will provide emergency health care. There are also new arrivals arriving at Burubiey directly from South Sudan and discussions are underway to start registration at Burubiey. If so, the strategy will be to provide primary health and nutrition services as done in Pagak. ARRA will also facilitate and support patients with continuing medications. IOM/ARRA will have an ambulance/vehicle available to refer obstetric emergencies. ARRA will ensure a package of medicines for survivors of sexual violence including post-exposure prophylaxis (PEP) or plan immediate referral to Gambella.

Key Health Interventions at Camps (Leitchuor and Kule)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
Vaccination (measles, OPV, EPI)	As per national and UNHCR guidelines	Selective for those not vaccinated at reception points	Ongoing by GRHB in both camps with support from UNICEF
Vitamin A supplementation	6 months to 5 years	Selective for those not vaccinated at reception points	Ongoing by GRHB in both camps with support from UNICEF
MISP/RH	As per MISP/RH guidelines	Comprehensive RH/HIV is planned for and started as emergency continues	Elements of comprehensive RH started by MSF-F in Leitchuor and by ARRA in Kule, e.g. antenatal care
OPD Clinical care	All refugees and surrounding community	During working hours (and 24 hours for emergency/ duty hours)	Ongoing by MSF-F in Leitchuor and by ARRA in Kule
In-patient Department (IPD) Clinical care	Patients needing admission	24 hour service	Ongoing by MSF-F in Leitchuor and through referral by ARRA at Kule to Itang (MSF-F in Itang)
Ambulance service	Patients needing referral	24 hour service	Ongoing by MSF-F in Leitchuor & ARRA in Kule; ICRC supporting with 4 ambulances (2 per camp)
Community outreach	All households in the camp	Ongoing	Ongoing by MSF-F, ACF, DRC, LWF (Leitchuor) and by ARRA, GOAL (Kule)

Isolation room	Patients with epidemic prone disease	Ongoing in Leitchuor	Ongoing by MSF-F in Leitchuor and pending construction in Kule
Distribution of mosquito nets	All refugees at ratio of 1 LLIN/ 2 individuals	Intensive health education to ensure proper use	Ongoing in Kule and Leitchuor
HIS	All facilities	Weekly data compilation for the HIS following the standard format	Emergency HIS started; routine HIS tools being provided and training planned for week of 23rd April
Support Itang and Nyinyang health facilities with medicines, medical supplies/ equipment	Local community	Local facilities have increased need for support due to increased target population needs	Medicines and supplies are provided by UNICEF, UNHCR and ARRA and will continue as needed

At camp level (Leitchuor and Kule), emergency preventive and 24/7 curative healthcare service will be provided by MSF-F and ARRA respectively. The curative services shall be provided at the outpatient and emergency OPD. The service should include triage, outpatient, referral, dressing/injection; case definitions; standard treatment protocols, procedures for patient management including SOPs for referrals. Cases requiring prolonged admission and further care will be referred to the local healthcare facility or hospital by MSF-F and ARRA.

An emergency in-patient department (IPD) of at least six beds (3 males and 3 females) will be established for patients requiring short term admission. Based on the number of severely malnourished children with medical complications (for calculation purpose it is 15% of SAM children), a stabilization center (SC) was established at Itang (see section below on nutrition). In addition, MSF-F and ARRA will ensure the implementation of all components of the MISP in reproductive health. Family planning services should be provided on demand. Once the health system is established, comprehensive reproductive health services including institutional delivery will be established. Comprehensive RH/HIV is ongoing in Leitchuor and Kule Camps.. All facility-based RH services should be coordinated with community-based RH services and they should complement each other e.g., community-based family planning, postnatal care, referrals and counselling. UN agencies and partners will organize training for health staff on the relevant health topics.

Access to continuum of care for patients who had already started treatment/medications e.g., for TB/HIV, in the country of origin will be established within the camp health facility or through referral to local health facilities.

Health service will be initially implemented in temporary health facilities which could be later on upgraded to semi-permanent infrastructure depending on funding availability and projected duration of existence of the camp. At all stages, the health facilities shall be equipped with infection prevention facilities such as hand-washing, sterilization, incinerator and medical waste disposal.

