Public Health Emergency Strategic Framework for the Burundi Refugee Influx Situation, Tanzania

As of 8 July, there are close to 76,000 Burundians in Nyarugusu camp, Kasulu. From 1 May to 20 June 2015, the field operation in Kigoma Region witnessed an influx of close to 58,000 Burundian refugees, 67% of whom arrived into Tanzania through Kagunga, while the remaining came through various other entry points along the border. From 20 June to 8 July, 17,825 individuals have arrived in the country with the majority (24%) arriving through Manyovu and other points along the Kibondo-Ngara axis. From 21 June to 8 July, the average daily rate of arrivals, into Nyarugusu camp stands at 1,048 individuals. UNHCR anticipates the arrival of some 150,000 Burundian refugees in Tanzania by end 2015.

The goal of the health 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.

## Inter-agency Coordination

* Collaboration with the Tanzania Ministry of Health/ local health officials should be regular, resulting in increased government support to the health response
* An interagency health coordination meeting takes place once a week at Nyarugusu camp. UNHCR and the District medical officer (DMO) co-chair the meeting.
* There are also regional level meetings led by the Kigoma Regional Medical Officer (RMO) every Monday and Friday at Kigoma level to which partners working in the refugee hosting areas and elsewhere in Kigoma are required to attend.

## Referral

All referrals should be done in line with Tanzania medical referral SOPs and UNHCR global guidelines. A specific referral pathway for the Burundi refugee influx situation has been developed.

## Data

The following is recommended:

* Emergency HIS (morbidity & mortality minimum) at way stations and transit locations. Data collection tools are available online at <http://www.unhcr.org/4a3374408.html>)
* Comprehensive HIS reporting to continue in Nyarugusu camp.
* Basic indicator report (BIR) for new and existing sites/camps receiving new arrivals and fill in the data on weekly basis.
* WASH monitoring system (WMS) is a tool for tracking key WASH indicators at household and community levels in refugee camp settings. The tool also monitors trends in diseases related to hygiene and sanitation conditions in camps.
* UNHCR and WFP should plan to conduct a Rapid JAM which is a condensed version of the full JAM (done every 2 years) that can be done during the first 6 months of an emergency to assess the food security and nutrition situation (NOT anything else), review the quality and appropriateness of the on-going food security interventions and/or identify new interventions to protect and ensure the food security and nutritional status of refugees.
* Nutrition survey in fourth quarter of 2015

## Monitoring

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| **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% |

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| **Expected output** | **Target** |
| **Health** |
| Number of direct beneficiaries from emergency drugs supplies (IEHK/RH kits, etc.) | Camp Pop. # |
| 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) | 100% |
| 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 |

## Services and standards

### Health facility

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| * At least one basic health unit is available for every 10,000 people. (Basic health units are primary healthcare facilities that offer essential health services.)
* At least one health centre is available for every 50,000 people.
* At least one district or rural hospital is available for every 250,000 people.
* More than 10 in-patient and maternity beds are available for every 10,000 people.
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* At entry points and transit centres, set up an emergency clinic. The minimum services it should have include OPD, nutrition treatment, emergency delivery room and dressing room. Plan for referral to nearest government hospital for all emergency deliveries and complicated medical conditions needing admission or specialist care.
* In emergencies with high acute malnutrition levels and depending on how long refugees stay at border or transit centres (more than 3 days), a nutrition centre may need to be constructed including OTP, SFP and BSFP (context specific, consult senior nutrition officer at regional or HQ level).
* At the camp for the emergency phase, plan for health centre with OPD, IPD, EPI, BEmONC, nutrition treatment centre, pharmacy, laboratory, isolation room.
* Always remember to construct the health centre at a more central part of the camp to ensure improved access. In addition plan for and construct decentralized health posts as needed (aim for 1 health facility per 10,000, depending on camp layout).
* The minimum services at health posts include OPD, EPI, emergency delivery, dispensary, nutrition treatment.
* For rural dispersed settings or urban locations, promote integration of services with national program and coordinate closely with Tanzania Ministry of health, Regional medical officers and Ministry of water and with support from UN and other partners to ensure equitable access to services for all refugees as for nationals.

