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 141,900 new arrivals from South Sudan, this number has soared above half a 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 3500,000 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. High malnutrition rates have continued to be reported over the past week at Pagak, Burbeiy and Akobo entry points as well as in the Camps (Kule 1, Kule 2 and Leitchuor). Crude and under five mortality rates have been maintained below the emergency thresholds (<1 and < 2 respectively). However, malnutrition remains the main cause of death among the under-fives. 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 Gambella provide a harmonized package of health and nutrition services;
- Assure compliance of health and nutrition services to national and UNHCR/UNICEF/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. HIV/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, Burbiey 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 in collaboration with UNICEF)
De-worming	2 to 5 years	Ongoing	Ongoing by GRHB with support from UNHCR/ARRA
Clinical Consultation	To asylum seekers (Akobo)	Ongoing	Ongoing by GRHB with support from UNICEF
MUAC screening	To all asylum seeker under five children	Ongoing	Ongoing by GRHB with support from UNICEF
Emergency clinic and disease surveillance	Pagak and Burbeiy refugee and host community	Clinic (24 hour emergency treatment/referral)	Ongoing by Médecins sans frontières (MSF-F) Weekly morbidity data and immediate reporting of outbreaks to UNHCR/WHO/ARRA/Woredas
Ambulance service	Pagak and Burbeiy refugee and surrounding community	24 hour emergency referral	Ongoing by MSF-F in Pagak and ICRC in Burbeiy
Implementation of MISP	As per MISP guidelines	Planning and implementation of comprehensive RH/HIV started	Ongoing by GRHB in Akobo and MSF-F in Pagak and Burbeiy with support from UNFPA, UNHCR
Identification of patients on previous treatment and ensure	HIV/TB patients, others	Ongoing	Ongoing by GRHB in Akobo and MSF-F in Pagak and Burbeiy. Itang and Nyingany

continuity of medication			Health Centers to support on the diagnosis. TB guideline revised.
Community health volunteers/workers	Pagak and Burbeiy refugee and surrounding community	Move around Pagak and Burbeiy to continuously identify vulnerable groups	MSF –Holland has trained 10 locally recruited community outreach workers (COWs) in Pagak. Activity to start in Burbeiy by MSF – France.
Outbreak disease control and surveillance	Pagak,Akobo and Burbeiy refugee and surrounding community	Ongoing measles outbreak; preparation/ prevention activities for any other outbreak	Ongoing by GRHB, UNHCR, ARRA, UNICEF, WHO, and MSF-F
Support Lare, Akula, Matar & 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, and MSF-F & ICRC and will continue as needed. Akula and Matar Health Centers added to the list.

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 (Matar)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
Emergency clinic	All refugees in at Matar Transit Site	Daily clinic with 24 hour emergency treatment/referral	Ongoing by MSF-F. Matar Health Center/RHB additional available for cases requiring immediate facility based care

Ambulance service	Patients needing referral	24 hour emergency referral	ICRC on standby but there is need for additional ambulance

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 Burbeiy will spend one night at Matar before proceeding to Kule-2 Camp on the following day. IOM will ensure medical escort for all refugees is provided. MSF - France will provide emergency health care. UNHCR and IOM to ensure prioritization of travel for all vulnerable cases and provide special arrangement as soon as possible where needed. ARRA will also facilitate and support patients with continuing medications. IOM/ICRC will have an ambulance/vehicle available to refer obstetric emergencies. Care for survivors of sexual violence including post-exposure prophylaxis (PEP) or plan immediate referral to Gambella will be provided by MSF- France and UNHCR. Matar health center with support from RHB and UNICEF will also provide care as needed at no cost to the refugees.

Key Health Interventions at Camps (Leitchuor, Kule 1 andKule-2)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
Vaccination (Routine EPI as per the Ethiopia National Schedule). Additionally, Selective vaccination for OPV and measles for those not vaccinated at reception points.)	As per national and UNHCR guidelines	Selective for those not vaccinated at reception points. Catch up vaccination for children under one as per national guidelines.	Ongoing by MSF-F in Lietchuor, By ARRA in Kule-1 and by MSF-Holland in Kule-2 with support from UNICEF and RHB. Facility and Outreach approach to be adopted. Catch up vaccination guideline developed by UNHCR/UNICEF/ARRA/RHB. Campaign planned for Polio, OCV and PCV by MSF-F/UNHCR/ARRA/UNICEF/RHB
Vitamin A supplementation	6 months to 5 years	Selective for those not vaccinated at reception points	Ongoing by MSF-F in Lietchuor, By ARRA in Kule-1 and by MSF-Holland in Kule-2
MISP/RH	As per MISP/RH guidelines	Comprehensive RH/HIV is planned for and started as emergency continues	Elements of Basic EMOC RH started by MSF-F in Leitchuor and by ARRA in Kule-1, and underway in Kule-2 and kule-1- Zone C by MSF-Holland e.g. antenatal care. Comprehensive EMOC including caesarian section to be provided at Gambella hospital. 24/7 ambulance