Partners will ensure adequate level of staffing required for both facilities based services such as medical doctors/experienced health officers, clinical nurses, psychiatric nurses, midwives, laboratory technicians and community-based health programs which should include an outreach coordinator and CHWs. The number of outreach workers shall meet the minimum UNHCR/ARRA requirement of 1:250 – 1:500 and should be the cumulative number between the health and nutrition partner to ensure a common/integrated pool of CHWs with a clear supervision/management structure. Health facilities will

be supplied with essential medicine and medical supplies for the treatment of major causes of morbidity and mortality. For the first 2 – 3 months, inter-agency emergency health kits (IEHK) and MISP supplies will be provided after which the needs should be customized. UNHCR has an arrangement with UNICEF and WHO for the provision of EDK/IEHK in the event of a sudden increase in need. UNHCR will also collaborate with UNFPA to provide MISP supplies.

In the medium-term, when the emergency phase is over, UNHCR will ensure the provision of adequate medicines and medical equipment through international procurement. The health activities will be expanded to include the in-patient department (IPD), antenatal, post natal, safe delivery, family planning, Elimination of Mother to Child Transmission (EMTCT), all essential laboratory facilities including microscopy, routine immunization and HIV/TB treatment.

Referral services (including provision of ambulances) will be established in camps and will follow the existing SOPs on referrals. UNHCR will continue to advocate with partners and/or donors for additional ambulances. UNHCR will also work with partners in prevention and control of disease outbreaks as a priority intervention as well as distribution of bed nets (LLINs) to the general population. Persons of concern at heightened risk like pregnant, severely malnourished cases and HIV patients will receive additional LLINs.

UNHCR and partners will ensure the integration of mental health services to the primary healthcare by ensuring that the health partners have assigned the required expertise in psychiatry and psychosocial support. In addition psychosocial support programs in the community/camp will be established and strengthened.

UNHCR and ARRA will collaborate with UNICEF and the Ethiopian Ministry of Health (MoH) to ensure supply of vaccines and cold chain items. Therefore, considering the potential risk of depletion of the national vaccine stock, UNICEF will assist in the procurement of additional vaccines and vaccine-related supplies, cold chain items and refrigerators for the new influx. UNICEF will also provide technical support and training in proper handling of cold chain and maintenance of refrigeration. The World Health Organization will provide technical support in surveillance and training of staff as well as related information education and communications (IEC) materials.

UNHCR and ARRA will also support the local woreda and zonal health facilities which will provide referral services to refugees, primarily at Lare Woreda Health Centre, Nyinyang Health Center, Gambella Referral Hospital and Akobo Health Post. The main form of support will be provision of medical supplies and equipment for diagnosing and treating patients.

II. Nutrition:

Key Emergency Nutrition Interventions

1. Vitamin A supplementation together with measles vaccination
2. Blanket supplementary feeding for all children 6-23 months (and expanded to 24-59 months depending on the level of the emergency)
3. Targeted supplementary feeding (including pregnant/lactating women, people with chronic diseases and other vulnerable groups including elderly and older children)
4. Therapeutic feeding for the treatment of SAM and MAM
5. Infant and young child feeding in emergencies (IYCF interventions)
6. Nutritional screening using MUAC, monitoring and surveillance, outreach and follow-up
7. Continued support for the host community nutrition program
8. Plan for Standard Extended Nutrition Survey (SENS)

Resources

UNHCR will provide therapeutic feeds, nutrition products, and programming. WFP will provide supplementary feeding and the general food ration. UNICEF will provide "nutrition kits" to support ACF; and nutrition products including ORS, zinc, therapeutic milk and ready-to-use therapeutic food (RUTF) to supplement UNHCR supply upon request. The rest of the operational costs will be funded by UNHCR, ACF or GOAL.

