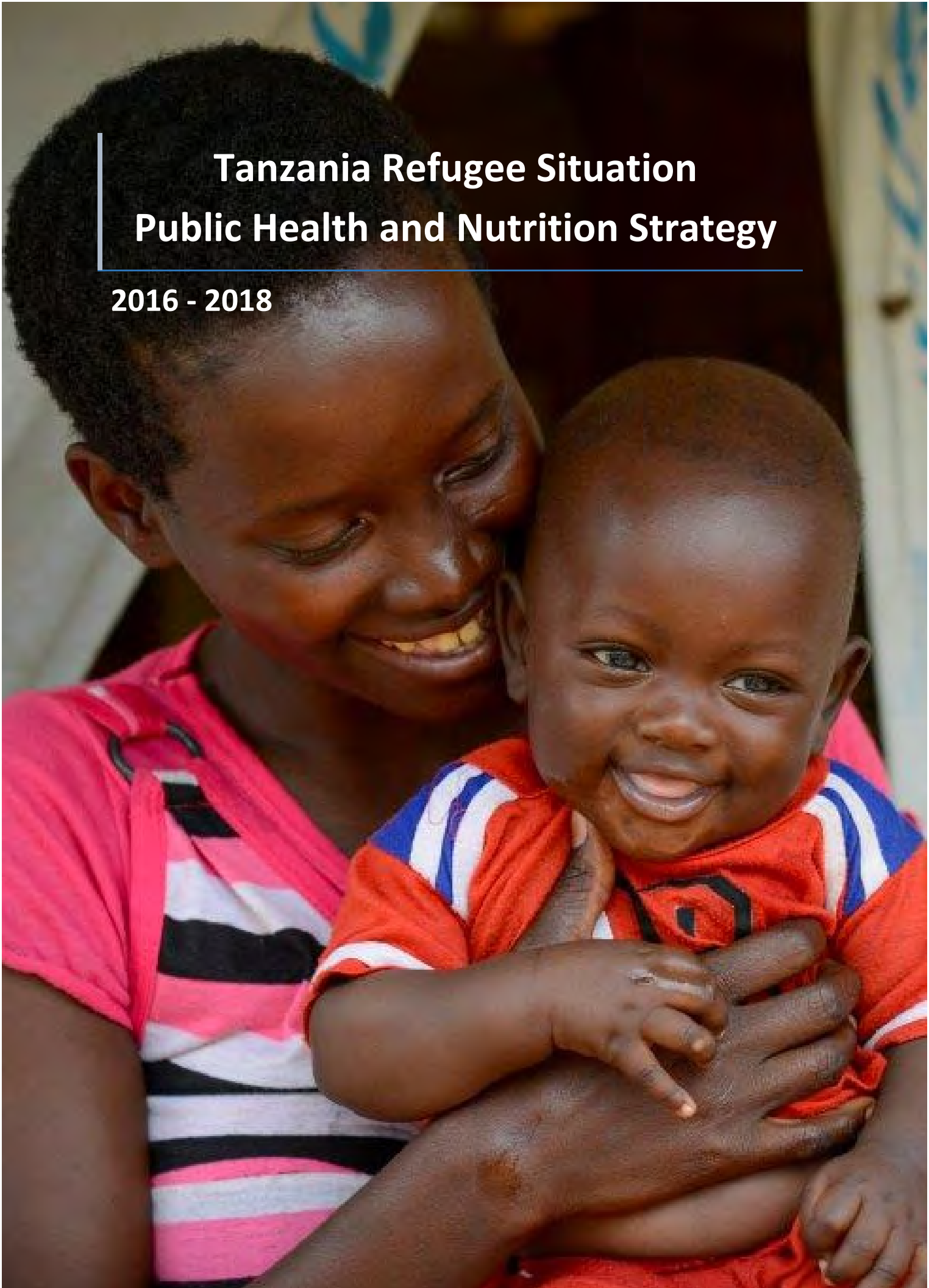

Tanzania Refugee Situation
Public Health and Nutrition Strategy

2016 - 2018


UNHCR
The UN Refugee Agency


unicef


WFP
World Food
Programme


65
YEARS
International Organization for Migration


World Health
Organization


UNFPA


MEDECINS
SANS FRONTIERES


TANZANIA
RED CROSS SOCIETY


ADRA
TANZANIA


INTERNATIONAL
RESCUE
COMMITTEE


World Vision


HelpAge
International

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INTRODUCTION AND BACKGROUND

Tanzania has been a consistent and generous host to millions of refugees over the years. The country has supported UNHCR and partners in all three durable solutions - from voluntary repatriation to countries of origin, resettlement to other countries willing to share the burden of displacement, to the unprecedented gift of citizenship for almost 200,000 former 1972 Burundian refugees. The test of time did not weaken the generosity; when the ongoing political tension in Burundi caused thousands of Burundians to flee to Tanzania.

Table 1. Map of Tanzania

By 31 December 2015, some 123,210 newly arrived refugees crossed into Tanzania with children below the age of 18 making up over half (58%) of the new arrivals.

Since the end of April 2015, once the restriction preventing asylum-seekers from coming to Tanzania was lifted by Burundi officials, a continuous influx of thousands entered the country through Kagunga, a small village located on a peninsula stretching into Lake Tanganyika. The living conditions on the village were deplorable.

As a result of lack of sufficient services, a serious Cholera outbreak emerged, leading to the loss of 30 refugees. At the time, UNHCR's efforts, in consultation and agreement with the Tanzanian Government and Partners, were mainly directed at evacuating refugees from the Kagunga peninsula, in order to take them to appropriate transit/reception centres in Kigoma and eventually to safety in Nyarugusu camp. In addition to refugees' relocation from Kagunga, which amounted to 33,000 by 30 June 2015, there were 44 other entry points from where refugees were relocated to Nyarugusu. The number relocated from these 44 entry points total 34,000.

Prior to this influx of Burundian refugees, Tanzania had only one remaining refugee camp; Nyarugusu. Accommodating just over 65,000 mainly Congolese (DRC) refugees, Nyarugusu was soon to shelter thousands of Burundian refugees with the newly arrived reaching the 100,000 mark by 1 October 2015, swelling the camp population to over three times its capacity and making Nyarugusu one of the largest and most overcrowded camps in the world.

This congestion resulted in the Government agreeing to open three former refugee camps – Nduta, Mtendeli and Karago camps. Consequently, a relocation exercise from Nyarugusu to Nduta camp to ease congestion was initiated.

Table 2: Population Statistics (As at 12 June, 2016)

Origin Country	Pre-Influx Pop Nyarugusu	Post April 2015 (Influx)										Population of Concern (Pre-Influx + Post April 2015)	
		Nyarugusu		Nduta		Mtendeli		Transit Center	Total Post April 2015 (Influx)				
		Arrivals	Births	Arrivals	Births	Arrivals	Births		Arrivals	Births			
Burundi	2,831	62,331	2,295	54,252	962	20,226	271	111	136,920	3,528	140,448	143,279	68.8%
Congo (DR)	62,048	2,570	56						2,570	56	2,626	64,674	31.1%
Rwanda	79	14							14		14	93	0.0%
Uganda	17	1							1		1	18	0.0%
Sudan	9											9	0.0%
Kenya	13											13	0.0%
Others	66											66	0.0%
	65,063	64,916	2,351	54,252	962	20,226	271	111	139,505	3,584	143,089	208,152	100.0%
		67,267		55,214		20,497							

To deliver health care to Persons of Concerns, UNHCR has partnered with the following:

Government of Tanzania Ministries

Ministry of Home Affairs **(MHA)**

Ministry of Health Community Development Gender Elderly and Children (**MOHCDGEC)**

National Non-Governmental Organizations (NGOs)

Adventist Development and Relief Agency **(ADRA)**

CARITAS

Relief to Development Society **(REDESO)**

Tanzanian Red Cross and Red Crescent Society **(TRCS)**

Tanzania Water and Environmental Sanitation **(TWESA)**

International NGOs

International Rescue Committee **(IRC)**

International Federation of the Red Cross and Red Crescent Societies **(IFRC)**

Medecins Sans Frontieres (**MSF** Switzerland and Holland)

Helpage International **(HI)**

World Vision International **(WVI)**

UN agencies

International Organization for Migration **(IOM)**

United Nations Population Fund **(UNFPA)**

United Nations Children's Fund **(UNICEF)**

World Health Organization **(WHO)**

UNHCR aims to ensure that all refugees are able to fulfil their rights in accessing life-saving and essential primary health care, HIV prevention, protection and treatment, reproductive health services, food security and nutrition, and water, sanitation and hygiene services.