			services provided by ICRC/MSF-F/MSF-Holland. RHB to start blood bank in Gambella.
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-1 and by MSF-Holland in Kule-1-Zone-C and Kule-2. 24 hours services to be started in Kule 1 and Kule 2 by ARRA and MSF – Holland respectively after security clearance. Medicines and supplies to be provided by MSF – F, MSF – Holland, UNHCR, UNICEF, and RHB(for vertical programs)
In-patient Department (IPD) Clinical care	Patients needing admission	24 hour service	Ongoing by MSF-F in Leitchuor and through referral by ARRA and MSF-Holland at Kule -1 and kule-2 to Itang (MSF-F in Itang). 24 hours services to start in Kule 1 and 2 by ARRA and MSF – Holland
Ambulance service	Patients needing referral	24 hour service	Ongoing by MSF-F in Leitchuor & ARRA in Kule-1 and by MSF-Holland in Kule-2; ICRC supporting with 3 ambulances (1 per camp) .
Community outreach	All households in the camp	Ongoing	Ongoing by MSF-F, ACF, DRC, LWF (Leitchuor) and by ARRA, GOAL,MSF-Holland (Kule-1),MSF-Holland, GOAL, ADRA, NRC(Kule-2)
Isolation room	Patients with epidemic prone disease	Ongoing in Leitchuor	Ongoing by MSF-F in Leitchuor and pending construction in Kule-1 and Kule-2 by ARRA and MSF – Holland.
Distribution of mosquito nets	All refugees at ratio of 1 LLIN/ 2 individuals	Intensive health education to ensure proper use	Ongoing in Kule-1,Kule-2 and Leitchuor with UNHCR/UNICEF technical support

HIS	All facilities	Weekly data compilation for the HIS following the standard format	Emergency HIS started; Routine HIS reporting also started and tools being provided and training has been provided. Weekly HIS reporting on going. Mortality to include both facility and Community Deaths.
Disease Surveillance	All facilities	Weekly data compilation and immediate reporting for any outbreaks. EPRP to be finalized for epidemic prone diseases.	MSF- France, MSF- Holland and ARRA to report on a weekly basis and immediately for outbreaks. UNHCR to provide updated surveillance data on a weekly basis. WHO/RHB/ARRA/UNHCR to investigate outbreaks within 48 hours. WHO/RHB to support specimen transportation and laboratory confirmation as needed. EPRP to be finalized by WHO/RHB/ARRA/UNHCR.
Chronic Cases(with specific focus on TB and HIV)	Patients with Chronic medical Conditions.	On going	Screening of cases to be done by ARRA, MSF-France and MSF- Holland. Referral, if needed, to be supported by ARRA and Gambella Hospital. Diagnosis for TB to be done at Itang and Nyingany Health Centers with DOTS/follow up treatment provided at the Camp Clinics.
Mental Health and Psychosocial Support	All refugees as needed.	Started by IMC in Kule 1 and Leitchuor Camp.	IMC to continue provision of facility and community based mental and psychosocial support. These should be in an integrated manner.
Support Itang and Nyinyang health facilities with medicines, medical and Laboratory 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,ICRC and ARRA and will continue as needed

At camp level (Leitchuor, Kule-1 and Kule-2), emergency preventive and 24/7 curative healthcare service will be provided by MSF-F, ARRA and MSF-H respectively. The curative services shall be provided at the outpatient and emergency OPD. The service should include triage, outpatient diagnosis treatment, RDT testing for malaria cases, 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, MSF-Holland and ARRA.