Key Nutrition Interventions at Reception Centre (Akobo and Pagak)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
Vitamin A supplementation	6 months to 5 years		Ongoing by MSF-F (Akobo) and GRHB (Pagak)
Rapid Nutritional Assessment (MUAC and oedema)	6 months to 5 years, pregnant and lactating women (PLW)		Screening of all newly arriving refugee children immediately after vaccination is ongoing by GRHB staff. MUAC screening ongoing at Pagak for all new arrivals (ACF) as part of the registration process
Blanket Supplementary Feeding Programme (BSFP)	6-23 months 24-59 months due to level of emergency PLW	As per rapid nutrition assessment results Monthly MUAC for all children in the BSFP to assess the nutrition status trends	Ongoing by ACF (Pagak)
Targeted Supplementary Feeding Programme (TSFP)	MAM cases	Weekly monitoring needed and home follow-up (see paragraph below)	In Akobo malnourished children are prioritized for relocation to camps (Helicopter relocations for sick persons) Ongoing by ACF in Pagak
Out-patient Therapeutic Programme (OTP)	SAM cases	Weekly monitoring needed and home follow-up (see paragraph below)	In Akobo malnourished children are prioritized for relocation to camps (Helicopter relocations for sick persons) Ongoing by ACF at (Pagak) Daily monitoring carried out

Referral to stabilization center (SC) or medical care	SAM cases or others needing medical referral		In Akobo malnourished children are prioritized for relocation to camps (Helicopter relocations for sick persons) Referral to Itang Health Center (run by MSF-F)
Community health volunteers/workers	Pagak refugees and surrounding community	Move around Pagak to continuously identify vulnerable or malnourished groups	Ongoing at Pagak (10 ACF staff). Increased number of community health workers is underway through possible support by MSF-H

Rapid nutritional assessment, as an immediate and cost-effective source of information on nutritional status, will be undertaken along with these activities. The target group is all children under 5 and pregnant and lactating women (PLW), but depending on capacity and based on the nutrition situation, screening of children 5-10 years and the elderly should be considered. If morbidity or mortality in this group spikes, then there might be an urgent need to include them in supplemental feeding programs. In addition, refugees will have access to basic emergency curative and referral services at reception sites.

Standard treatment for SAM and MAM is weekly distribution of RUTF and ready-to-use supplementary food (RUSF) for SAM and every 2 weeks (bi-weekly) for MAM. In the current emergency situation, partners should evaluate the need to increase the frequency of distribution to 3 days (from 7 days) and 1 week (from 2 weeks), respectively, based on whether feeding and caring practices, and selling is a concern (based on partner feedback). As much as possible, community based management of acute malnutrition model should be followed (see explanation note under key interventions at camp level).

The BSFP for children 6 to 59 months and PLW will be implemented by ACF in Pagak with support from WFP and UNHCR. At Akobo there will be no BSFP, unless ongoing rapid nutritional assessment results indicate otherwise (if threshold exceeds critical level it should be considered). The BSFP program at the entry points should provide high energy biscuits (HEB), but after one week of distribution, it is recommended to be changed to wet feeding program (hot CSB+/oil/sugar porridge) hygiene permitted. A safe place to sit and monitor the daily feeding including breastfeeding should be ensured.

Prioritized relocation of all malnourished children, PLW and their respective families is ongoing and should continue to be emphasized.

Key Nutrition Interventions at Transit Center (Burubiey)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
All interventions will be necessary if Pagak Reception Center stars registration services			Currently services including screening are carried out on arrival at the camps due to the short length of stay at the transit site (one day)

Refugees in transit from Akobo spend one night at Burubiey before proceeding to the camp on the following day. All the interventions provided at the Pagak reception centre will be necessary if the refugees' length of stay at the transit exceeds one day.

Key Nutrition Interventions at Camps (Leitchuor and Kule)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
Vitamin A supplementation	6 months to 5 years	Selective supplementation for those who did not receive at the reception sites through outreach	Ongoing by GRHB with support from UNICEF in both camps
Nutritional screening (MUAC and oedema)	6 months to 5 years, PLW	Arrival screening for all target groups together with information package for new arrivals Regular outreach screening through the use of community volunteers/ CHWs Mop-up screening	Ongoing by ACF (Leitchuor) and GOAL (Kule) Started on 9 April 2014 using an integrated pool of community outreach workers (ACF, MSF-F, ERCS & DRC) at Leitchuor In Kule ARRA, GOAL and NRC have also integrated their community outreach workers Ongoing by ACF in Leitchuor and by GOAL in Kule
BSFP	6 months to 5 years, PLW	As per rapid nutritional assessment results Monthly MUAC for all children in the BSFP to assess the nutrition status trends	Ongoing by ACF in Leitchuor and by GOAL in Kule NRC constructed the feeding centres
TSFP	MAM cases	Need to ensure RUSF is available (by WFP)	Ongoing by ACF in Leitchuor and by GOAL in Kule
OTP	SAM cases	Adequate RUTF to be made available(UNHCR)	Ongoing by ACF in Leitchuor and by GOAL in Kule
Baby Friendly Space (BFS)	All under-two children and their mothers	Assessment of breastfeeding and general feeding at the screening site and at community level Infants and young	Ongoing by ACF in Leitchuor and by GOAL in Kule

		children found to have breastfeeding and feeding difficulties to be referred to the BFS for counselling and support	
Mother to mother support groups for Infant and Young Child Feeding (IYCF)	Mothers of under-two children and pregnant women	Identify women in the community who can serve as lead mothers (trained on appropriate feeding practices after which they will lead groups of 10-15 mothers and facilitate peer to peer support)	To start in Leitchuor and Kule as the second phase after the community outreach response scale up
Community outreach	All households	1:50 households (integrated health, nutrition and hygiene promotion)	An integrated community outreach response strategy in place. Implementation by ACF, ERCS, MSF-F, LWF & DRC in Leitchuor and by GOAL, NRC & ARRA in Kule
Stabilization Center	SAM cases with medical complications needing inpatient stabilization	This service is integrated with IPD, however strong linkage is needed between the partner implementing the IPD and the nutrition interventions.	Ongoing by MSF-F (Leitchuor) In Kule the cases found are referred to Itang HC (MSF-F) Discussions are underway with ARRA to approve the relocation of the SC to the camp for easier access
HIS	All facilities	Weekly compilation of HIS following the appropriate format	Planned for week of 23rd April 2014

Screening for malnutrition will systematically continue to be carried out and all identified cases referred immediately to the nutrition center in the camp for treatment. The services provided at the nutrition center will include stabilization centers, outpatient therapeutic centers, targeted supplementary feeding centers, BSFP center providing a blanket ration to children 6-59 months and PLW, appropriate infant and young child feeding promotion and protection program enrolment for all caregivers with children 0-24 months and the anaemia reduction programs. UNHCR will continue to work closely with UNICEF in supporting the above programs.

A community based management of acute malnutrition (CMAM) approach will be the mainstay of the nutrition program. As the name CMAM suggests it is advised to provide care at home except in cases with medical complications where inpatient treatment and care is inevitable. CMAM links prevention of malnutrition and treatment of malnutrition at the community level, so that while children are being effectively treated, the underlying causes can also be addressed. Caretakers have other children at home who need care and other tasks, thus requiring them to come to the centres daily is not advised. During

the distribution days the nutrition workers should carry out an appetite test where feeding is observed and corrections made. Thereafter, home follow-up and feeding support at that level is preferred. Nutrition education to ensure the beneficiaries understand the importance of the nutrition products is also essential.

III. Food Security

Access to adequate food will be provided through a variety of means. High energy biscuits (HEB) will be provided by WFP to newly arriving refugees at entry points, and during relocation.

Refugees are foraging for firewood. Alternative energy solution is needed. Until a more substantial investment in domestic energy can be made (a specific donor might be necessary given the high costs associated with safe access to fuel) then there is a plan to procure and deliver firewood to the refugees for a limited period until alternative solutions are found.

Key Food Security interventions at Reception Centre (Akobo and Pagak)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
High Energy Biscuit (HEB)	New arrivals before being registered and relocated	This option to be followed when pre-screening, registration and relocation takes place within 3 days and also for the initial 3 days under the option where relocation takes place after 3 days	WFP provides HEBs on arrival → Maximum of 3 days 5 bars HEB /day /adult (2312 Kcal/day) 4 bars HEB for children (1850 Kcal/day)
General Food Distribution (GFD)	All refugee families/ individuals	Distribution center with shade, water, latrine needed If relocation is to take between 3 to 7 days after arrival, a 7 day ration should be provided in addition to the 3 days of HEB If relocation is to take place between 7 to 10 days after arrival, a 14 day ration should be provided in addition to the 3 days of HEB GFD to take place concurrently with the registration/relocation activities (min 2 distribution staff present on a daily basis)	Distribution centers to be constructed by ARRA/NRC GFD started on 10 March in Pagak and on 1 April in Akobo for the backlog that had not received food April GFD will include CSB+

Core Relief Items (CRIs)	All refugee families/ individuals	Kitchen sets to be provided if the refugees cannot be relocated within 3 days	Ongoing
Access to safe energy	All refugee families/ individuals	A more comprehensive solution for safe access to energy needs to be identified using alternatives to firewood	UNHCR to provide firewood to targeted groups at the outset

On 1 March 2014, UNHCR, WFP and ARRA met to examine the various options to provide food to the refugees. While it was clear that the location posed a challenge, it was agreed that such an intervention would contribute greatly to addressing the malnutrition problem by ensuring that family members have adequate food which will in turn ensure that special food for the malnourished children is shared less.

The option of providing hot meals in Pagak was explored but this was ruled out because: 1) it means confining people to a location that is very small as they wait for rations which has health and hygiene implications; 2) the logistical challenges of feeding over 15,000 refugees is very complicated and expensive; 3) providing a hot meal has large associated wastage in the medium/long term because the food is fixed and does not meet everyone's tastes; and 4) a hot meal can give the refugees a false impression that these needs will be met in the longer term, when in fact, they are expected to be independent once arriving at the camps. In evaluating the best option, it was necessary to balance the needs of refugees (immediate hunger, access to water, fuel and cooking sets) with the challenges of an effective hot meal program (efficiency, effectiveness, hygienic concerns).

Consequent discussions agreed to the GFD being distributed by WFP/ARRA to all refugees to cover an initial period of 15 days in both Akobo and Pagak. This was initially carried out as a one-off distribution taking care of all the backlog with registration activities being suspended in favour of the food distribution due to lack of adequate staff to take care of both activities. To determine the level of capacity of new arrivals to manage their own food preparation, it was also agreed that a post distribution monitoring (PDM) be conducted to see if the refugees are selling to buy prepared food, sharing with households that have access to cooking or just cooking it as expected after which subsequent decisions on distribution modality and need for kitchen sets would be made.

Discussions on the improvement of the food response have been ongoing and challenges identified with the initial mode of distribution addressed in the second half of March 2014. As of 1 April 2014 the food response strategy in place is as below:

A combination of high energy biscuits and general food distribution has been agreed as the option for emergency feeding at the entry point with the modality of distribution depending on the length of stay at the entry points before relocation. The distribution modality is as per the options below:

Option 1: Pre-screening, Level 1 Registration and relocation carried out within 3 days

- Provision of 3 days of HEB on arrival

Option 2: Pre-screening, level 1 registration and relocation carried out post 3 days but within 7 days

- Provision of 3 days of HEB on arrival
- Provision of a 7 days general food ration after registration (Assumption that registration is carried out between the 1st and the 2nd day of arrival)
- Provision of core relief items including kitchen sets and water jerican

Option 3: Pre-screening, Level 1 Registration and relocation carried out post 7 days but within 14 days

- Provision of 3 days of HEB on arrival
- Provision of a 14 days general food ration after registration (Assumption that registration is carried out between the 1st and the 2nd day of arrival)
- Provision of core relief items, including kitchen sets, jerricans, buckets and soap

As of 5 April 2014 there is no registration backlog and registration is carried out on arrival at all the entry points. Option 3 was in place until the 7 April after which with the clearance of the relocation backlog Option 1 would be followed as of 9 April 2014. Review on a week-to-week basis to ensure the right option is in place is ongoing.

Agencies have also agreed that the best solution for refugees at entry points is to relocate them to camps as soon as is possible so that subsequent new arrivals should only stay 1-2 days in the reception site before being relocated to the camp.