The focus of this 3 year strategy is not limited to the emergency phase but extends to a possible protracted phase as well. The strategy is developed following series of meetings and consultations with refugees (participatory assessments), Ministry of Health Community Development Gender Elderly and Children (MOHCDGEC) hereinafter known as MOH, Ministry of Home Affairs (MHA) and the health and nutrition partners working in the refugee program.

HEALTH SYSTEM AND SERVICES IN TANZANIA

Tanzania mainland is divided into 25 administrative regions and 113 districts with 172 councils. The districts are semi-autonomous in health planning and implementation, which is an important point to take into account when developing the strategy for Refugee Camps. Currently there are a total of 8,528 health facilities (dispensaries, clinics, hospitals) throughout the country, and 90% of the population is said to live within 5 kilometres of a primary health facility. However, the greatest challenge is access to hospitals and specialist services. Rural population are at a disadvantage as expected.

Health and social welfare services are provided from the grassroots level up through higher levels of care, beginning with community health care, dispensaries and health centers, and proceeding through first level hospitals, regional referral hospitals and zonal and national hospitals, all providing increasingly sophisticated and well-defined services. Due to constraints in human resources and supplies of medicines and health products, not all primary health services are of sufficient quality. In certain geographical areas, populations still live far away from health services. This is especially problematic in terms of maternal and newborn care. The referral system does not always function as required, sometimes due to a lack of adequate transport to the next level of care or due to an inability at the referral level to provide adequate services.

According to the National Cost Sharing Policy Guidelines, children aged less than five years and pregnant women are eligible for exemption from user charges for basic services. Other groups of eligible people include those presenting with illnesses associated with diabetes, cancer, meningitis, TB and leprosy, HIV/AIDS, people attending for family-planning-related services and people aged 60 years and above.

Currently, many different health insurance schemes operate in Tanzania, e.g., Community Health Fund (CHF) and TIKA (a scheme for urban, periurban areas), National Health Insurance Fund (NHIF), etc., There is some notable progress in raising coverage with the existing schemes. The Health Financing Strategy (HFS, 2015-2025) proposes an expansion and con-

solidation of health insurance around a new mandatory Single National Health Insurance (SNHI) programme. All Tanzanian citizens are expected to participate through contribution payments. The poor and vulnerable will be identified, based on the national socio-economic targeting mechanism and will receive full subsidisation. However, it is important to note that none of these services have as yet to reach a sufficient scale as a proportion of the total population covered.

OVERVIEW OF HEALTH SERVICES IN TANZANIA REFUGEE PROGRAM

Kigoma Region, where there are three existing refugee camps (Nyarugusu, Nduta and Mtendeli) and a fourth proposed camp (Karago), consists of 6 administrative districts. Primary Health Care (PHC) services form the basement of the pyramidal structure of health care services with a number of dispensaries, health centres and one district hospital at the district level. There is one district hospital (Kasulu District Hospital) in Kasulu district serving as the 1st level referral facility for Nyarugusu camp residents, one district hospital (Kibondo District Hospital) in Kibondo serving Nduta Camp residents and one recently elevated District Hospital (Kakonko District Hospital) serving Mtendeli and Karago camps. Within each existing camp there is one main camp health facility and satellite static or mobile health posts that are accessible and serve both the refugees in the camps and the host community members from nearby villages. Services in the camp based facilities are provided free of charge while in the district hospitals some fees apply to both refugees and nationals accessing care therein.

Nyarugusu Refugee Camp is located in Kasulu district and health services are provided in 7 health facilities: the 128-bed capacity main hospital, 2 (80 and 48 bed capacity) health centres that operate for 24hrs, and 4 health posts offering out-patient services for treating uncomplicated cases. Following the emergency influx, 3 health posts were established in the new zones (zone 8, 9 and 11) to increase access to health services for Burundian refugees. Tanzania Red Cross Society (TRCS) with support from the International Federation of Red Cross and Red Crescent Society (IFRC) and additional support from other UN agencies are running inpatient and outpatient facilities, Nutrition, HIV and Reproductive health services, Disease surveillance and community health programs. The International Rescue Committee (IRC) is operating a 24 hour maternity facility catering to both old caseload and Burundian refugees. MSF Switzerland (MSF-CH) currently operates 3 “malaria” health posts in the Burundian zones to test, treat and refer complicated malaria cases. In addition, MSF-CH implements community surveillance, health promotion activities and Mental Health services. MSF Switzerland (MSF-CH) is providing malaria treatment, distributing LLITNs, health promotion, as well as providing Mental Health services in the camp.

Nduta Refugee Camp which is located in Kibondo district was opened in October, 2016. MSF-CH is the main health partner in Nduta camp and oversees all health programs. They operate a 110 bed capacity hospital and 4 health posts serving the more than 57,000 refu-

gees in Nduta camp. MSF is providing inpatient and outpatient facilities, Nutrition, HIV and Reproductive health services, disease surveillance and community health, community surveillance, health promotion and mental health services. World Vision International with support from WFP is implementing food distribution and nutrition program.

Mtendeli Refugee Camp which is located in Kakonko district was opened in January 2016 to decongest Nyarugusu camp. Relocation activities are still on-going. TRCS with support from IFRC are running inpatient and outpatient facilities, Immunization, Nutrition, HIV and Reproductive health services. They currently operate a 75-bed capacity hospital and provide services to the more than 5,000 refugees in the camp. World Vision International with support from WFP is implementing food distribution and nutrition program. MSF Holland is conducting community surveillance and health promotion activities in Mtendeli Camp.

Triage, vaccination (measles and polio) and emergency referral is the main focus of services provided at the *entry points/ reception centres*. The *transit centres* provide emergency clinic, vaccination, nutrition screening and emergency referral.