An emergency in-patient department (IPD) of at least six beds (3 males and 3 females) is (Leitchuor/Kule 1)/will (Kule 2) 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 Leitchuor and 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. Comprehensive RH/HIV is ongoing in Leitchuor and Kule-1 Camps providing Basic EMOC functions, with referrals for Caesarian Sections made to Gambella Hospital. 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. IMC has started providing community based RH services which should be integrated with services provided at the Health Facilities. 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 has been established within the camps health facility or through referral to local health facilities.

Health services are provided in temporary health facilities which will be 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 COWs. The number of outreach workers per household shall meet the minimum UNHCR/ARRA requirement of 1:250 – 1:500 and should be the cumulative number between the health, nutrition and WASH partners to ensure a common/integrated pool of COWs 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. Inter-agency emergency health kits (IEHK) and MISP supplies have been provided to all partners. Partners should now routinely monitor and report their consumption data as they transition towards needs based/consumption based supply of drugs. 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. Also, MSF – France and MSF – Holland are in the process of procuring drugs and medical supplies to be used at their supported health facilities. ICRC has also donated drugs and medical supplies to ARRA, Nyingany Health Center and Gambella Hospital.

In the medium-term, UNHCR and partners will ensure the provision of adequate medicines and medical equipment through international procurement. All partners will be expected to comply with Ethiopia Food Medicine and Health Care Administration and Control Authority (FMHACA) rules on medicine procurement including provision of complete pre-import documentation. ARRA will provide support letter to facilitate speedy acquisition of importation permit. 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 (WHO) will provide technical support in surveillance and training of staff as well as related information education and communications (IEC) materials.

UNHCR, UNICEF, ICRC and ARRA will also support the local woreda and zonal health facilities which will provide referral services to refugees, primarily at Itang 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-E) interventions including Baby Friendly Spaces
6. Nutritional screening using MUAC,
7. Monitoring and surveillance
8. Community outreach and follow-up
9. Continued support for the host community nutrition program
10. Standard Extended Nutrition Survey (SENS)

Resources

UNHCR will support coordination and provide therapeutic feeds, nutrition products, and programming. WFP will provide supplementary feeding and the general food distribution 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 and GOAL.

Key Nutrition Interventions at Reception Centre (Akobo,Pagak and Burbiey)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
Vitamin A supplementation	6 months to 5 years	Vitamin A provided at registration points.	Ongoing by GRHB Akobo, Burbiey and Pagak
Rapid Nutritional Assessment (MUAC and oedema)	6 months to 5 years.	MUAC screening done at the registration points with SAM and MAM cases cleared tagged and referred.	Screening of all newly arriving refugee children immediately after vaccination is ongoing by GRHB staff in Akobo-. MUAC screening ongoing at Pagak and Burbiey for all new arrivals (ACF) as part of the registration process
Blanket Supplementary Feeding Programme (BSFP)	6-59 months months due to level of emergency Pregnant and Lactating Women	As per rapid nutrition assessment results Monthly MUAC for all children in the BSFP to assess the nutrition status trends	Ongoing by ACF in Pagak and Burbiey , but not implemented in Akobo To be reviewed based on the malnutrition rates and the food pipeline.
Targeted Supplementary Feeding Programme (TSFP)	MAM cases	Weekly monitoring needed and home follow-up (see paragraph below)	Ongoing by GRHB for Akobo and malnourished children are prioritized for relocation (Helicopter relocations for sick persons) Ongoing by ACF in Pagak and Burbiey
Out-patient Therapeutic Programme (OTP)	SAM cases	Weekly monitoring needed and home follow-up (see paragraph below)	Ongoing by GRHB for Akobo and malnourished children are prioritized for relocation (Helicopter relocations for sick persons) Ongoing by ACF at Pagak and Burbiey Daily monitoring carried out

Referral to stabilization center (SC) or medical care	SAM cases or others needing medical referral		No implementing partner for Akobo where malnourished children are prioritized for relocation (Helicopter relocations for sick persons) Referral to Leithuor and Itang Health Center (run by MSF-F)
Community Outreach workers	Pagak and Burbeiy refugees and surrounding community	Move around Pagak and Burbeiy to continuously identify vulnerable or malnourished groups	Ongoing at Pagak and Burubiey (10 ACF staff each).