Key Food Interventions at Transit Center (Burubiey)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
HEB	All refugee families/ individuals	This option to be followed when pre-screening, registration and relocation takes place within 3 days and also for the initial three days even if the relocation will take place after 3 days	The use of Burubiey as a reception centre registering people is being deliberated on ACF on standby if there is need to set up nutrition services

Refugees on transit from Akobo will spend one night at Burubiey before proceeding to the camp the following day. During the overnight stay HEB are being provided. UAM will need to be identified and given their ration and water for trip. Women with small children should be carefully monitored, especially to ensure dehydration is managed in a timely fashion.

Key Food Security Interventions at Camps (Leitchuor and Kule)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
Distribution of CRIs	All refugee families/ individuals	Preferably given on day of arrival and latest on second day	Ongoing by UNHCR, ARRA UNICEF has also supported with bed nets, plastic sheets
Hot meal	All refugee families/ individuals	First 2 days; thereafter refugees are expected to cook own food from WFP food basket	Ongoing by UNHCR
GFD	All refugee families/ individuals	Distribution center with shade, water and latrine	To be constructed (ARRA/NRC)

		One month ration	Ongoing by ARRA Clustering distribution days to start at the beginning of the month and be finalized with 3-5 days for old arrivals is underway
Cereal Grinding Mill	All refugee families/ individuals	Private contractor preferred initially as community structures are developed	One installed in Kule and plans to install one in Leitchuor Additional grinding mills are under procurement by UNHCR
Alternative energy	All refugee families/ individuals	Short, medium and long term solutions needed	Implementation plan developed by environment team
Complementary food	All refugee families/ individuals	Enhancing access to food commodities not provided in GFD basket Would require UNHCR receiving funding from a food donor (not typical) If this can happen; cash would be the most efficient modality	Under review by food security experts based on resource availability

On arrival in the camps each family receives a hot meal. On the second day, they receive a dry food ration allotment alongside CRIs (like kitchen sets, jerry cans, blankets, sleeping mats, bed nets etc). However, in the newest camp (Kule), refugees receive CRIs immediately on arrival. This is an encouraging trend and meets the immediate need of refugees to collect hot meal/cook own food on arrival.

GFD is provided by ARRA to the refugee population at camp level in collaboration with 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, etc).

Milling services will be provided in all camps to mill the sorghum/wheat grain provided to refugees. There is already one grinding mill established at Kule Camp. A proposal for support to the refugee committee by UNHCR to install an existing grinding mill in Leitchuor has been submitted. Four (4) additional grinding mills are in Addis Ababa awaiting relocation to Gambella and another six (6) are in the procurement pipeline.

Currently refugees are foraging for firewood. Alternative energy options need immediate support with initial plan to procure firewood and provide fuel saving stoves. Medium and longer term sustainable options proposed by the environment team need to be considered.

IV. Monitoring

Goal	Target
Reduce the Crude mortality rate (per/10,000/day)	1
Reduce the Under-five mortality rate (per/10,000/day)	2
Reduce prevalence of global acute malnutrition (% W/H Z-score)	<10.0%

Expected output	Target
Health	
Number of direct beneficiaries from emergency drugs supplies (IEHK/RH kits, etc.)	120,000
Proportion of communicable diseases detected and responded to within 48 hours	100%
Proportion of live births at EMOC facility	>90%
Proportion of births attended by skilled personnel	100%
Proportion of rape survivors who have been examined and provided Post Exposure Prophylaxis (PEP) within 72hrs	100%
Proportion of rape survivors who have been examined and provided emergency Contraception (EC) within 120 hrs	100%
Facilitate universal access to antiretroviral therapy	90%
Nutrition	
IYCF programmes targeting children 0-24 months established or maintained (yes/no)	100%
IYCF programmes targeting pregnant and lactating women established or maintained (yes/no)	100%
Coverage community management of acute malnutrition programmes	>90%
Written strategy to address anaemia and other micronutrient deficiencies established or maintained (yes/no)	
Functional nutritional screening system established or maintained (yes/no)	
Coverage of 6-23 months to blanket supplementary feeding programmes	>90%
Coverage of 6-59 months to blanket supplementary feeding programmes	>90%
Coverage of pregnant and lactating women targeted for blanket supplementary feeding	>90%
Food security	
Proportion of people receiving food aid (in kind)	100%
Average # of Kcals distributed per person per day	2100Kcal/p/d

V. Training

In collaboration with relevant partners emphasis will be given to build capacity of the healthcare workers to provide up-to-date and quality service. A training plan will be developed and 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 partners will ensure that the trained staff is retained, appropriately assigned and provided the required support following the training.