### Surveillance

* Health screening and including malnutrition, measles and polio vaccination, and basic disease surveillance systems have been established at the transit locations and in the camp.
* Cholera remains the top disease of outbreak potential following recent cholera outbreak in May among refugees and Tanzanians. No new case has been reported among refugees since 5th June 2015.
* A national Epidemic Preparedness and Response (EPR) plan for Cholera is available and an operational plan for the refugee emergency has been developed.

### Recommended Key Health Interventions at Way Station

**NOTE:** At way stations we should support the dispensaries to only provide emergency health services and referral of critically ill.

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| **KEY INTERVENTION** | **TARGET GROUP** | **REMARK** |
| Emergency clinic and disease surveillance | Refugee and host community | 24 hour emergency treatment/referral |
| Vaccination (refer to annex 2 below) | All children under 15 years | If refugees stay longer than three days |
| Ambulance service | Refugee and host community | 24 hour emergency referral |
| Outbreak disease control and surveillance | Refugee and host community | Prevention / Preparation activities for any outbreak ( Ensure there is EPR Plan) |
| Support local government health facilities with medicines, medical supplies/equipment | Local community | Support integration of services with MOH in line with UNHCR policy & consideration of local context (consult experts in HQ/Reg) |
| **Nutrition** |
| Rapid Nutritional Assessment (MUAC and oedema) (next to registration desk) | To all asylum seeker/refugees under five children | MUAC screening done at the registration points with SAM and MAM cases prioritized, registered and referred |
| **Food Security** |
| High Energy Biscuit (HEB) | New arrivals before being registered and relocated | This option to be followed when pre-screening, registration & relocation takes place within 3 days & also for the initial 3 days if relocation takes place after 3 days |
| Core Relief Items (CRIs) | All refugee families/ individuals | Kitchen sets to be provided if the refugees cannot be relocated within 3 days unless hot meal provided |

### Recommended Key Health Interventions at Transit Centres

**NOTE:** This should be a temporary site with aim to relocate the refugees to camp within 3 days, otherwise, based on experience, there will be significant health risks including disease outbreaks and avoidable need to scale up interventions at transit locations despite limited resources.