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 the age of 5 years. But depending on capacity and based on the nutrition situation, screening of children 5-10 years, PLW and the elderly will 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 ready-to-use therapeutic food (RUTF) for SAM children and every 2 weeks (bi-weekly) distribution of ready-to-use supplementary food (RUSF) for MAM children. In the current emergency situation, partners are providing treatment on a daily basis given the transit nature of the population at these sites. 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 is being implemented by ACF in Pagak and Burbiey with support from WFP and UNHCR. At Akobo there is no BSFP, due to lack of nutrition partner, however daily relocations ensure refugees get to the camp within 48hours to access services including BSFP. The BSFP program at the entry points should provide high-energy biscuits (HEB). Prioritized relocation of all malnourished children, PLW and their respective families is ongoing and should continue to be emphasized. Additionally, appropriate screening, labelling and referral for SAM and MAM cases should be made when these children are relocated to the Camps.

Key Nutrition Interventions at Transit Center (Matar)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
Monitoring of the malnourished children, ensure prioritization and provide HEB on need basis. All interventions will be necessary if POC stay longer at Matar	6 months – 59 months PLW	On going	Currently, children are provided 2 days HEB by ACF as they depart Burbeiy. More services to be considered if POC stay longer at the way station.

way station.			

Refugees in transit from Burbeiy spend one night at Matar before proceeding with relocation to Kule 2 camp on the following day. All the interventions provided at the Matar reception centre will be necessary if the refugees' length of stay at the transit exceeds one day. Concern Worldwide will monitor the children at the waystation and , provided HEB on need basis.

Key Nutrition Interventions at Camps (Leitchuor, Kule 1 and Kule 2)

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 at Leitchuor, ARRA in Kule 1 and MSF-H in Kule2.
Nutritional screening (MUAC and oedema)	6 months to 5 years	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 needed	Ongoing by ACF (Leitchuor) and GOAL (Kule1 and Kule 2) Starting on 9 April 2014 using an integrated pool of community outreach workers (ACF, MSF-F, ERCS & DRC) at Leitchuor In Kule1 ARRA, MSF-H, GOAL and NRC have also integrated their community outreach workers. In Kule2 community outreach workers from GOAL, MSF-H, ADRA and NRC integrated. Ongoing by the pool of integrated community outreach workers
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 Kule1 and Kule2 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 Kule1 and Kule2

OTP	SAM cases	Adequate RUTF to be made available (UNHCR)	Ongoing by ACF in Leitchuor and by GOAL in Kule1 and Kule2
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 children found to have breastfeeding and feeding difficulties to be referred to the BFS for counselling and support	Ongoing by ACF in Leitchuor and by GOAL in Kule1 and Kule2
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)	Started in Leitchuor and Kule1 as the second phase after the community outreach response scaled 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, MSF-H, NRC & ARRA in Kule1 and GOAL, MSF-H, ADRA and NRC in Kule2.
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 Kule1 and 2 the cases found are referred to Itang HC (MSF-F) GOAL together with ARRA are in the process of setting up a stabilisation centre in Kule1 In Kule 2 MSF-H plans -to set up a stabilisation centre in the coming weeks.
HIS	All facilities	Weekly compilation of HIS following the	Training was conducted for all implementing partners in April2014. A follow up

		appropriate format	training will be planned for new implementing partners

Screening for malnutrition will systematically continue to be carried out and all identified cases will be referred 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 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 for 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, 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, Pagak and Burbiey)

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 → for a 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	Distribution centers constructed by ARRA/NRC GFD started on 10 March in Pagak and on 1 April in

		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)	Akobo for the backlog that had not received food April GFD included CSB+ GFD in Burbiey started on 18th of May 2014
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

UNHCR, WFP and ARRA met to examine the various options to provide food to the refugees during the early phase of the emergency. 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 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 many 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 Pagak and Burbiey. This was initially carried out as a one-off distribution taking care of the refugees waiting to be relocated. 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 jerry can

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 the 6 June 2014 there is no registration backlog and registration is carried out on arrival at all the entry points. Option 3 is in place in Burbiey though enhanced relocation plans are being implemented to clear the backlog of refugees. At Pagak and Akobo option 1 is being implemented. 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 (Matar)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
HEB	All refugee families/ individuals	This option to be followed when relocation takes more than 3 days.	Matar is the transit site between Burbeiy and Kule2 Camp.

Refugees on transit from Burbeiy will spend one night at Matar before proceeding with relocation to the camp the following day. ACF will provide 2 days ration of HEB while Concern Worldwide will monitor and provide additional HEB if stay at Matar is extended or on need basis. 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, Kule1 and Kule2)

KEY INTERVENTION	TARGET GROUP	REMARK	STATUS
Distribution of CRIs	All refugee	Preferably given on day	Ongoing by UNHCR, ARRA

	families/ individuals	of arrival and latest on second day	UNICEF has also supported with bed nets, plastic sheets
GFD	All refugee families/ individuals	Distribution center with shade, water and latrine One month ration	To be constructed (ARRA/NRC) Ongoing by ARRA Clustering distribution days to start at the beginning of the month and be finalized within 3-5 days for old arrivals This has started in June for Leitchuor and will start in Kule 1 in July In Kule2 a one month food distribution is conducted upon arrival
Cereal Grinding Mill	All refugee families/ individuals	Private contractor preferred initially who is DRC as community structures are developed	Two mills are installed in Kule1 and plans to install one mill in Leitchuor and Kule 2 are still underway. Additional grinding mills were procured by UNHCR and are awaiting installation
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 should be considered based on market analysis and feasibility.	Under review by food security experts based on resource availability

On arrival in the camps each family receives. a dry food ration allotment on the second day alongside CRIs (like kitchen sets, jerry cans, blankets, sleeping mats, bed nets etc.). However, in the newest camp (Kule2), 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, CRIs etc.). Milling services will be provided in all camps to mill

the sorghum /wheat grain provided to refugees. There is already two grinding mills established at Kule1 Camp. Additional grinding mills were delivered from Addis Ababa by UNHCR and are awaiting installation. DRC will support the operation of the grinding mills.

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.)	142,000
Proportion of communicable diseases detected and responded to within 48 hours	100%
Proportion of live births at EMOC facility	>90%
Measles vaccination coverage rate	>90%
Proportion of births attended by skilled personnel	>60%
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) BFS established and maintained in all camps and reception centers.. (e.g.)	100%
Coverage community management of acute malnutrition programmes	>90%
Written strategy to address anaemia and other micronutrient deficiencies available (yes/no)	
Functional nutritional screening system established and maintained in each site (yes/no)	
Coverage of blanket supplementary feeding programmes for 6-23 months	>90%
Coverage of blanket supplementary feeding programmes for 6-59 months	>90%
Coverage of blanket supplementary feeding for pregnant and lactating women.	>90%
Food security	
Proportion of people receiving food assistance (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, based on identified needs through consultation with ARRA and nutrition partners. 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 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. To this end, MSF-H has established a decentralized health post at Kule-1 –zone-C and other partners have started preparation.
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(including Matar)	Leitchuor camp	Pagak transit site	Kule-1 camp	Kule-2	Raad corridor Okugo camp	Pochalla corridor Pugnido camp
Pre-departure medical screening	IOM	IOM	N/A	IOM	N/A	NA	ARRA	ARRA
Immunization (new arrival)	GRHB/ MSF-F	GRHB	GRHB/MSF-F	Lare Woreda Health Office/UNICEF	ARRA	MSF-H	ARRA	ARRA
Immunization (Routine EPI)	GRHB/ UNICEF	NA	MSF-F	Lare Woreda HO/UNICEF	ARRA	MSF-H	ARRA	ARRA
Curative services	MSF-F	MSF_F	MSF-F	GRHB/MSF-F	/ARRA	MSF-H	ARRA	ARRA
Rapid Nutrition assessment	MSF-F/GRHB	ACF(Concern Worldwide – Matar)	ACF	ACF	GOAL	GOAL	ARRA	ARRA
Nut. treatment (SAM, MAM), IYCF, comty. outreach	Gap	NA	ACF	ACF	GOAL	GOAL	ARRA	ARRA
BSFP	Gap	ACF	ACF	ACF	GOAL	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)	MSF-F (SC in Itang)	ARRA	ARRA
MHPSS	Gap	N/A	MSF-F(health)/ACF (Nut program)	ACF (Nut program)	ARRA(health)/ GOAL (Nut program)	MSH_H(health)/ GOAL (Nut program)	ARRA	ARRA
RH/HIV (MISP) (UNFPA supply) Comprehensive	GRHB	MSF-F	MSF-F/ IMC	MSF-F	ARRA/ IMC	MSF-H	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	OCT & plan developed
Referral	UNHCR helicopter/ IOM	MSF-F/ IOM	MSF-F	MSF-F	ARRA, ERCS, ICRC	MSF-H	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 staffs 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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