Table 3: Accountability Matrix

Thematic Area	Kigoma	Kasulu	Ngara	Kibondo	Kigoma	Ngara	Kigoma	Kasulu District	Kibondo District	Kakonko District	Dar-es-salaam (Tertiary referral)
	Kagunga/ Manyovu RC	Kasulu RC	Ngara RC	Kibondo RC	Kigoma Transit centre	Lumasi Transit centre	Kigoma NMC	Nyarugusu camp	Nduta camp	Mtendeli camp	
Pre-departure medical screening	IOM	IOM	IOM	IOM	IOM	IOM	IOM	IOM	N/A	N/A	N/A
Immunization (arrival)	IRC	IRC	TRCS	IRC	IRC	TRCS	IRC	TRCS	MSF-CH	TRCS	N/A
Immunization (routine EPI)	N/A	N/A	N/A	N/A	N/A	N/A	IRC	TRCS	MSF-CH	TRCS	N/A
Food distribution	Caritas	Caritas	Caritas	Twesa	Caritas	Caritas	IRC	ADRA	WVI	WVI	N/A
Nutrition screening	IRC	IRC	TRCS	IRC	IRC	TRCS	IRC	TRCS	WVI	WVI	N/A
Nutrition treatment (SAM,), IYCF, community outreach	N/A	N/A	N/A	N/A	N/A	N/A	N/A	TRCS	MSF-CH	TRCS	N/A
Nutrition treatment of MAM	N/A	N/A	N/A	N/A	N/A	N/A	N/A	TRCS	WVI	WVI	N/A
BSFP	N/A	N/A	N/A	N/A	N/A	N/A	N/A	TRCS	WVI	WVI	N/A
Curative services including Stabilization centre and CHWs	N/A	N/A	N/A	N/A	N/A	N/A	IRC(Emergency clinic)	TRCS/ MSF-CH	MSF-CH	TRCS/MSF-H	N/A
Persons with disabilities	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IRC	HAI	HAI	N/A
MHPSS	N/A	N/A	N/A	N/A	N/A	N/A	IRC	TRCS/IRC	MSF-CH	TRCS	N/A

RH/HIV	IRC	IRC	TRCS	IRC	IRC	TRCS	N/A	TRCS/IRC	MSF-CH/MOH	TRCS	N/A
Referral	IRC	IRC	TRCS	IRC	IRC	TRCS	IRC	TRCS/IRC	MSF-CH/IRC	TRCS/IRC	Redesso

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

UNICEF: Vaccines, medical and nutrition supplies, bed nets (LLINs), ANC, PMTCT, Child health; capacity building; technical staff support, community mobilisation for health education and services uptake

WHO: Medicines, supplies, equipment; Laboratory support; Disease surveillance; technical staff support

UNFPA: Reproductive health kits, RH equipment; capacity building; technical staff support

IOM: Medical screening prior to relocation; medical escort; technical staff support

Despite the influx, all mortality indicators were maintained at low levels well within the recommended SPHERE standards during the emergency period. The 2015 Crude Mortality Rate (CMR) and Infant Mortality Rates (IMR) were 0.4/1000 population/month (standard: <1/1000), and 0.9/1000/month (standard: <2/1000/month). Malaria was the leading cause of mortality in 2015 constituting 19% of total deaths followed by lower respiratory tract infections (13%), and anaemia (8%). Clinicians attended to an average of 73 refugees/clinician/day and 4% of consultations were made my nationals. Reproductive health services include ante-natal care (ANC), deliveries, post-natal care (PNC), and family planning (FP). The fertility rate among refugees is high with an average of 130-150 deliveries per week (600/month) and an average of 90 caesarean sections every month. Coverage for ANC, complete ANC visits, hospital deliveries and PNC remains high at 98%. However, the FP coverage is low at 10%. Three maternal deaths were reported and investigated jointly with the District Medical Officer (DMO) within 24 hours.

HIV counselling and testing services including testing pregnant women to prevent mother-to-child transmission of HIV (PMTCT) are available in the camp and are supported by the National HIV/AIDS program. Anti-retroviral treatment (ART) is provided free-of-charge to refugees. Before July 2015, refugees with HIV were being transported to Government health facilities located outside the camp for ART. This situation was not ideal since it increases the risk of stigma and steps were taken to initiate ART services in the main hospital in Nyarugusu. Currently there are 521 HIV positive patients enrolled in the care and treatment program, of which 413 are on treatment and all are receiving cotrimoxazole preventive therapy. PMTCT coverage is 82% and 100% of refugees tested for HIV receives post-test counselling. 82% of pregnant women were tested for HIV during antenatal visit and 100% of those tested receive post-test counselling.

Malaria was responsible for 26% of all health consultations followed by upper and lower respiratory tract infections (20%), and urinary tract infections (7%). In response to the high malaria cases, distribution of Long Lasting Insecticide Nets (LLIN) was done for the entire camp using the standard of 1 net to 2 persons (standard 1:2 with generous support from donors through the UN agencies Additionally awareness on malaria prevention and control is on-going in the various zones including education on the use of mosquito net. In first half

of 2016, mass distribution of LLINs took place in all three camps with coverage rates of almost 100%.

Watery diarrhoea only constituted 5% of overall consultations despite the occurrence of a cholera outbreak in May 14, 2015 which affected 30 refugees. The outbreak was quickly controlled and had a case fatality rate of 0.5% by the end (June 4, 2015) by quick build-up of WASH and case management activities supported by various partners. Subsequent response activities included two rounds of Oral Cholera Vaccination (OCV) campaigns which were conducted in Nyarugusu camp in June and September 2015. More than 100,000 refugees aged ≥1 year received the vaccine.

Currently, infectious diseases account for the leading causes of morbidity and mortality in all three camps. The top five causes are malaria, followed by upper and lower respiratory tract infections, watery diarrhoea and intestinal worms. During the first quarter of 2016, both the CMR and U5MR were 0.1/1000 and 0.1/1000 per month respectively which is well within the emergency thresholds. As expected, the burden of diseases is borne mainly by children aged less than five years and malaria is the leading cause of morbidity in this age group. There is a high demand for health care services in the camp, and malaria accounts for more than 40% of the OPD consultations.

GUIDING PRINCIPLES

1. Access and Equity

UNHCR and partners seek to ensure that all refugees have access to essential health services at equal levels to that of nationals.

2. Coordination and Partnership

UNHCR works closely with other UN agencies through the UN Reform, Delivering as One initiative and participates in the UN Development Assistance Plan (UNDAP) 2011-2016, providing leadership for the Refugee Programme Working Group comprised of WFP, UNHCR, UNFPA, UNICEF and IOM. UNHCR also works with the Ministry of Home Affairs, its direct counterpart in Tanzania, while maintaining excellent and productive relations with other Government agencies.

Under the Refugee Coordination Model (RCM), the Regional Medical office (RMO)/ District health office leads and coordinates with support from UNHCR, the public health and nutrition response to the Burundi refugee emergency in Tanzania. The RCM is intended to provide an inclusive platform for planning and coordinating refugee response in order to ensure that refugees and other persons of concern receive the protection and assistance they require through the collective efforts and capacities of all partners involved.

UNHCR will 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 accountability matrix above). These partners include other UN agencies (WFP,

UNICEF, WHO, UNFPA, IOM), national and international agencies, civil society, non-governmental organizations, academic institutions, multilateral institutions, donors and the private sector.

Selection of partners to work in refugee camps is done under leadership of UNHCR and MHA through a multifunctional team approach, with adequate due diligence and in an objective, consistent, transparent and timely manner.

3. Integration and Sustainability

UNHCR and partners will aim to ensure that the public health; HIV; food security; nutrition; and water, sanitation and hygiene (WASH) responses are integrated within national systems. In addition, UNHCR and partners (including development partners) will plan to support the existing local health facilities by providing supplies, equipment depending on resource availability.

4. Community Approach and Age Gender Diversity Mainstreaming (AGDM)

Communities should be central throughout the operational cycle of the health, nutrition, water and sanitation responses with the community outreach workers creating an effective link between facility-based services and the community. Building partnerships with refugee women and men of all ages and backgrounds by promoting meaningful participation through structured dialogue will be continuously ensured. Participatory assessment is essential in determining priorities of the community and to address them effectively by incorporating expressed priorities in to programmes.

5. Scalability, Flexibility and Effectiveness

Public Health and nutrition interventions must be needs-based, adapted to the Tanzania and local context, meaning flexible and scalable to respond adequately as required.

