WHO Mission to Refugee Camps in Gambella Region

Interagency Coordination meeting participants

21-26 April 2014

Rapid Assessment of Health, Nutrition and WASH at Kule and Leitchuor Refugees camps in Gambella Region

World Health Organization
Ethiopia Country Office

Introduction

On 15th December 2013, violence broke out in South Sudan's government which led to influx of refugees to neighboring countries including Ethiopia. The refugees are hosted in two locations in Ethioipia, on the western border: primarily in Gambella Region (94,324 as of April 24, 2014[1]); and a smaller number in B.Gumuz Region.

In light of this crisis, WHO team comprised of 6 experts including Malaria, WASH, EPI/Surveillance, ERCM (Emergency Risk and Crisis Management) and Communication officer have conducted Rapid assessment in Gambella Refugees camps under the leadership of the WHO country Representative. The team was joined by ARRA medical team leader and public health coordinator in Gambella to undertake the assessment.

This assessment was initiated following reports from UNHCR with critical health information including high morbidity and mortality due to health complication of Severe Acute Malnutrition (SAM), diarrheas as well as high case load of Malaria, Upper Respiratory Tract Infection (URTI) and increasing Measles cases.

The assessment was carried out between 21-26 April 2014 with the Objective of conducting a Rapid assessment of the situation at the refugee camps related to health, nutrition and WASH and come-up with recommendations that enhances WHO's support as well as mobilization of resources to fill identified gaps.

To undertake this assessment, the team has reviewed document/Report, weekly UNHCR update and meeting minutes, Guidelines and Emergency Preparedness and Response Plans, held bilateral discussion with ARRA, UNHCR and Health Bureau and participated in the weekly Inter agency partners meeting. Camps including Kule, Leitchuor and registration point at Pagak were visited. In addition, the team conducted group discussions with partners working at the site like ARRA, UNHCR, MSF, DRC, Red Cross, NRC, ACF and LWF.

[1]Data Source: UNHCR weekly update

At the end of the mission, the team provided debriefing for UNHCR (bilaterally) and Health and Nutrition taskforce members at Regional level during the weekly Health and /Nutrition taskforce meeting.

Based on assessment findings a plan of action is prepared indicating WHO's (all levels) support as per available capabilities and required resources to fill gaps.

Findings

Overall Public Health Conditions

As of 24 April, 94,324 South Sudanese refugees arrived in Ethiopia's Gambella region, mainly through Pagak (59,289 people) and Akobo Tiergol (28,367 people) entry points. A smaller number of refugees continue to trickle into Ethiopia through Matar (4,961 people), Raad (841 people), Burubey (499 people) and Pugnido (367 people) entry points. Of the total arrivals, 95 per cent are women and children, of which 70 per cent are children, including significant numbers of unaccompanied or separated children.

This calls for an increase in protection interventions among other specialized assistance targeting these groups. A long travel to arrive in Ethiopia and lack of public health service during this travel exacerbated vulnerability of the refugee population which are mainly children and women. It is also the underlying cause for the critical and continued health conditions reported by UNHCR which includes high child mortality due to medical complication of Severe Acute Malnutrition(SAM), diarrheal as well as high case load of Malaria, Upper Respiratory Tract Infections (URTI) and increasing Measles cases in the refugee camps

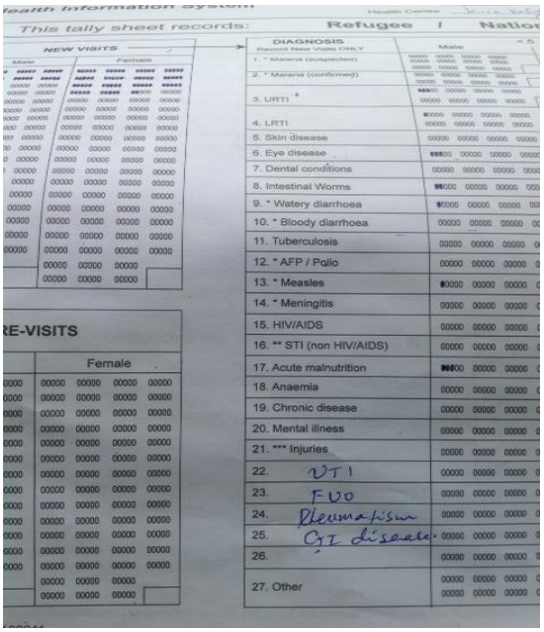
Up on arrival of the refugees at Pagak entry point, the critical public health conditions under which they arrived demonstrated by moderate and severe acute malnutrition rates among 2,407 children 6-59 children screened showed alarmingly high with GAM rates of 37.3 per cent and SAM rates of 11.1 per cent . These are above the emergency threshold, and the situation may further deteriorate with a sustained influx. As community reporting on mortality is low, it is difficult to determine mortality rates accurately. Measles cases were confirmed at entry points, in camps, as well as among the host community.

Over all situational analysis of morbidity and mortality shows the major leading causes are medical complication of SAM, diarrhea, eye infection, measles, URTI, Malaria and skin and eye infection. Based on the review of reports and discussion made with partners providing health service to the

two refugee camps the current health facility based crude and under-five mortality rates are under the emergency threshold indicated as 0.2/10,000/day and 0.8/10,000/day respectively.

Response and Gaps[2]

Health and Nutrition Response and Gaps



The Administration for Refugees and Returnee Affairs (ARRA), the Government's refugee agency, and UNHCR are coordinating activities under the standing Refugee Task Force, both at the central, regional and camp levels. There are proactive Coordination forums, Technical Task forces, Memo-random of understanding (MOU), Standard Operating Procedures(SOPs), guidelines and good representation of partners with minimal duplication of efforts which is helping a lot in facilitating health service delivery, Nutrition and WASH interventions.

The continuous provision of vaccination and Vit-A supplementation at entry point are important public health intervention given the vulnerability of the incoming refugees. Provisions of essential medical services are available (24/7) with referral system to Itang health center and Gambella hospital in addition to availing the basic health service to the refugees, the referral system linked to the host community health service delivery is a good opportunity to strengthen the health service delivery of the host community. HMIS has been initiated at Kule camp by ARRA.

Effort has been started to start routine immunization. As of 1 April, 49,202 children less than 15 years have been vaccinated for Measles, 25,800 for Polio and 23,582 children less than 5 years of age have received Vitamin -A. Confirmatory diagnosis and treatment for Malaria are available and the refuges are getting the necessary services. With the support of RHB and ARRA, indoor residual spraying of houses was done and over 14,000 long-lasting insecticidal nets were provided to the refugee community as preventive measures against malaria.

[2] F for detail of response, gaps and recommended actions see annex 1

The effort made by UNHCR, ARRA and other partners are encouraging which includes presence of pediatricians, committed health staffs, use of guidelines for treatment of priority diseases and good infection prevention(IP) practice at health service provision, presence of health and nutrition community outreach workers in the refugee camps including Pagak entry point.

Despite sound and commendable effort being delivered, there are critical gaps which include weak linkage of disease surveillance data and information sharing with Woreda health office, fragmented activity by the two segments of COWs (Health/Nutrition and Hygiene COWs), inadequate Community participation (especially Volunteer participation is greatly lacking) and COWs education is not complemented by demonstration.

There are gaps in the current health service delivery, as critical health services have not been initiated like mental health/Psycho social , SGBV counseling service and shortage of Mid wives, trained staff on BEmONC, TB, HIV, IMNCI and PHEM. In such setting, where majority of the population are highly vulnerable to various threats of ill health, missing an opportunity to provide required health assistance should not be tolerated,

There are also shortage and lack of drugs and medical supplies including HIV test kit, family planning commodities, national guidelines and treatment protocols and IEC materials using the local languages. Utilization of mosquito nets is hampered due to inconvenient shelter structure putting the distribution under question as it is not being used for the intended purpose. There is no functioning surveillance or HMIS in place and information sharing to appropriately follow trends and evolution of diseases including early warning for potential public health priority diseases. In the absence of such early warning/disease surveillance, prediction, forecasting and early detection of outbreaks could not be realized further hampering effective planning process and preparedness in an environment where threats and risks of communicable disease outbreak are high.

WASH Response and Gaps

Different partners are providing WASH service in the refugee camps including UNHCR, ARRA, DRC, NRC, MSF – Holland, ACF, LWF and others. There is good coordination between the partners at camp level in delivering the service having SOPs, community outreach workers for hygiene (COWH) promotion and joint key messages development every week and review of H-COWs activities.

The safe drinking water currently distributed to the refugees is with recommended Chlorine residual. Temporary water treatment plant at the edge of Baro River is a very important intervention in the provision of Safe water supply. There is ongoing construction of latrines and installment of permanent water pipe lines which is highly commendable. In both camps risk of flooding is identified and work towards reducing risk through relocation of settlements has been initiated. The re-location is currently under construction as witnessed during the visit.

The efforts to avail communal latrine to the refugees within the current temporary shelter/tents are also very encouraging In Kule and Pakag, MSF-H is continuing with water trucking increasing the water supply to over 20 liters per person per day and in Kule, 43 blocks of latrines comprising 209 stances are under construction.

Nevertheless, there are observed gaps in WASH response despite a lot of efforts by partners. Safe drinking water provision is below the SPHERE standard for instance in Leitchuor camp (established 3 months before) about 7 liters per person per day provided. Currently available communal latrine is inadequate and access stands at one unit for 65 people. The constructed ones lack safety and privacy due to loose soil formation and poor construction. These led to poor sanitary conditions including rampant open defecation and poor environmental management providing breeding sites for vectors like flies and Mosquitoes in the camps, There is no any kind of hand washing facility with existing latrines.

Though, partners indicated during discussion the presence of environmental cleaning campaign on regular bases, solid waste management is also area of concern from public health point of view.

Like that of the health and nutrition COWs the Hygiene COWs education, also is not complemented by demonstration and lacks volunteer community participation. Lack of IEC material on Health and WASH related issues in local language is a major gaps in addressing the behavior and practice of the refugee community especially open defecation. Thus, the poor health and nutrition status might be exacerbated by existing poor sanitary conditions which might pose a major public health risk, including potential communicable disease outbreaks among the refugees and hosting community . Therefore, provision of WASH service as per the standard is still a major gap which needs immediate action.

Host community Health System

According to the 2013 estimation of regional population, the total population of the 3 Woredas of the region namely Lare, Itang and Wanthoa hosting the South Sudanese refugees are estimated to be 106, 652 with < 5- year old children being 15,212 and surviving infant >1 year of age 2,533; There are 8 health centers with ratio of 1 Health center to 15, 000 population on average and 30 health posts in the 3 Woredas hosting the refugees. Though, there is no enough capacity for provision of adequate public health interventions, the presence of health infrastructure, woreda health offices and health staffs are very encouraging. The routine immunization coverage is below 60% in the host woredas while human resource has the potential or opportunity to be strengthened with minimum inputs. Health workers assigned in the existing 8 health centers lacks training in EPI, Public Health Emergency management which include communicable disease outbreak, management of nutritional emergencies and WASH related health complications. The capacity of staffs at health posts also has similar and often more pronounced challenges. The top leading cause of morbidity in the woredas include Malaria, diarrhea, URTI, skin and Eye infections, and intestinal parasite infestations. Limited capacity of the health system in provision of public health service delivery is also challenged by movement of the community following seasons of the year (to Baro River side during the dry season and coming back to dry area during rainy seasons) in order to look for means of livelihood.

Immediate Public Health Threats and Risks

Based on the review of various reports, epidemiological profile of the host and refugee population and the environmental situation, the assessment revealed the following major threats as impending risks to the health of the population:

1. Risk of water related disease outbreak
    a. AWD/Cholera
    b. Dysentery
    c. Typhoid Fever
    d. Guinea Worm
2. Risk of vector borne disease outbreak
    a. Malaria
    b. Yellow Fever
3. Risk of vaccine preventable disease outbreak
    a. Measles
    b. Meningitis

Recommendations

The following major recommendations were identified based on the assessment findings and discussion made with partners during the assessment

Health and Nutrition

- Enhancing health and nutrition intervention in light of the expected rainy season which is expected to increased risk of communicable disease outbreak
- Strengthen linkage with host community though ensuring their active involvement and sharing relevant information regularly
- Establish Early warning/IDS system based on the national reporting requirements including establishment of Rapid Response Team(joint host community health system and refugee health system)
- Ensure appropriate collection and transportation of laboratory specimen as per the existing standard and protocol
- Ensure initiation of absent medical services delivery:
    - Routine Immunization
    - Mental health, Maternal and Reproductive health, SGBV, HIV/TB
- Capacity building of health staff and provision of relevant guidelines as well as treatment protocols such as SAM management, Acute Water Diarrhea/ Cholera and health risks

- Explore other effective vector control measures based on the local/evolving situation and consideration of entomological study in the current settlement setting of the refuges
- Prioritize high risk/Vulnerable groups for disease prevention and control activities
- Development of preparedness and response plan for Public health emergencies/Epidemics
- Preposition of required vaccine, drugs and medical supplies
- Consider implementation of risk reduction and prevention activities based on prevailing risks and availability of resources.

WASH

- Provision of Safe water as per the standard (minimum of 15-20l/p/day) and ensure household level safe management through hygiene promotion including conducting residual chlorine test at point of collection and from randomly selected household
- Increase Latrine construction and ensure its quality based on the existing standard for refugee setup
- Monitor quality of construction and appropriate utilization
- Include management solid waste and drainage to WASH service
- Ensure community participation based on Volunteerism with emphasis on sanitation and environmental management
- Decontamination of existing open defecation areas
- Initiate and ensure regular and frequent environmental sanitation campaign to minimize vector borne diseases including malaria and trachoma
- Conduct capacity building training on WASH and Environmental management for coordinators of partners working in the refugee camps on WASH
- Develop and test IEC material in local language tailored to culture of the refugees for promotional activities in the area of Water, Sanitation, personal Hygiene, food hygiene, diarrheal and other priority communicable diseases in the refugees and host community

Overall Coordination

- Strengthening, existing forums and coordination mechanism with strong leadership of UNHCR and ARRA, especially in the area of strengthening linkage with host community through ensuring their active involvement and sharing relevant information regularly and establish early warning/IDS system
- Integration of public health interventions and others at refugee community level to up lift the disease preventions and control through health promotional activities including volunteer refugee community participation

WHO's Support

All levels of WHO will provide technical support to the refugees and host community in order to strengthen the emergency response and ongoing health service delivery with a focus on capacity building in the area of routine immunization, mental health, maternal and reproductive health, SGBV, HIV/TB, water quality monitoring and entomological monitoring, IEC material development related to health, WASH , joint assessment, Planning and Resource mobilization, establishing early warning/IDS and information sharing. The WHO will also take part in monitoring in order to ensure implementation of prevention and control activities as per the norm and standard in refugee setup. It is also planned to provide materials, supplies and financial resources based on the priority gaps which include provision of IAEHK, guidelines, protocols and others through regional health bureau or implementing partners. In Summary WHO Actions will focus on **s**ustained technical support to the region and refugee response through deployment of additional Staff for WASH, surveillance and monitoring. Resource mobilization through advocacy for additional resource from WHO AFRO/HQ and existing portfolio resource mobilization mechanism such as CERF and bilateral organization will be carried out and participation of relevant WHO officers in activities like entomological studies and relevant task forces of health, nutrition and WASH to guide prevention and control interventions will be given due emphasis.

Plan of Action

This plan of action is prepared based on the immediate action to be taken by different WHO programs using currently available resource and resource to be mobilized for sustained support to the refugees and host community from within the country portfolio resource mobilization mechanism and at different levels of WHO including g IST/AFRO and HQ (see table 1)

Table 1: Plan of Action for WHO support to the South Sudan Refugee influx in Gambella Region

Thematic Area	Activity	Finance	Responsible	Month		
				May	Jun	Jul
Coordination	Participate in the various forums including Interagency Coordination forum and Health and nutrition TF and provide relevant information, advice and technical guidance	**NA**	• Regional Coordinator • Gambella ECM field officer • Crisis response coordinator • WCO Program officer/s			
	Joint assessment, planning and monitoring	**NA**	• Gambella ECM field officer • WCO Program officer/s			
Strengthening Early warning/Integrated Disease Surveillance system	Establishment of a TWG to identify priority diseases, prepare tools , define reporting frequency and channel and monitor trends	**10,000**	• Regional Coordinator • Gambella ECM field officer • WCO			
	Information sharing , rumor verification and outbreak investigation					
Strengthening case management	Provision of drugs, medical supplies and relevant materials	**10,000**	• Crisis response coordinator • WCO Program officers			
Strengthen Routine Immunization and surveillance for Polio and Measles with in the platform of IDS	Assignment of TA and provision of relevant materials	**10,000**	• EPI/IDS/NTD/ Malaria/ TB/HIV/Maternal Health/ Reproductive health/Mental health/WASH/ECM			
	Regular monitoring of performance					
Capacity building	Training material preparation	**7,000**				
	Conduct field level training					
Monitoring	Periodic field visit	**NA**				
	Water quality monitoring	**2,000**				
Resource mobilization	Project proposal preparation and submission to OCHA		• Initial Assessment Team			
	Request support from all levels of WHO					

Annex 1: Findings

Site Visited	Service Provided	Service Provider	Strengths	Gaps	Recommendation
Kule Population= 36-37,000	Health	ARRA MSF – France	• Child-<5, Adult OPDs and Delivery service available • 24 hour service provided • Emergency HMiS initiated • Referral system established to Itang • Effort started to provide static RI • ITN distribution • Appropriate use of RDT for Malaria diagnosis	• Shortage of Mid wives , trained staff on BeMoNC, TB , HIV, IMNCI and PHEM • Inadequate drugs and medical supplies • Lack of Guidelines, treatment protocol and IEC materials • Lack of HIV test kit • Family planning commodities • Absence of Power for 24/7 service provision • Lack of Mental health/Psycho social service ; SGBV counseling service • Inappropriate ITN utilization due to unfit shelter structure	• Capacity building on BeMoNC, Communicable and vaccine preventable disease case and outbreak management ; IMNCI and TB/HIV case management • Provision of essential drugs and medical supplies • Avail FP commodities • Avail Relevant guidelines and treatment protocol • Provision of Mental Health and SGBV counseling service
	WASH and Environment	ARRA DRC NRC MSF - Holland	• Availing safe drinking water – with recommended Chlorine residual • Construction of Latrines • Presence of Community Outreach workers for Nutrition and Hygiene with SoPs • Review of COWs activities and identification of Key	• Safe drinking water provision is below the SPHERE standard • Inadequate Latrine and lack safety and privacy • COWs education not complemented by demonstration and lacks volunteer community participation • Poor sanitation including open defecation and environmental	• Look for sustainable water source like bore holes in the permanent settlement areas • Increase Latrine construction and ensure its quality based on UNHCR standard • Monitor quality of construction and appropriate utilization • Ensure Community

			messages on Health, Nutrition and Hygiene	management providing breeding sites for vectors like flies and Mosquitoes • Lack of IEC material on WASH related issues	participation based on Volunteerism with emphasis on sanitation and environmental management • Avail WASH related IEC material on local language tailored to culture of the refugees
Leitchuor **~25,000** **>60% under 15years**	Health	MSF - France	• Child, Adult OPDs and Delivery service available • Presence of Paediatricians • 24 hour service provided • ITN distribution • Appropriate use of RDT for Malaria diagnosis • Health and nutrition COWs • Initiation for startup RI • Use of Guidelines for treatment of priority diseases • Referral system to Gambella • Good IP practice at health service provision site	• No service for RI, HIV/Mental Health • Mixed services for child and Adult • Shortage of trained staff on BeMoNC, TB , HIV, IMNCI and PHEM • Shortage of Ambulance (only one Ambulance) • Inadequate drugs and medical supplies • No formal surveillance or HMIS in place and information sharing to appropriately follow trends and evolution of diseases • Lack of Guidelines, treatment protocol and IEC materials • Lack of HIV test kit • Family planning commodities • Lack of Mental health/Psycho social service ; SGBV counseling service	• Initiate service provision for RI, HIV , mental health and laboratory • Capacity building on BeMoNC, Communicable and vaccine preventable disease case and outbreak management ; IMNCI and TB/HIV case management • Establish a formal surveillance/HMiS system based on the national reporting requirement • Provision of essential drugs and medical supplies • Avail Relevant guidelines and treatment protocol • Provision SGBV counseling service • Avail FP commodities
	WASH and Environment	UNHCR DRC	• Availing safe drinking water – with	• Safe drinking water provision is below the SPHERE standard	• Increase Latrine construction and ensure its

		NRC LWF ACF	recommended Chlorine residual • Construction of Latrines • Presence of Community Outreach workers for Hygiene with SoPs • Review of COWs activities using Monitoring tools by assigned supervisors and identification of Key messages on Health, Nutrition and Hygiene • Identified risk and initiated work towards reducing risk like relocation of settlements • Provision of integrated training for health, nutrition and WASH activities • Installment of permanent water pipe lines	• Inadequate Latrine and lack safety and privacy which has led to rampant open defecation • COWs education not complemented by demonstration and lacks volunteer community participation • Poor sanitation including open defecation providing breeding sites for like flies • Lack of IEC material on WASH related issues using local language	quality based on UNHCR standard • Monitor quality of construction and appropriate utilization • Ensure Community participation based on Volunteerism with emphasis on sanitation and environmental management • Decontamination of open defecation areas • Initiate regular and frequent environmental sanitation campaign to minimize vector borne diseases • Avail WASH related IEC material on local language tailored to culture of the refugees
	Coordination	ARRA UNHCR	• Presence of functional coordination forum with MoA and SoPs		• Strengthening, leadership of UNHCR and ARRA, especially in the area of strengthening linkage with host community though ensuring their active involvement and sharing relevant information • Integration of public health interventions and others at refugee community level promotional activities including

					volunteer refugee community participation

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