VI. Service Delivery Arrangements and Standards:

Based on lessons from the Dollo Ado response, the below proposed key service delivery arrangements and standards are outlined:

SERVICE DELIVERY ARRANGEMENT	MINIMUM STANDARD	REMARK
Decentralization	• 1 health facility per 10,000 population • 1 nutrition facility per 10,000 population • 1 stabilization center (SC) maximum of 50 children	It is encouraged that the health facility and the decentralized nutrition center are located at the same locations so that referral between the two is smoothly undertaken
Community outreach	• 1 community outreach worker per 50 households • No parallel health and nutrition community outreach workers • The training package for community outreach workers is standardized and delivered jointly by concerned IPs.	UNHCR and partners 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

VII. Accountability Matrix (3Ws)

Thematic Area	Akobo Woreda	Wanthowa Woreda	Jikawo Woreda	Lare Woreda		Dimma Woreda	Gog Woreda
	Tergol reception centre	Burubiey transit site	Leitchuor camp	Pagak transit site	Kule camp	Raad corridor Okugo camp	Pochalla corridor Pugnido camp
Pre-departure medical screening	IOM	IOM	N/A	IOM	N/A	ARRA	ARRA
Immunization (new arrival)	GRHB/ MSF-F	N/A	GRHB/MSF-F	Lare Woreda Health Office/UNICEF	GRHB	ARRA	ARRA
Immunization (Routine EPI)	GRHB/ UNICEF	ARRA	MSF-F	Lare Woreda HO/UNICEF	GRHB/ARRA	ARRA	ARRA
Curative services	MSF-F	ARRA	MSF-F	GRHB/MSF-F	GRHB/ARRA	ARRA	ARRA
Rapid Nutrition assessment	MSF-F/GRHB	ACF	ACF	ACF	GOAL	ARRA	ARRA
Nut. treatment (SAM, MAM), IYCF, comty. outreach	Gap	Gap	ACF	ACF	GOAL	ARRA	ARRA
BSFP	Gap	Gap	ACF	ACF	GOAL	N/A	N/A
Stabilization centre	Gap	N/A	MSF-F	Referral to Itang HC run by MSF- F	MSF-F (SC in Itang local HC, 9km)	ARRA	ARRA
MHPSS	Gap	N/A	MSF-F(health)/ACF (Nut program)	ACF (Nut program)	ARRA(health)/ GOAL (Nut program)	ARRA	ARRA
RH/HIV (MISP) (UNFPA supply) Comprehensive	GRHB	ARRA	MSF-F/ IMC	MSF-F	ARRA/ IMC	ARRA	ARRA/ RaDO
EPR	Outbreak control team formed; plan developed	OCT & plan developed	OCT & plan developed	OCT & plan developed	OCT & plan developed	OCT & plan developed	OCT & plan developed
Referral	UNHCR helicopter/ IOM	ARRA/ IOM	MSF-F	MSF-F	ARRA, ERCS, ICRC	ARRA	ARRA

WFP: Food supply for GFD, BSFP and nutrition program, technical staff support

UNICEF: Medicines, medical and nutrition supplies, bed nets (LLINs), technical staff support, liaison and financial support to GRHB, cholera kits

WHO: Disease surveillance, technical staff support

UNFPA: Reproductive health kits

IOM: Medical screening prior to relocation, medical escort and prioritization of malnourished and other vulnerable individuals

ICRC: Ambulance support, donation of surgical and other equipment to Gambella Referral Hospital, local health centers

ERCS: Ambulance services

Key References and Guidelines

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