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| **KEY INTERVENTION** | **TARGET GROUP** | **REMARK** |
| Arrival measles vaccination (next to registration desk) | 6 months to 15 years | In case of measles outbreak in higher population groups, the target for measles vaccination could be extended based on the proportion above 15 years affected by measles |
| Vitamin A supplementation (next to registration desk) | 6 months to 5 years | Important to ensure there is at least an interval of four months between the doses |
| Oral polio vaccine (next to registration desk) | 0 to 15 years |  |
| De-worming (next to registration desk) | 2 to 5 years |  |
| Rapid Nutritional Assessment (MUAC and oedema) (next to registration desk) | To all refugees under five children | MUAC screening done at the registration points with SAM and MAM cases prioritized, registered and referred |
| Emergency clinic and disease surveillance | Refugee and host community | 24 hour emergency treatment/referral |
| Ambulance service | Refugee and host community | 24 hour emergency referral |
| Implementation of Minimum initial service package for RH (MISP) | As per MISP guidelines | Important to concurrently start planning for comprehensive RH/HIV |
| Mental health | All refugees | Psychological first aid |
| Identification of patients on previous treatment & ensure continuity of medication | HIV/TB patients, others | Ongoing |
| Community based health workers | Refugee and host community | Continuously identify/refer the sick & vulnerable groupsFocus on targeted messages |
| Outbreak disease control and surveillance | Refugee and host community | Prevention / Preparation activities for any outbreak ( Ensure there is EPR Plan) |
| Support local government health facilities with medicines, medical supplies/equipment | Local community | Support integration of services with MOH in line with UNHCR policy & consideration of local context (consult experts in HQ/Reg) |
| **Nutrition** |
| Rapid Nutritional Assessment (MUAC and oedema) (next to registration desk) | To all asylum seeker/refugees under five children | MUAC screening done at the registration points with SAM and MAM cases prioritized, registered and referred |
| Blanket Supplementary Feeding Programme (BSFP) | 6-59 months based on level of emergency (>15% GAM or >10% with aggravating factors)Pregnant and Lactating Women | As per rapid nutrition assessment resultsMonthly MUAC for all children in the BSFP to assess the nutrition status trends |
| Targeted Supplementary Feeding Programme (TSFP) | MAM cases | Weekly monitoring needed and home follow-up  |
| Out-patient Therapeutic Programme (OTP) | SAM cases | Weekly monitoring needed and home follow-up  |
| Referral to stabilization center (SC) or medical care | SAM cases or others needing medical referral |  |
| Community based health workers | Refugees and host community | Continuously identify/refer vulnerable or malnourished |
| **Food Security** |
| High Energy Biscuit (HEB) | New arrivals before being registered and relocated | This option to be followed when pre-screening, registration & relocation takes place within 3 days & also for the initial 3 days if relocation takes place after 3 days |
| General Food Distribution (GFD) | All refugee families/ individuals | Distribution center with shade, water, latrine neededIf 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 HEBIf 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) |
| Core Relief Items (CRIs) | All refugee families/ individuals | Buckets, Jerry cans, blankets, soap. Kitchen sets to be provided if the refugees cannot be relocated within 3 days unless hot meal provided  |
| Access to safe energy | All refugee families/ individuals | A more comprehensive solution for safe access to energy needs to be identified & consider alternatives to firewood |

### Recommended Key Health Interventions at Camps

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| **KEY INTERVENTION** | **TARGET GROUP** | **REMARK** |
| Vaccination (**Routine EPI** as per the National Schedule). Additionally, Selective vaccination for OPV & measles for those under 15yrs not vaccinated at reception points) | EPI 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. |
| Vitamin A supplementation | 6 months to 5 years | Selective for those not vaccinated at reception points |
| Reproductive Health  | All refugees in RH age | **Comprehensive RH/HIV** is planned for and started as emergency continues |
| OPD Clinical care | All refugees and host community | During working hours (and 24 hours for emergency/ duty hours) |
| In-patient Department (IPD) Clinical care | Patients needing admission | 24 hour service  |
| Ambulance service | Patients needing referral | 24 hour service  |
| Community outreach | All households in the camp |  |
| Isolation room | Patients with epidemic prone disease |  |
| Distribution of mosquito nets | All refugees at ratio of 1 LLIN/ 2 individuals | Intensive health education and Household visit/supervision to ensure proper use |
| HIS | All facilities | Weekly data compilation for the HIS following the standard format |
| Disease Surveillance | All facilities | Weekly data compilation and immediate reporting of any outbreaks.EPRP to be developed for epidemic prone diseases |
| Chronic Cases(with specific focus on TB and HIV) | Patients with Chronic disease Conditions. | Ensure continuation of treatment for those with chronic disease conditions |
| Mental Health  | All refugees as needed. | Ensure that mental health care is functionally linked to, and preferably integrated in the general health system; avoid establishing parallel mental health services |
| Support local government health facilities with medicines, medical and Laboratory supplies/ equipment | Local community | Support integration of services with MOH in line with UNHCR policy & consideration of local context (consult experts in HQ/Reg) |
| **Nutrition** |
| Nutritional screening (MUAC and oedema) | 6 months to 5 years | Arrival screening for all target groups together with information package for new arrivalsRegular outreach screening through the use of community based health workforceMop-up screening needed  |
| BSFP | 6 months to 5 years, PLW | As per rapid nutritional assessment results & guidelinesMonthly MUAC for all children in the BSFP to assess the nutrition status trends |
| TSFP | MAM cases | Need to ensure RUSF is available (by WFP) |
| OTP | SAM cases | Adequate RUTF to be made available (UNHCR/UNICEF) |
| 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 |
| 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) |
| Community based health workforce | All households | Minimum 1 per 25 households (integrated health, nutrition & hygiene promotion preferred) |
| Stabilization Center | SAM cases with medical complications needing inpatient stabilization | This service is integrated with IPD, however strong linkage is needed between the partner managing the SC and the nutrition interventions’ partner |
| Nutrition survey | All camps  | Plan for nutrition survey once population movements stabilize |
| **Food Security** |
| Distribution of CRIs | All refugee families/ individuals | Preferably given on day of arrival and latest on second day |
| GFD | All refugee families/ individuals | Distribution center with shade, water and latrineOne month ration |
| Alternative energy | All refugee families/ individuals | Short, medium and long term solutions needed |
| Complementary food | All refugee families/ individuals | Enhances access to food commodities not provided in GFD basket Would require UNHCR receiving funding from a food donor (not typical)If feasible, cash should be considered based on market analysis and feasibility. |