6. Capacity Building

UNHCR will work closely with Tanzania MOH and partners, to ensure that staff working in the public health, HIV, reproductive health, food security, nutrition and WASH, will be included in on-going country training, such as organised by MOH and other authorities. The refugee program will ensure that any training organized by UNHCR or its partners, will benefit the national staff. Specific programmes developed to capacity-building of refugees and the surrounding national populations will be implemented.

UNHCR and partners have completed a training needs assessment and the subsequent training plan is under development and will be updated on annual basis or as need arises.

To address the need for knowledge refreshment for staff, continuous medical education (CME) will be planned and scheduled appropriately. This will need commitment by staff and follow up by UNHCR and partners who would convene a quality assurance committee to ensure success and sustainability. Regular feedback will be provided to members of the working group.

7. Effective and Efficient Response during Emergency and Post-emergency

UNHCR and partners will prioritize rapid and effective response in emergencies through financing and coordination, technical leadership, physical infrastructure and supplies and streamlined data collection, analysis and management. Comprehensive primary health care services will be planned and delivered during the emergency phases including when new camps are opened.

STRATEGIC OBJECTIVES

1. Strengthen public health and nutrition coordination and collaboration at all levels
2. Ensure integrated service delivery towards quality, equitable and sustainable access to essential primary health care
3. Ensure universal access to HIV protection, prevention, care, treatment services and comprehensive integrated reproductive, maternal and new-born health services

1. STRENGTHEN PUBLIC HEALTH & NUTRITION COORDINATION AND COLLABORATION AT ALL LEVELS

A. ENSURE REGULAR AND EFFECTIVE PUBLIC HEALTH & NUTRITION COORDINATION

UNHCR together with MOH will lead health and nutrition and WASH coordination mechanisms with partners and the relevant government ministries on public health, nutrition services and WASH programmes.

A Health and Nutrition Sector Working Group (HNSWG) meets regularly at field level. The working group will aim for regular meetings at a minimum every two weeks, subject to review by the group as situation evolves. RMO/DMO and UNHCR will lead the meetings and the venue will rotate between Kasulu/Nyarugusu and Kibondo. This will also allow opportunity for inter-camp visits and information exchange to enhance knowledge, experience and harmonization of service delivery approaches.

A National (Dar Es Salaam) level health and nutrition coordination meeting is not deemed necessary considering the Decentralization-by-Devolution approach of MOH in which case the Kigoma Regional Medical officer (RMO) and District Medical officer (DMO) is in charge of management of health programs at region and district level respectively.

Partners will be required to continue to ensure appropriate technical coordination capacity at field level. Occasionally, national level meetings with MOH, UNHCR and key partners may be called to discuss topical policy matters affecting the refugee program.

Based on identified needs, sub-working groups on Mental Health, Reproductive and Child Health (RCH), Nutrition and Community Health have been proposed. These groups will meet

monthly. Terms of Reference (ToRs) for the coordination groups have been developed and shared with members (see attached).

Food security coordination meetings take place at respective camp level after each general food distribution will continue to be chaired by WFP.

In addition to project partnership agreements (PPA) signed with UNHCR funded partners, other tools to enhance coordination and monitoring for example, Letters, Memoranda of Understanding (LoU/MoU), Joint Plan of Action (JPA) etc. will be developed to clarify roles, responsibilities and commitments by operational partners.

B. INCREASE EFFICIENCY THROUGH INTEGRATION OF SERVICES

Control of communicable diseases and outbreak preparedness and response among other interventions, requires integration of services between health, nutrition and WASH sectors. Inter-sectoral coordination and collaboration will be a key focus of the strategy. Regular meetings between health and WASH on topical issues will be ensured.

UNHCR and partners will aim to ensure primary health care components are integrated rather than implemented parallel. This will avoid duplication, overlap and inefficiency that ultimately affect the quality of service provided to the beneficiaries.

Appropriate and inclusive consultations with health and nutrition partners under leadership of MHA/ MOH and UNHCR before decisions are made that affect delivery of health services will be emphasized to ensure efficiency, ownership and coordinated support towards effective implementation.

Policy dialogues with the MOH, UNHCR, implementing and operation partners and other UN agencies will be key to adopt and/ or strengthen current policies that affect the health status of persons of concern as well as the affected host population, to ensure that relevant issues are presented and clearly addressed in these policies and to advocate that refugees are included alongside nationals in relevant national health programs like malaria control program etc.

2. ENSURE INTEGRATED SERVICE DELIVERY TOWARDS QUALITY, EQUITABLE AND SUSTAINABLE ACCESS TO ESSENTIAL PRIMARY HEALTH CARE

A. INCREASE ACCESS TO QUALITY PRIMARY HEALTH CARE PROGRAMS

UNHCR and partners will work closely with MHA and MOH to ensure that all refugees have access to good quality curative and preventative health-care services.

The health programme will continue to emphasize on quality of services. This will focus on ensuring that universal precautions are met; essential quality medicines are available without stock-outs; national clinical protocols are adhered to and that laboratories are functioning and providing quality services; and that qualified staff are trained and retrained.

Equipping and providing necessary supplies for the health infrastructure will also be an area of focus to ensure effective delivery of services.

Disability friendliness shall be adhered to in the design and subsequent construction of infrastructure. Community based rehabilitation programs will be supported and ensure close linkage with primary health care services.

Collaboration and support to local/referral health facilities in the region including around the camps, entry points and transit centres will be an area of regular review and coordination of joint efforts to support based on identified needs and resource mobilization efforts. This will enhance cost-efficiency in medical referrals from camps, benefit the local communities and improve social cohesion, ownership and sustainability.

Health facilities in refugee camps will continue to serve both refugees and surrounding communities.

B. STRENGTHEN COMMUNITY HEALTH THROUGH AN INTEGRATED AND HARMONISED PROGRAM

The refugee health program will expand the vital role that the community based health workforce plays in all phases of emergency risk management (prevention, preparedness, response and recovery) as well as regular health care program; and training and equipping them for interventions in line with MOH guidelines and the refugee program SOPs. Partners will aim to integrate community health workers (health information teams, health promoters, social workers) with hygiene promoters (sanitation information teams) to enhance efficiency and effectiveness in community based surveillance and education at household level. The incentive pay will be harmonized under leadership of MHA and UNHCR and thereafter all partners will be expected to apply the same.

Enhanced community participation in management of the health facilities will be ensured to build refugee trust in the health care system and increase acceptability.

C. DECREASE MORBIDITY FROM COMMUNICABLE DISEASES AND EPIDEMICS

Immunization is the most effective means for the prevention of vaccine preventable disease outbreak. Health screening and including measles and polio vaccination, and disease surveillance systems have been established at the transit locations and upon arrival to the camp. Other routine vaccines will be provided to children according to the national guideline and additional antigen will be considered upon necessity in consultation with MOH and partners. Malaria and cholera remain among the top diseases of outbreak potential. An effective outbreak response will depend on adequate level of preparedness and therefore, emphasis will be placed on epidemic preparedness and response. Prevention and control measures will be sustained including stockpiling medicines and supplies to ensure adequate and timely response.

Disease surveillance and reporting will be streamlined in line with the government reporting system. Multi-sectorial preventative and response programmes will be established, ensuring strong linkages to the WASH sector. Furthermore, UNHCR in collaboration with MOH and partners will strengthen and support implementation of cross-border surveillance mechanism, on arrival vaccination and EPI programs). In acute emergencies, measles immunization may increase beyond 6 months to 15 years, as is the standard. Depending on the vaccination status of the population and risk assessment the target age category for vaccination should be modified accordingly in consultation with MOH and partners.

A comprehensive malaria control programme, including appropriate preventive interventions and a treatment policy based on latest efficacy models will be prioritized. UNHCR and partners will continue to advocate for refugees to be included in national malaria control programmes (just like for HIV/TB programs), as well as support from donors for the preventative elements of the control programme. Strategies to ensure appropriate utilization of long- lasting insecticide treated nets (LLITNs) will be explored proactively together with the community.

Control programmes for acute respiratory infections will be supported including community sensitization, immunization, early case finding and proper case management. Cross-sectorial preventive activities will be promoted, including the provision of adequate shelter and blankets, drainage of stagnant water, and the reduction of residual smoke through proper cooking-energy provision.

Refugees have access to National TB and Leprosy control programs. However there will be need to advocate for improved diagnostic capacity in the refugee camp health facility. Linkages to the HIV programmes will continue to be strengthened, and advocacy for inclusion into the National Malaria control programme.

D. IMPROVE CHILDHOOD SURVIVAL

Refugee children bear a disproportionately higher risk of dying unnecessarily due to preventable diseases like pneumonia, diarrhoea and malaria than all other age groups. Public health program in the refugee camps will take timely effective measures to achieve a sustainable progress in reducing neonatal and under-five mortality to protracted standards as the operation moves into protracted phase.

Strong focus will be made on ensuring that all refugee children have access to full expanded programme on immunization (EPI) and improved diagnosis and treatment of childhood infections through the use of updated clinical protocols, the establishment of linkages with national Integrated Management of Childhood Illness (IMCI) approaches, as well as strengthened linkages to nutrition and reproductive health programmes. Catch-up and mass immunization campaigns to improve immunization coverage especially in consideration of newly arriving refugees and in line with national protocols will be advocated for. The refugee health program will continue to emphasize the critical role of community-based health interventions in addressing childhood illnesses.

The IMCI strategy seeks to improve case management skills of healthcare staff, overall health systems and family and community health practices. Linkages to nutrition and reproductive health programmes are critical for infant survival. UNHCR and partners will therefore seek to ensure that all children receiving nutritional treatment can benefit from interventions that improve general health, such as completing the EPI vaccinations, Vitamin A supplementation, deworming, HIV testing and growth monitoring.

E. FACILITATE ACCESS TO INTEGRATED PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES, INCLUDING MENTAL HEALTH SERVICES

UNHCR and partners will strengthen the mental health programmes providing mental health care integrated in the primary health care level, multisectoral referrals and supporting and collaborating Mental Health and Psychosocial Support (MHPSS) programs. Appropriate capacity building of health care providers will be planned.

The health program will further support the development of an integrated approach that will target all major common risk factors of cardiovascular diseases, diabetes mellitus, and chronic respiratory diseases. This integrated approach will focus on treating chronic diseases at the primary health care level. There will be a strong preventative component to reduce referral to costly secondary and tertiary health care.

F. ENSURE RATIONAL ACCESS TO SPECIALIST REFERRAL CARE

All referrals will be governed by Tanzania refugee medical referral care standard operating procedures (SOPs) which includes arrangements with host district/region for specialised care in health facilities outside the camp. Annual evaluation of the referral process is required to ensure efficiency in resource utilization and coordination. Adequate supply of ambulances in good working condition should be ensured. Planning and facilitating visits by medical specialists to the camp will reduce the need to refer patients out of camps and thus save costs while benefiting from skills transfer/ training to health staff that would benefit a larger number of refugees in long term and improve quality of services.

G. IMPROVE MEDICINE MANAGEMENT AND PRESCRIPTION PRACTICE

UNHCR will provide essential medicine and medical supplies through international procurement. Support from operational partners will also be sought depending on needs. Project partner will maintain the monthly drug consumption reports and report to UNHCR monthly basis. Rational prescription of medicine and usage of essential drugs shall be respected.

UNICEF and MOH collaborate to ensure constant and regular availability of potent vaccines for emergency as well as routine immunization for all refugees, as integrated in the national vaccine management system. Vaccines forecast and procurement is done by UNICEF, but their storage and distribution to the camps is done by Regional Immunization and Vaccines Officer (RIVO) through District Vaccines Stores (DVS).

In addition to providing vaccines, UNICEF, UNHCR and partners will support in provision of cold chain equipment to the refugee camps and the District Vaccine Stores. A drug management monitoring tool has been developed training conducted to TRCS who will be expected to report on weekly basis. MSF procures own medicines and supplies and has a separate monitoring system. Monthly joint monitoring of medicine management will be planned to ensure quality and provide opportunity for timely on-the-job capacity building and support. UNHCR Balance Score card (BSC) monitoring tool will also be used to monitor prescription practice on a regular basis alongside government monitoring tools.

H. IMPROVE LABORATORY EFFECTIVENESS AND QUALITY

Strengthen the quality of laboratory tests; improve the use and interpretation of laboratory tests by clinicians and public health workers through capacity building and supervision; ensure and establish integration and linkages with the national referral laboratory networks, or where national capacity is not available, with other academic, independent or private institutions; improve laboratory involvement in disease surveillance and outbreak management; ensure timely order, procurement and maintenance of laboratory equipment, reagents and supplies.

I. ENHANCE PREVENTION OF UNDER NUTRITION AND MICRONUTRIENT DEFICIENCIES INCLUDING ANAEMIA

In December 2014, a nutritional survey was conducted for the old case load in the camp and it showed a low prevalence of Global Acute Malnutrition (GAM) for children of 6 to 59 months. The GAM rate was 1.4 % (0.7 - 3.0 95% CI) with 0% Severe Acute Malnutrition (SAM). The stunting in this population was at a critical level according to the World Health Organization (WHO) classification criteria with 40.7% (35.2-46.4 95% CI) identified with chronic malnutrition or stunting However, this figure is a reduction from the 46% reported in the 2012 survey. Since 2012, WFP has provided CSB+ for children 24 to 59 months to address the stunting situation.

Malnutrition is common in the Great Lakes Region and especially chronic malnutrition in the country of origin of the refugees is reported to be high and this is symptomatic of the broader food insecurity that exists in both Burundi and Congo. The situation is similar in the host country Tanzania. According to the Tanzania National survey done in 2014 reported GAM rates of 3.8% for children aged 0 to 59 and SAM rates of 0.9%. In Kigoma region the prevalence of GAM was 3.8 and SAM of 0.4 respectively and stunting of 48.6% which is critical levels according to sphere standards.[1] Refugees are thus at risk of further deterioration of their nutritional status during flight or even during their stay in the refugee camps.

Factors thought to add on the food insecurity situation in Burundi include: limited access to agricultural inputs and credit; small household farm plots; poor post-harvest techniques; soil

[1] Tanzania National Nutrition survey 2014, www.lishe.org

degradation and poor natural resources management; limited off-farm employment opportunities; inadequate water and sanitation coverage and poor hygiene practices; high rates of childhood illness; lack of access to quality health care; and inappropriate infant and young child feeding practices.

Since the mid-1980s, the food deficit in Burundi is said to have worsened as kcal per capita available from staple foods has declined from over 1,400 kcal in 1985 to under 1,100 in 2009. The entire food basket available for consumption declined from just under 2,000 kcal per capita in 1985 to just over 1,600 kcal in 2009[2]. This has resulted in the non-production of enough food by the majority of households to feed their families until the following crop harvest, much less sell a portion of the produce to generate income. This has made households becoming more vulnerable to shocks—crop failure, serious sickness, or death in the family—and lack the resilience to recover from shocks. This vulnerability also makes many Burundian farmers risk averse, i.e. they adhere to low-input (and low-cost) traditional agriculture, which relies on extensive farming

In the DRC, FAO estimates the number of malnourished at 44 million since 1990, 75% of the total population. It is estimated that the kilocalorie availability is only 1650 kcals per person per day, versus the FAO standard of 1750 kcals. On average, the number of meals eaten per day in rural households is 1.7 for adults and 2.1 for children; this rises to 2.3 and 2.6 respectively during the harvest period and falls to 1.3 and 1.6 during the lean season. The Congolese diet is about 80% carbohydrate, mostly from cassava, and 6% protein and 14% fat[3].

Several nutrition surveys have been done in Kigoma camps in the recent past. The October 2012 survey found Global Acute Malnutrition (GAM) and Severe Acute Malnutrition (SAM) rates of 2.6% (1.7 - 4.0 95% CI) and 0.9% respectively, and the prevalence of stunting was 46%. The last nutrition survey which was conducted in December 2014 - still valid for the Congolese population, found GAM and SAM rates of 1.4% (0.7 - 3.0 95% CI) and 0% respectively, and the prevalence of stunting had reduced to 40.7% though it is still classified as critical according to the WHO classification criteria for children of age below five years. Furthermore, prevalence of anaemia was 33% (28.6% - 37.8% 95% CI) among children aged 6 – 59 months, and 21% (16.2%-28.5% 95% CI) among women of child bearing aged (15 – 49 years) anaemia prevalence among children has decreased in the 2014 survey compared to 38% for children and 31.2% for women in a year 2012[4].

Though recommended, it was not possible to conduct a nutrition survey in the first few month of the influx because the refugee population was not stable and was constantly on the move, which made it difficult to organise a comprehensive survey. UNHCR/UNICEF and WFP is planning to conduct a SENS survey in June/July 2016. Nutrition partners have conducted rapid mass mid-upper arm circumference (MUAC) screening to assess the nutritional

[2] http://data.unhcr.org/burundi/country.php?id=212
[3] FAO website 2009
[4] Nyarugusu SENS survey 2014, www.unhcr.org

status of refugees, and have reported proxy GAM of <5% among Burundian and Congolese. The prevalence of anaemia among children age 6-59 months is 33% and 21.9% among women of reproductive age. Further analysis showed a higher prevalence of anaemia among children age 6-23 months at 44.8% compared to 26.7% among children age 24-59 months. Camp specific MUAC reports are as follows:

Nyarugusu		
Date	**GAM**	**SAM**
July, 2015	3.6%	0.6%
August, 2015	2.8%	0.6%
September, 2015	1.2%	0.2%
October 2015	2.8%	0.6%
November 2015	1.3%	0.01%

Nduta		
Date	**GAM**	**SAM**
October, 2015	6.7%	3.1%
October, 2015	5.6%	1.3%
October, 2015	3.0%	0.8%
January, 2016	4.9%	2.3%
February, 2016	5.4%	0.7%
March, 2016	2.7%	0.7%
April, 2016	8.3%	2.3%
April, 2016	0.13%	0.0%

Mtendeli		
Date	**GAM**	**SAM**
March, 2016	3.8%%	0.47%

Refugees receive the minimum daily requirement of 2,100 kilocalories per person/day. The food basket consisted of 380gms of maize meal, 120gms of pulses, 50gms of CSB+/Super Cereal, 20gms of vegetable oil and 5gms of salt. Several nutritional programmes are in place to cater to different target groups i.e., Targeted Supplementary Feeding Program (TSFP) for Moderately Acute Malnourished (MAM) children aged 6 -59 months; Blanket Supplementary feeding programme for children aged 6 – 23 month and Pregnant Lactating Women. Additional fortified blended food is provided to children aged 24 -59 months for the prevention of micro nutrient deficiencies. HIV positive patients on treatment also receive nutrition support in addition to the general food rations. The coverage and recovery rates for SFP program are 98% and 99.8% with zero death and default rates. In 2015, a total of 3,187 new MAM cases, 6,170 pregnant and 5,590 lactating women were enrolled in the SFP program.

Effective prevention of under nutrition and micronutrient deficiencies are optimally achieved through the provision of, and ensuring access to, adequate foods, as well as the promotion of adequate infant and young child feeding (IYCF) and care practices. Prevention is also assured through the improvement of the WASH situation and health conditions and improved shelter and livelihoods opportunities.

If there is established nutrient gap in the diet to meet the requirements of special groups, such as children aged 6-23 months, pregnant and lactating women, implementation of blan-

ket supplementary feeding programme or use of special micronutrient products will be recommended.

Promoting and supporting adequate IYCF and care practices will play a key role in preventing malnutrition and micronutrient deficiencies in mentioned health program. Sensitization, demonstrations and other interventions, such as baby and child-friendly spaces and community-based support networks, will be put in place to promote and support feeding and care practices that maximize survival and reduce morbidity in children less than 24 months. These include, but are not limited to: timely initiation of exclusive breastfeeding, exclusive breastfeeding for six months; continued breastfeeding to 24 months and beyond; and introduction of safe, adequate and appropriate complementary foods at 6 months as well as support (psychosocial or otherwise) to mothers of young children.

Vitamin A supplementation of children 6-59 months and deworming of children 12-59 months will be strengthened through bi annual campaigns and routine based on national guidelines. MUAC screening will be integrated during the campaigns to ensure that all at risk children for malnutrition are identified and referred for appropriate management.

UNHCR and WFP will continue to promote the expanded use of cash and vouchers among refugees. Increasingly, where markets are functional and refugees have access to them, UNHCR provides cash and/or vouchers to refugees, to increase their purchasing power to access nutritious, diversified and culturally appropriate foods.

J. INCREASE EFFECTIVE TREATMENT OF ACUTE MALNUTRITION

Treatment of acute malnutrition shall follow the principles of community-based management of acute malnutrition (CMAM), according to relevant national treatment guidelines.

- Continuous systematic screening will be ensured using standard anthropometry.
- Treatment of severe acute malnutrition (SAM) will be provided through inpatient and outpatient platforms. Continuous coordination with UNICEF, in order to secure the supply of severe acute malnutrition treatment products and training will be advocated. Treatment of moderate acute malnutrition (MAM) using outpatient modalities will be provided, with WFP providing the food products required for the treatment of moderate acute malnutrition.
- Community involvement and awareness in the identification of malnourished individuals, and their inclusion and retention in the treatment of acute malnutrition is crucial in the success of this programme, as well as in obtaining effective coverage.
- The staff will receive continuous refresher training on the management of acute malnutrition to improve the quality of care.
- Monitoring of ongoing treatment programmes will be systematic, with documentation through an improved nutrition module in the HIS which will ensure routine monitoring of nutrition programs.

- MUAC assessments will be done every quarter in all camps, and SENS surveys will be conducted every year.

3. HIV AND REPRODUCTIVE HEALTH

A. REDUCE TRANSMISSION OF HIV USING A PROTECTION AND RIGHTS-BASED APPROACH

The HIV programme will focus on evidence informed combination prevention interventions which is adapted to local contexts. These will include raising awareness on sexual and reproductive health and HIV; through peer-led approaches and campaigns, as well as promoting universal access to male and female condoms, providing youth friendly HIV prevention and response services in health clinics, and empowering youth and youth led organizations to champion HIV prevention in line with national policy.

UNHCR and partners will work closely with regional and district hospitals and the National Blood Transfusion Service (NBTS) in mobilising and recruiting blood donors to ensure increased availability and access to safe and quality blood and blood products, preventing HIV transmission from blood donors to recipients. Hepatitis B virus (HBV) testing in addition to other screening tests will be key areas of focus to ensure sustained supply.

With newer models of improving uptake of HIV testing services, UNHCR will support the introduction of these models in the refugee camps in line with national policy. Emphasis will continue to be placed on strengthening quality-assured testing and counselling services at multiple entry points in the health system, and at community level, guided by the HIV prevalence. Care will be taken to ensure that the voluntary and confidential nature of these services and privacy concerns are respected at all times.

B. FACILITATE UNIVERSAL ACCESS TO ANTIRETROVIRAL THERAPY

UNHCR and partners will continue to advocate, work with and support MOH and National AIDS program to ensure that refugees access ART services. Just as Nyarugusu camp has an ART clinic, effort will be made to ensure Nduta, Mtendeli and any other new camp has a nationally accredited ART clinic in the respective camp to avoid stigma and other challenges associated with referrals and mobile clinics.

When treatment and prevention programmes are well established, UNHCR in collaboration with partners will focus on scaling-up testing services, early detection of HIV and rapid enrolment in care and treatment. Equal emphasis will be placed on ensuring adherence to treatment as much as access to treatment. Efforts will likewise be put into further strengthening access to prophylaxis and treatment for opportunistic infections, with particular emphasis on TB/HIV co-infection.

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

C. FACILITATE THE ELIMINATION OF MOTHER-TO CHILD TRANSMISSION OF HIV

UNHCR with its partners will support standard activities leading to EMTCT, including universal access to voluntary counselling and testing for pregnant women and access to appropriate ART regimens for pregnant women and exposed babies, including adherence counselling, counselling on infant feeding practices and early infant diagnosis and follow-up testing at 18 months. The full range of elimination of mother-to child transmission services will be firmly integrated within strengthened maternal and child health systems including focused ANC and skilled birth attendance at delivery. UNHCR and partners will support capacity-building of staff to be able to effectively provide appropriate elimination of mother-to-child transmission regimens according to national guidelines.

D. IMPROVE ACCESS TO COMPREHENSIVE REPRODUCTIVE, MATERNAL AND NEWBORN HEALTH SERVICES

Provision of comprehensive reproductive health programmes will be ensured in all camps. The main components of such a programme will comprise:

- Antenatal care,
- Access to supplementary feeding programmes including macro and micro-nutrients,
- Delivery by skilled birth attendants in institutions with adequate facilities including emergency referral,
- Access to safe blood and caesarean sections,
- Post-natal care, including post-partum family planning counselling and early new born and neonatal care.

Emergency obstetric and neonatal (EmONC) services are provided at Nyarugusu camp. Nduta and Mtendeli rely on Kibondo district hospital for EmONC services. All efforts will be made to minimize delays in access to maternal health services including provision of ambulances. Considering distance and other factors, there will be need to provide EmONC service in Mtendeli camp that will benefit both refugees and surrounding communities. In the event of a maternal death, an audit will be conducted within 48 hours in collaboration with MOH, adhering to UNHCR and MOH standards and guidelines.

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

UNHCR will work with key stakeholders and use the widest spectrum of family planning methods in health clinics to be provided with quality counselling and by trained healthcare

workers. Various community mobilization strategies, including partnering with men, will be used to increase uptake of family planning services.

Evidence-informed *adolescent sexual and reproductive health* services which include quality, gender sensitive youth-friendly information and services for young people (10-24 years) in both school and out-of-school settings will be provided.

Prevention and treatment of sexually transmitted infections (STIs) will continue to be a high strategic priority. A syndromic approach, e.g. treatment of symptoms, to managing STIs will be strengthened through awareness-raising, training, ensuring availability of drugs and supplies, display of protocols and carrying out prescription audits. Partner tracing, voluntary HIV counselling and testing for STI patients and their partners, venereal disease research laboratory and rapid plasma regain testing during ANC will be actively pursued.

Presumptive treatment for high-risk groups will also be encouraged. Sexual and gender-based violence remains both a protection and a public health challenge and combating it requires the adoption of an integrated approach involving health, protection and community-based protection. In line with the GBV strategy for Tanzania refugee operation, partners will coordinate and collaborate closely to strengthen the referral systems and SOPs for clinical management of rape survivors. Clinical care for rape survivors should be integrated with primary health care. Clinical staff will be trained in clinical management of rape survivors and awareness of the population on early reporting, availability of services and referral pathways would be improved.

E. INCREASE USE OF INNOVATIVE AND APPROPRIATE TECHNOLOGIES IN REPRODUCTIVE HEALTH SERVICES

Prevention and primary level care for gynaecological conditions, such as cervical cancer and breast cancer will be provided. As soon as national screening programmes are scaled up in Tanzania and affordable treatment is feasible, screening for reproductive cancers will be undertaken. UNHCR will follow closely with MOH on outcome of the human papillomavirus (HPV) vaccination pilot and plans for scale up so as to ensure refugees are also included.

FINANCING

UNHCR health and nutrition budget for 2016 is approximately 9 million USD (UNHCR Supplementary Appeal for the Burundi situation, Jan-Dec 2016). This considers projected budget as of December 2015. However, there is a considerable contribution through external donors and partner fund raising to the health and nutrition program.

UNHCR and operational partners made a joint appeal of approximately 17 million USD for health and nutrition program implementation from January to December 2016 (Burundi situation Regional Refugee Response Plan 2016).

The estimated annual budget will vary depending on among other factors, increased morbidity burden as refugee influx continues, additional cost implications due to infrastructure development/rehabilitation in new and existing camps, capacity improvements to meet objective to improve access to quality primary health care services etc.

MONITORING FRAMEWORK

UNHCR and partners are jointly responsible for the monitoring and analysis of the health and nutrition data. Any assessments, studies, surveys etc done by any partner will be shared as soon feasible with the coordination team for appropriate discussion/ implantation support. Feedback and analysis of HIS reports will be shared and discussed regularly at the coordination meetings.

A joint annual health strategy review will have the necessary inputs for strategic decisions for improvement on the performance of the health and social welfare sector. This strategy will be reviewed based on the strategic monitoring framework (annex 1) and different monitoring tools listed below. Any additional reporting tools proposed by any partner or person should be discussed and agreed at the coordination forum with emphasis on need to harmonize and use existing comprehensive reporting tools rather than duplicate or increase number and/or frequency of reporting requirements.

- MOH Health management information system (HMIS) and UNHCR's Health Information System, (HIS)
- UNHCR Standardized Expanded Nutrition Survey (SENS) Guidelines, http://www.sens.unhcr.org/; for the implementation of nutritional surveys. It should be reported at least annually per site (every 6 months in emergencies)
- Use the balanced score card (BSC) to assess the quality of the primary health care facilities and the reproductive health programmes. BSC should be reported annually per site
- Joint Assessment Missions (JAMs) will be co-led by UNHCR and WFP in a systematic and in a timely manner (every two years). The last JAM was conducted in 2015.
- Medical Referral care database- Used to continuously collect key data on referrals in countries where UNHCR and partners run health programmes. The purpose of the database is to monitor referral outcomes and expenditure.
- Maternal and neonatal death reviews. This is a systematic and structured process to understand the medical and social reasons that contributed to a maternal and neonatal death. The death review and reporting should be done immediately following a maternal/neonatal death.
- Action plans governing MoU/LoU between agencies/ partners.

The following are recommended interventions at various sites that asylum seekers/refugees would pass through up to camp level.

RECOMMENDED HEALTH INTERVENTIONS AT WAY STATIONS

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

KEY INTERVENTION	TARGET GROUP	REMARK
Emergency clinic and disease surveillance	Refugee and host community	24 hour emergency treatment/referral
Vaccination (refer to interventions for Transit centre)	All children under 5 years (To be reviewed if evidence of increased risk of outbreak above target age group).	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 and refugee community	Support integration of services with MOH in consideration of local context.
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 prescreening, 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 wet feeding provided

RECOMMENDED KEY HEALTH INTERVENTIONS AT TRANSIT CENTRES

NOTE: A transit centre 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.

KEY INTERVENTION	TARGET GROUP	REMARK
Arrival measles vaccination (next to registration desk)	6 months to 5 years *(To be reviewed if evidence of increased risk of outbreak above target age group).*	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 -59 months	Important to ensure there is at least an interval of four months between the doses.
Oral polio vaccine (next to registration desk)	0 to 5 years *(To be reviewed if evidence of increased risk of outbreak above target age group).*	
De-worming (next to registration desk)	12-59 months	
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 triage, emergency treatment/referral.
Ambulance service	Refugee and host community	24 hour emergency referral.
Implementation of Minimum initial service package for RCH (MISP)	As per MISP guidelines	Important to concurrently start planning for comprehensive & integrated RCH/HIV.
Mental health	All refugees	Psychological first aid.
Identification of patients on previous treatment & ensure continuity of medication	HIV/TB patients, others on long term treatment	

Community based health workers	Refugee and host community	Continuously identify/refer the sick & vulnerable groups. Focus 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 and refugee community	Support integration of services with MOH in consideration of local context.
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 if emergency malnutrition levels (>15% GAM or >10% with aggravating factors) Pregnant and Lactating Women	As per rapid nutrition assessment results. Monthly 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)/ Wet Feeding	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/wet feeding. 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/wet feeding. 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 wet feeding 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

KEY INTERVENTION	TARGET GROUP	REMARK
Vaccination (**Routine EPI** as per the National Schedule). Additionally, Selective vaccination for OPV & measles for those under 5yrs not vaccinated at reception points)	EPI as per national guidelines	Selective for those not vaccinated at reception points. Catch up vaccination for children under one as per national guidelines.
Vitamin A supplementation	6 -59 months	Selective for those not vaccinated at reception points.
Reproductive Health	All refugees in RH age	Comprehensive integrated 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	Integrate health, nutrition and hygiene promotion.
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 and Monthly 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 and refugee community	Support integration of services with MOH in consideration of local context.
Nutrition		
Nutritional screening (MUAC and oedema)	6 -59 months	Arrival screening for all target groups together with information package for new arrivals. Regular outreach screening through the use of community based health workforce. Mop-up screening needed.
BSFP	6-23 months or 6-59 months (emergency malnutrition levels), PLW	As per rapid nutritional assessment results & guidelines. Monthly MUAC for all children in the BSFP to assess the nutrition status trends.
TSFP	MAM cases	Need to ensure SNF – Super Cereal Plus is available (by WFP)
OTP	SAM cases	Adequate RUTF to be made available (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 diffi-

		culties 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
HIS	All facilities	Weekly and Monthly compilation of HIS following the appropriate format
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 latrine. One month ration.
Alternative energy	All refugee families/ individuals	Short, medium and long term solutions needed
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 feasible, cash should be considered based on market analysis and feasibility.
WASH in Health Facilities		
Sanitation	Health Facilities	1 latrine for every 20 users in in-patient departments (IPDs) 1 latrine each for staff, females, males, and children in out-patient departments (OPDs).

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ANNEX

Health and Nutrition Working Group Terms of Reference

OBJECTIVES

The main objectives of the Health and Nutrition Sector Working Group (HSWG) are to:

1) Support and strengthen the capacity of health partners to respond to the Health and Nutrition needs of refugees and asylum seekers in Tanzania, by maintaining a platform for all partners and stakeholders to coordinate their response through information sharing and through pooling of health expertise, resources and health information.

2) Coordinate assessment, design, planning, resource mobilization, implementation, monitoring and evaluation of health strategies, projects and activities, including joint interventions that target persons of concern, with the avoidance of duplication and overlaps and ensuring geographical coverage;

3) Advocate and initiate a policy dialogue with the Tanzanian Ministry of Health (MoH), UNHCR, implementing and operation partners and other UN agencies to adopt and/ or strengthen current policies that affect the health status of persons of concern as well as the affected host population, to ensure that relevant issues are promoted and clearly addressed in these policies;

CORE FUNCTIONS

The Health and Nutrition Sector is co-chaired by MOH and UNHCR. The District Medical Officer (DMO) for Kasulu, Kibondo and Kakonko districts where Nyarugusu, Nduta and Mtendeli camps are located, are co-chairs of the Health and Nutrition Sector Working Group Meetings. The secretariat of the sector is provided by UNHCR. The secretariat will call for meetings and disseminate relevant documentation. Meeting minutes are taken by all partners in a rotational basis.

The joint Health and Nutrition Sector Working Group Meetings will take place bi-weekly on Thursdays in UNHCR offices in Kibondo, unless otherwise communicated:

Sector chairs (MOH & UNHCR) may call for ad-hoc meetings to discuss specific topics when need arises. The duration of the meeting will be a maximum of 2 hours. A draft agenda will be shared before the meeting and inputs sought from all agencies. The meeting minutes will be circulated within 5 working days after the meeting has been held. A Health Strategy and Emergency Preparedness and Response plan will be developed collectively and all partners will be encouraged to use the strategy for planning their health activities.

UNHCR will be responsible for coordinating the preparation and implementation of the sector's work plan, based on the priorities periodically identified by the sector members. The core members of the HSWG are:

a) Ministry of Health
b) UNHCR
c) Tanzanian Red Cross Society
d) MSF-Switzerland

e) International Rescue Committee
f) MSF-Holland
g) World Vision
h) Help Age
i) WFP
j) UNICEF
k) WHO
l) UNFPA
m) International Federation of the Red Cross and Red Crescent Societies (IFRC)

Other agencies, donors or organizations involved or funding health activities are also encouraged to attend meetings and be on the Health and Nutrition Sector mailing list. These agencies' focal pints should be knowledgeable about their agency's mandate, capacities, priorities, and perspectives when attending the Health and Nutrition Sector Working Group meetings. The focal points will be responsible for briefing their organization on the orientation, recommendations, and decisions etc. of the Health and Nutrition Sector Working Group and will also be responsible for ensuring that appropriate mechanisms are established to facilitate information sharing within their own agency.

MOH and UNHCR in consultation with the group members or based on their request may invite other speakers/ resource persons to participate in the group meetings and activities to provide specific tasks/ inputs.

SUB-GROUPS AND AFFILIATES

Based on the identified needs, the Health and Nutrition Sector Working Group may decide to establish sub-groups. UNHCR is currently developing three sub-working groups that will report to the Health and Nutrition Sector:

a) Reproductive Health, to be co-chaired by UNHCR and UNFPA;
b) Nutrition, which to be co-chaired by UNHCR and UNICEF;
c) Mental Health to be co-chaired by UNHCR and IRC;
d) Community Health and Disease Surveillance, to be chaired by UNHCR and WHO

Each sub-working group will have its own terms of reference (TOR) and will report to the sector chairs of the Health and Nutrition Sector Working Group.

GUIDING PRINCIPLES

The work of the HWSG will be guided by international principles of equity of access and human rights. Reference to the Sphere *Humanitarian Charter and Minimum Standards in Humanitarian Response* will also be made.

In addition, all members of the HSWG agree to base their partnership on the globally agreed upon Principles of Partnership:

a) Equality among partners in consultation and decision making
b) Transparency among partners
c) The primacy of a result-oriented approach to humanitarian action
d) Responsibility between partners to accomplish undertaken tasks
e) Complementarity between the capacity and activities of local and international actors.

AMENDMENTS TO THE TERMS OF REFERENCE

These terms of reference will periodically be amended, in particular when there are substantial changes in the situation on the ground.

Diagram 1: Organogram Health and Nutrition Sector Coordination, Tanzania