## Mapping

Arrange with UNHCR site planner/ Information Management Officer (IMO) for mapping location and type/level of health services and service providers (government, not-for-profit and private) in areas where refugees are residing including transit locations/ way stations.

Gaps in service provision will be highlighted and mechanisms identified to fill these gaps (e.g. if certain health centres are sub-standard, certain hospitals do not have specific specialties).

## Templates

### Accountability matrix (refer to detailed excel format attached)

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| **What**  | **Where**  | **Who**  | **When** | **Frequency** | **Status** |
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### Recommended health work force in UNHCR supported health facilities

(To be adapted to context)

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| **Role** | **Number against population size** |
| Medical doctor | 1: <30,000 or 1 per facility if smaller population |
| Clinical consultant | 1: <10,000 |
| Nurses | 1: <10,000 |
| Psychiatric nurse / clinical officer trained in mental health | 1: <50,000 |
| Visiting psychiatrist and psychologist (if available in country) | 2 days per month < 50,000 (increase days for > 50,000 persons) |
| Qualified pharmacist | 1: < 50,000 |
| Pharmacist assistant (dispenser) | 1: <20,000 |
| Qualified laboratory technician | 1 : <15,000 ( 1 per 30 test per day) |
| Midwives | 5 : MCH/maternity wards 2: <10,000  |
| HIV counsellor | 1: < 50,000 |
| Nutrition supervisor | 1 per camp (<10,000) |
| Nutrition auxiliary workers | 4 per centre or 4 per OTP (per camp <10,000) |
| Nutrition Community Health Workers | 1: 1,500 in camps where GAM is above 10% |
| Community Health Workers (CHW) | 1: 250 (emergency), 1: 1,000 (post-emergency) |
| Specialist CHW for mental health and psycho social support | 1: 2,500 |
| Specialist CHW for RH and HIV  | 1: 2,000  |

## References

* Global public health strategy, 2014-2015: <http://www.unhcr.org/530f12d26.pdf>
* Digital Emergency Handbook: <https://emergency.unhcr.org>
* Twine: <http://twine.unhcr.org/app/>
* Ensuring access to health care: operational guidance on refugee protection and solutions in urban areas. UNHCR 2011. <http://www.unhcr.org/4e26c9c69.html>
* UNHCR’s Essential Medicines and Medical Supplies Policy and Guidance. UNHCR, 2013. <http://www.unhcr.org/527baab09.html>
* UNHCR’s Principles and Guidance for referral Health Care for Refugees and Other Persons of Concern. UNHCR, 2009. <http://www.unhcr.org/pages/49c3646cdd.html>
* Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies, mhGAP Humanitarian Intervention Guide (mhGAP-HIG) <http://apps.who.int/iris/bitstream/10665/162960/1/9789241548922_eng.pdf?ua=1>
* Public Health Indicators and Standards:

