Photo by Niki Clark (ARCS). A woman gets her child vaccinated at the Tanzania Red Cross run health post in Nyarugusu

MID-TERM REVIEW REPORT
MDRTZ017
TANZANIA – POPULATION MOVEMENT

July 2016

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Acknowledgments

The authors, Mr. John Thomas Kinyagu, Planning Monitoring Evaluation and Reporting Officer from Tanzania Red Cross Society (TRCS) Dar Es Salaam Head Office and Dr. Cecile de Milliano, Emergency Planning, Monitoring, Evaluation and Reporting (PMER) Delegate from the International Federation of Red Cross and Red Crescent Societies (IFRC) Nairobi Regional Office, would like to thank all those who made this mid-term review possible. Special gratitude is extended to all the people that participated in the review, Many thanks go out to the team of Red Cross volunteers who assisted during the data collection including; Mr. Mabara Gwantaho, Mr. Manirakiza Charles, Mr. George Gregory, Mr. Ndayiziga Peres, Mr. Ntwengeye Fabian, Mr. Mohamedi Rashid, Ms. Ashura Hamaza, Mr. Nasoro Amir, Mr. Nahayo Emile, Mr. Uwineza Callixte, Mr. Buchumi Wiston, Mr. Nimubona Josias, Mr. Onesmo Ndayumeruje, Mr. Nyambera Ernest, Mr. Abson Kaje, Mr. David Buulu, Mr. Manirambona Sylvan, Mr. Ndikumkija Joseph Amos, Ms. Nicimpaye Joselyne and Mr. Moses M. Gugwe.

Special thanks also go out to Mr. Joseph Kimaryo (TRCS), Dr. Florence Mashana (TRCS), Mrs. Mama Winifrida Rwehumbiza (TRCS), Ms. Rahabu and Mrs. Brigitte Gaillis (IFRC), who played a key role in ensuring the logistics of the review.

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Abbreviations

BSS	Beneficiary Satisfactory Survey
DM	Disaster Management
DREF	Disaster Response Emergency Fund
EAIOI	East African and Indian Ocean Islands
ECHO	European Commission of Humanitarian
EPoA	Emergency Plan of Action
ERU	Emergency Response Unit
FACT	Field Assessment Coordination Teams
FGD	Focus Group Discussion
FGD's	Focus Group Discussions
HIT	Health information teams
HP	Health Post
HP5	Health Post 5
HQ	Head Quarters
IFRC	International Federation of the Red Cross
IPC	Infection Prevention and Control
IRC	International Rescue Committee
KII	Key Informant Interview
PNS	Partner National Societies
LLW	Lessons Learnt Workshop
MDRTZ017	Emergency Appeal – Tanzania: Population Movement
MHA	Ministry of Home Affairs
MSF	Medicines Sans Frontiers
NS	National Society
NYA	Nyarugusu
OPD	Out Patient Department
ORS	Oral Rehydrated Solution
TBA	Tradition Birth Attendant
TRCS	Tanzania Red Cross Society
TWESA	Tanzania Water and Environmental Sanitation Agency
UNHCR	United Nations High Commissioner for Refugees
WASH	Water Sanitation and Hygiene
WFP	World Food Programme

Contents

Executive summary

From April 2015 onwards, an influx of Burundian refugees fled pre- and post- election violence. Many refugees have been seeking refuge in Tanzania. Nearly one year after the Tanzania population movement (MDRTZ017) was launched, an internal review was commissioned. The main aim is to review the effectiveness, the main successes & challenges of the operation to date and to identify some key lessons learnt. In order to review the operation in Nyaragusu camp, 5 methods have been used to gain insights: the study of documents, 27 key informant interviews (KII), 18 focus group discussions, 528 completed beneficiary satisfaction survey (BSS) and a lessons learnt workshop (20 participants). Respondents included: beneficiaries, volunteers, Tanzanian Red Cross Society (TRCS) Branch & Head Quarter (HQ) staff, International Federation of the Red Cross (IFRC) staff based in Kigoma region and Nairobi and partner organisations such as UNHCR, MSF, MHA and TWESA.

The main aim of BSS was to gain insights on beneficiaries' satisfaction about the support they received, but it also provided some insights on the background. Of the beneficiaries who participated in the survey, 79% (N=418) almost lost their life, 46% (N=245) lost a family member and 35% (N=188) lost their home.

Different elements of the appeal were reviewed, which were found to be of varying quality. The review included (in order of satisfaction) the coordination and coverage of the appeal, followed by the efficiency and sustainability and more critical remarks were made on the effectiveness and relevance of the appeal. TRCS and IFRC have been applauded for their hard work under very difficult circumstances. However, the majority of the respondents also felt that more can be done. The key factors identified as hindering achievements are: the lack of resources/funds leading to: lack of facilities/fuel/tools, lack of sufficient staff and (quality) staff welfare conditions, leading to over-worked and less motivated staff which has been leading to a decrease in quality care.

The key outcome areas of the appeal were reviewed which included: health and care, water, sanitation and hygiene promotion, shelter and non-food items and capacity building of the National Society. Especially health information and water, sanitation and hygiene were assessed positively. But also the increased access and utilization of health services and the holistic services being provided (preventative and curative services available) was applauded. Nevertheless, health facilities/services and National Society capacity building were also the two areas where more achievements are yet to be made. The strengths and challenges of the (IFRC) operational support services were reviewed. The ERU support during the immediate influx between May and July 2015 was widely applauded. Longer-term and increased medical technical support would be beneficial for the future and sustainability of the operation and TRCS.

Based on the review the key recommendations are:

1. More emphasis and efforts should be put towards resource mobilization for the appeal/ situation
2. A strong (health) strategy needs to be developed for and with TRCS and the health partners
3. Funds should especially be identified to be able to address the staff welfare conditions, fuel and other key assets. Funds should also be made available to ensure maintenance of infrastructure and equipment/assets.
4. Jointly, TRCS and IFRC should liaise with the government to facilitate operation related logistics such as medicines, import taxes, working permits/visas
5. A strong HR plan and overview needs to be developed and implemented, both for TRCS and IFRC. Preferably and if funding allows, longer-term IFRC delegates are to support the operation.

6. Increased clinical/medical on-the-job support and training needs to be provided and it needs to be ensured that there is a strong PMER system in place. This will allow a clear picture on the patients and care, through accurate collection of data and analysis of the situation.
7. More regular coordination meetings need to be held, during which clarity is provided on the financial situation of the appeal (funding that has been received and funds that have been spent).
8. To prevent delays in implementation, returns need to be processed as fast as possible on all levels (including field, Dar es Salaam and Nairobi).
9. Clarity on the procurement plans and requirements of TRCS systems and IFRC supported appeals and further on the job medical logistics support needs to be provided.
10. Drug procurement, logistics and distribution needs to be tightly managed
11. TRCS and IFRC should maintain close contact and cooperation with UNHCR to ensure the procurement and delivery of drugs is ensured
12. The visibility of volunteers and TRCS staff should be increased, by ensuring TRCS materials are widely available (bibs etc.)
13. Given that health services are the core focus of the appeal and they were rated as being of average quality, increased attention needs to be put on ensuring quality control of the services.
14. Since funds are limited, it is recommended to focus efforts to ensure quality health service is provided.
15. Jointly, TRCS and IFRC should further develop a contingency plan, identify where they will focus their efforts and IFRC should develop an exit strategy.

Chapter 1: Introduction

The election violence that started in late April in Bujumbura (Burundi) resulted in a number of casualties. Following the re-election of the President in July 2015, civil unrest and increasing numbers of casualties continued. At the onset of the crisis in April 2015, 210 refugees fled to Tanzania from Burundi. By July 2015, this number of Burundi refugees fleeing to Tanzania had increased to nearly 80,000. Currently (June 2016), more than 235,000 people have fled to Democratic Republic of the Congo (DRC), Rwanda, Tanzania and Uganda. The majority (200,931) are choosing to settle in Tanzania which continues to see a daily influx of people seeking refugee status, an average of 90 to 245 people per day (see UNHCR 2016).

Since 1993, the Tanzanian Red Cross has been host to hundreds of thousands refugees from various Great Lakes countries such as Rwanda, Burundi and the Democratic Republic of Congo. They have been supporting the Congolese refugee population in the Nyarugusu camp for over 10 years. With the influx of the Burundi population the IFRC launched the Tanzania Population Movement Emergency Appeal (MDRTZ017) in May 2015. It is aiming to enable the International Federation of the Red Cross (IFRC) to support the Tanzania Red Cross Society to deliver assistance and support to 250,000 refugees in Nyarugusu and Mtendeli Camps.

Since the operation has been running for one year and since there is an intention to extend, a mid-term review has been organized. The main objective is to identify the effectiveness, the main successes and the main challenges of the operation to date. The finding will be used by TRCS and IFRC to learn lessons about the operation and modify action if needed. [1] Yet the findings of the

[1] Please note that the operational mid-term review is commissioned by the TRCS Appeal management, the IFRC EAIOI disaster management operation unit in collaboration with the IFRC EAIOI PMER unit and is intended as an internal quality

review are to ensure that: *'In the end of the day it's about ensuring that the most vulnerable refugees get good health care.'* (Partner of TRCS/IFRC during KII)

1.1 What to expect?

This report contains four key chapters. Chapter 1 is an introduction to the review, it spells out the objectives and explains which methods have be used to gain insights on the operation. Chapter 2, presents the key findings on the quality of the emergency appeal and discusses the relevance, efficiency, effectiveness, coverage, coordination and sustainability of the appeal. Chapter 3 presents the key lessons learnt related to the main outcome areas (Health, WASH, Shelter and National Society Capacity Building). It also highlights the findings on the strengths and challenges of the operational support services. Based on the findings, chapter 4 draws some key conclusions and presents recommendations.

1.2 Objectives

The objectives of this mid-term review are four-fold:

1. **Review the effectiveness of the MDRTZ017 operation in meeting the planned objectives and outputs in the EPoA. The review assesses (according to a common methodology) the following:**
   - **Relevance and appropriateness:** the interventions suit the priorities of the affected population, if other interventions are more suitable; how they could be revised
   - **Efficiency:** the extent to which the appeal operation is managed in an organized and competent way; if the allocation is adequate to deliver the expected outputs / activities; if costs could be reduced or if the most cost effective approaches are taken
   - **Effectiveness** – the extent to which the appeal operation is able to meet its intended objectives and outputs in accordance with recognized international standards (SPHERE).
   - **Coverage** – the extent to which the appeal operation is able to reach the populations/areas most at risk by the crisis; how the criteria for this are identified/ implemented.
   - **Coordination** – the extent to which coordination is occurring with the key stakeholders during the appeal operation.
   - **Sustainability & connectedness** – the extent to which the outcomes of the operation will be sustained (where relevant); particularly in relation to capacity and learning gained through the interventions (National Society capacity); and how they can be integrated within contingency planning activities and future new activities being carried out by the TRCS.
2. **Assess the usefulness of the operational strategy of having a separate IFRC operations unit at Kigoma level and look at the effect of the support of the IFRC to the effectiveness of the operation implementation and coordination.**
3. **Provide a means of establishing successes, challenges, lessons learned from the MDRTZ017 operation in order to inform recommendations for the Emergency Plan of Action.**
4. **Use the outcome of the review to promote the appeal to partners/ donors (ECHO).**

assurance, and not a complete evaluation. Nonetheless efforts have been made to ensure that the exercise is carried out in accordance with the IFRC ethics and legality standards (refer to the IFRC Evaluations Framework / 4.3), and the International Red Cross and Red Crescent Movement's Fundamental Principles.

1.3 Methodology

To ensure a holistic and quality mid-term review, the following considerations were made in terms of the scope, the methods, the participants and the data collection teams.

1.3.1 The scope

The appeal was implemented in 2 areas: Nyaragusu and Mtendeli refugee camp. However since refugees were only relocated to Mtendeli since January 2016, the majority of the activities have been undertaken in Nyaragusu. The mid-term review has therefore predominantly focussed on the activities in Nyaragusu camp.

1.3.2 The main participants

The findings in this report are based on the feedback provided by:

- Beneficiaries
- TRCS Volunteers
- TRCS Branch staff
- TRCS HQ staff
- IFRC staff based in Kigoma region and Nairobi
- Partner organisations such as UNHCR, MSF, MHA and Twesa.

1.3.3 The main methods

The following methods were employed in order to collect sufficient data to review the emergency appeal. This approach also allowed for triangulation. [2]

- **Desk review and review of secondary data, including but not exclusive to:**
    a. MDRTZ017 Tanzania Population Movement – EPoA (original and revised versions)
    b. MDRTZ017 Tanzania Population Movement – Budget
    c. MDRTZ017 Tanzania Population Movement – Operations Updates
    d. The Heops Situational Analysis (IFRC January 2016)
    e. The Health Assessment Report (IFRC January 2016)
    f. The Health Assessment Report (IFRC July 2016)
    g. Report of participatory review exercise conducted by UNHCR (March 2016)
    h. IFRC/TRCS detailed Assessment Report
    i. Inter-agency updates
    j. Task Force minutes of meetings
    k. TRCS Financial Monitoring/Expenditure Reports

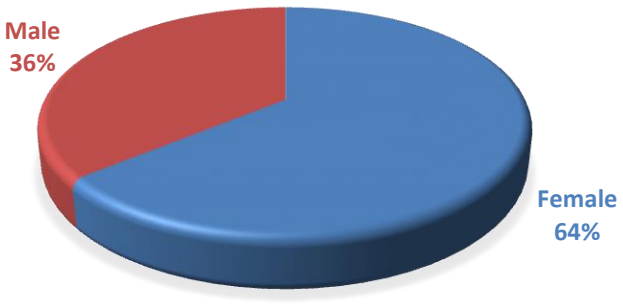
- **Beneficiaries Satisfaction survey**

Using a standardized tool that was slightly adapted to fit the context, the perception of 528 beneficiaries were collected. Given the scope of the operation, the target population was mainly refugees living in Zone 8 and Zone 9 of Nyaragusu camp. From the total of 528 Beneficiary Satisfactory Survey entries collected via Mobile Devices, the following findings were presented after the analysis.

Out of **528** participants, **338** were female and **190** were men. As illustrated in the figure 1 below.

Figure 1: Gender Distribution Beneficiaries Satisfaction Survey

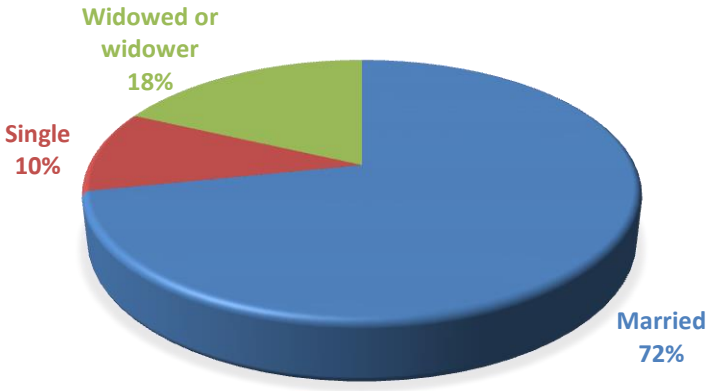
[2] A copy of all the tools that were used for this review are available upon request to the authors



Source: MDRTZ017 BSS Analysis, June 2016

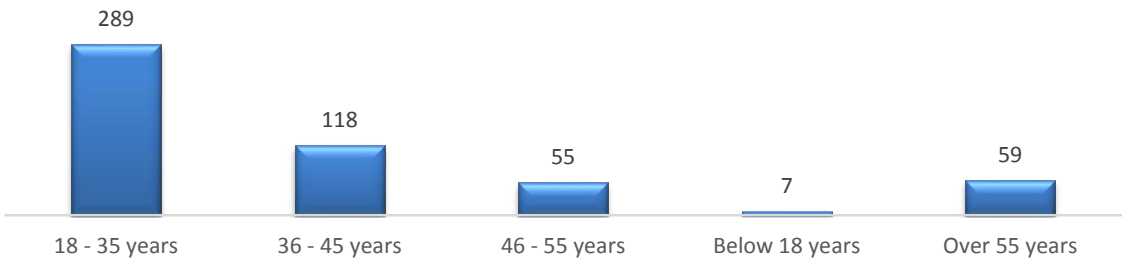
It was reported that, 379 were married, 54 single and 95 were widowed or widower as illustrated in the figure 2 below.

Figure 2: Marital Status Distribution Beneficiaries Satisfaction Survey



Source: MDRTZ017 BSS Analysis, June 2016

Figure 3: Average Age of Head Of Household



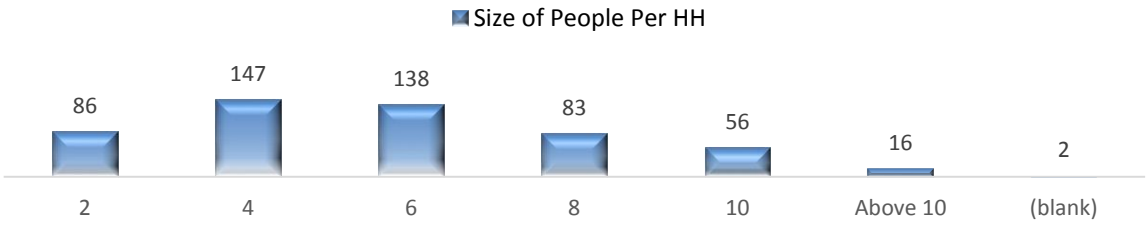
Source: MDRTZ017 BSS Analysis, June 2016

It was interesting to find out that, the majority age of the head of the households is fairly young. About 289 persons and is equivalent to 55% of Head of the House Hold ranges between 18 and 35 years old. Only about 1% were headed by the Head of about the age below 18 years.

The majority of the households are identified to have between 4 and 6 people living under the same roof. From the Survey findings, about up to 147 out of 528 responses households has 4 people each,

138 households has 6 people in. Quite a few of the household has more than 10 people. Figure below shows the distribution of people in the households.

Figure 4: Number of people per Household



Source: MDRTZ017 BSS Analysis, June 2016

- **Focus Group Discussions**

In total of 173 people participated in Focus Group Discussions that were held. The following Table1 indicate the FGDs Sessions' Date held, Number of Volunteer Groups, Characteristics, Gender and Age Distribution.

Table 1: Focus Group Discussions Schedule

Date	FGDs Characteristics	V/Group 1	V/Group 2	V/Group 3	Total
26/4/2016	Male FGDs	10	10	9	29
	Female FDGs	11	9	12	32
	Youth	15	11	8	34
		36	**30**	**29**	**95**
27/4/2916	Male FGDs	8	10	-	18
	Female FDGs	10	10	-	20
	Youth (15 to 22years)	10	9	-	19
		28	**29**	**-**	**57**
28-29/4/2916	Volunteers	11	9	-	20
	Staff	10	-	-	10
		21	**-**	**-**	**21**
				Total	**173**

Table 1 above illustrates the Gender Distribution in percentage of the three types of FGDs. Though male participation was 61% in total, the majority of these male respondents (46%) were part of the beneficiary population. Only few female volunteers were part of the respondents (1%).

Table 2: Focus Group Discussions Clusters-Gander-Percentage Distribution

FGDs	Male	Percentage	Female	Percentage	Total	Percentage
Beneficiaries	79	46%	49	28%	128	74%
Volunteers	17	10%	1	1%	18	10%
Staff	10	6%	17	10%	27	16%
Total	**106**	**61%**	**67**	**39%**	**173**	**100%**

- **Key informant interviews**

Using a standardized tool, in total 27 key informant interviews were held. Participants included:

- 14 TRCS staff representatives from relevant technical areas, branch staff, TRCS management and head quarter.

- 6 IFRC staff representatives working on the operation
- 7 In-country NGO/UN partners (with presence in Nyaragusu and active in the same response).

- **Lessons learned workshop**

Using a standardized tool, in total 20 persons participated in a lessons learnt workshop which included all levels involved in the operation:

- Branch staff from Kigoma/Kasulu/Nyaragusu
- Headquarters staff (TRCS Senior DM Management, PMER department representatives)
- TRCS management
- IFRC EAIOI staff from Kigoma and IFRC Nairobi
- Other key stakeholders/partners as relevant (UNHCR, WFP, IRC, TWESA) at branch level,
- PNS (American Red Cross).

This mid-term review has put emphasis on the quality and relevancy of the assistance provided to the beneficiaries.

1.3.4 The mid-term review data collection team:

The mid-term review was led by a TRCS Planning Monitoring Evaluation and Reporting (PMER) staff from TRCS Head Quarter (HQ) level and an Emergency Operations PMER staff from the IFRC Eastern Africa and Indian Ocean Island (EAIOI) staff. They received support from 12 volunteers to perform the beneficiary satisfaction survey and from 8 volunteers to perform the focus group discussions (FGD's) and process the findings.

Picture 1 The TRCS data collection team

Picture 2 Training of the data collection team

One day of training and continuous on the job support was provided to the volunteers, for them to get a good understanding of the main questions for the review and the main tool they were using. The volunteer using the mobile devices were trained on ODK and during training the translation from Swahili to Kirundi was thoroughly discussed and trained.

1.4 Limitations

There were various limitations:

- **Language**: data was collected in three languages namely Kirundi, Swahili and English. This always holds a risk of misinterpretations.
- **Weather circumstances**: Various days of bad weather slowed the BSS teams down. The volunteers were provided gumboots and rain-jackets to be able to work under these circumstances.
- **Geographical dispersion** of the camps. Distances are vast, due to which a lot of time was spent in travelling. In addition, this was a key reason for not including Mtendeli in the review. Not including the operation in Mtendeli camp means the review only gives a partial scope of the operation.
- **Availability of various key informants** for the interviews and for the lessons learnt workshop was limited. Although initially planned, staff (IFRC and TRCS), volunteers and beneficiaries from Mtendeli were not made available and thus did not participate in the review. Due to the unavailability of some of the key informants, various interviews were held by phone.

Chapter 2: Key Findings

The following chapter presents the key findings related to the review of the quality of the emergency appeal. It starts by giving a short introduction to the appeal and its intended outcomes (section 2.1 – 2.2) and subsequently presents the respondents perceptions on the quality of the delivered support (section 2.3 – 2.8).

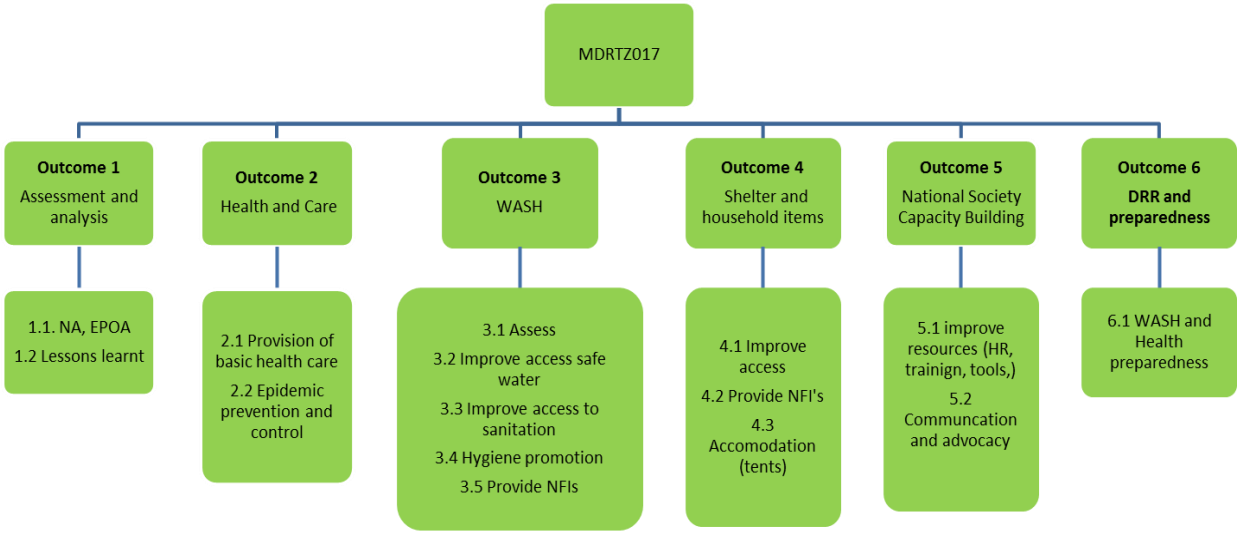
2.1 The emergency appeal

The main objective of the Tanzania population movement emergency appeal is to ensure that the immediate survival and basic needs of Burundian refugee population are met through the provision of essential emergency health, relief, water and sanitation services targeting a total of up to 250,000 people (50,000 households) at border entry points, Nyarugusu and Mtendeli camps. At the time of the review, around 134000 people have been reached at border entry points, the Lumassi transit center, Nyarugusu and Mtendeli camps. See annex I for a map of Nyarugusu camp.

2.1.1 An overview of the key outcomes and outputs

In total six outcome areas are targeted by the Tanzania population movement appeal (see figure 5).

Figure 5: Tanzania Population Movement Appeal Outcome Areas



Source: MDRTZ017 BSS Analysis, June 2016

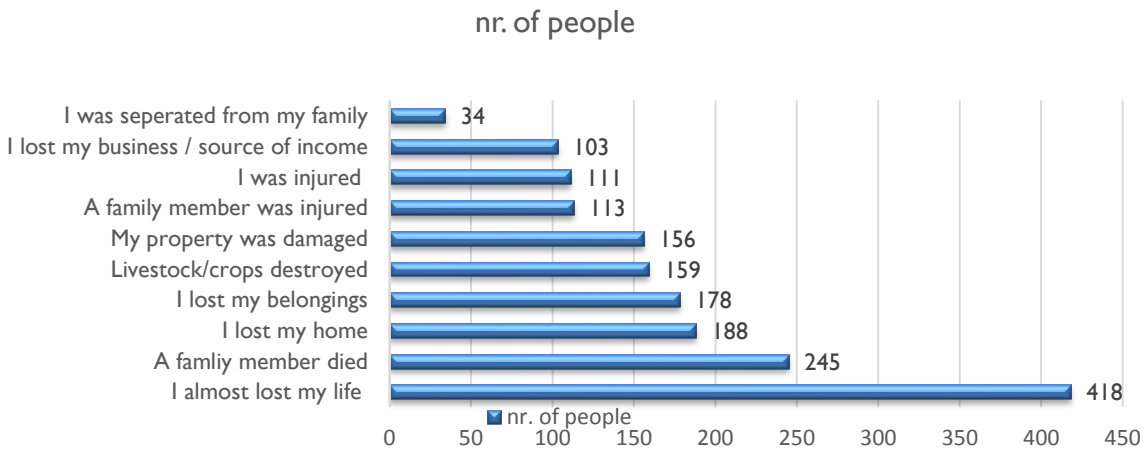
More specifically the outcome areas entail:[3]

- **Outcome 1: Quality Programming:** Continuous assessment, analysis and a final evaluation is performed in order to inform the design and implementation of the operation.
- **Outcome 2: Health and care:** The immediate risks to the health of the target population are reduced, at the entry points, Lumassi Transit Center, in the Nyarugusu(and Mtendeli) camps, for a period of 15 months.
- **Outcome 3: WASH:** The immediate risks of waterborne and water related diseases to the target population are reduced in the Nyarugusu (and Mtendeli Camps), for a period of 15 months.
- **Outcome 4: Shelter and Household Items:** Immediate shelter and household items are provided to refugees at entry points and reception centres.
- **Outcome 5: National Society Capacity Building:** The NS is supported to be self-reliant to respond to the humanitarian crisis.
- **Outcome 6: Disaster Preparedness and Risk Reduction:** The NS is supported to be prepared to respond to an increased influx of refugees.

2.1.2 The affected refugee population

Before looking at the activities provided to the affected population, the BSS provides some insights in the background of the affected population. Respondents were asked how they were affected by the situation in Burundi and what made them leave the country. As visible in the graph below, 79% (N=418) of the beneficiaries almost lost their life, 46% (N=245) lost a family member and 35% (N=188) lost their home.[4]

Figure 6: How people were affected by the situation and what made them leave their country

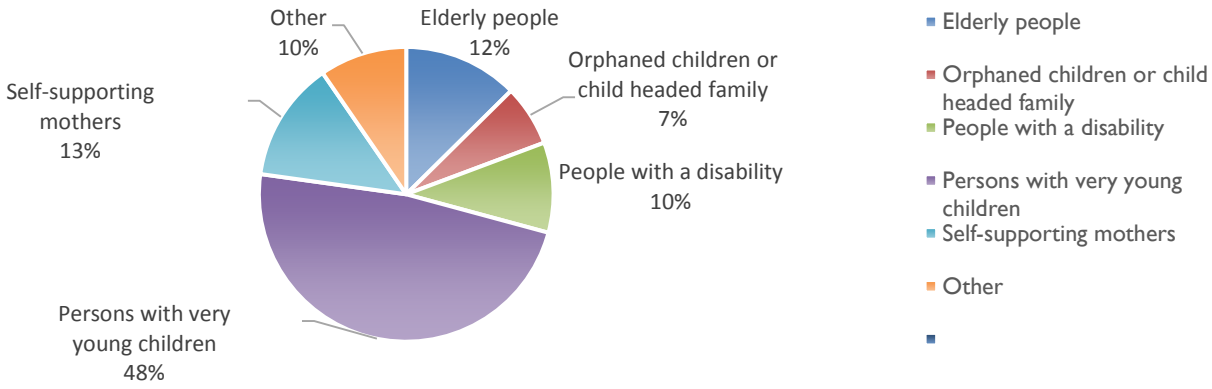


Source: MDRTZ017 BSS Analysis, June 2016

The BSS shows, as visible in Graph 7, that of the beneficiaries, 7% were orphaned children or child-headed households, 10% were persons with a disability, 13% were self-supporting mother and 48% were persons with very young children.

[3] For further details please consult the Emergency Plan of Action MDRTZ017 (www.ifrc.org/appeals)
[4] Multiple answers are possible, meaning the totals adds up to more than 100%

Figure 7: Type of Vulnerability of Respondents (N=523)



Source: MDRTZ017 BSS Analysis, June 2016

2.1.3 Key events and milestones in the appeal

When discussing the key events and milestones, the majority of the respondents of the KII and LLW emphasized the great impact the first period of the operation made on them. One of the TRCS staff explains:

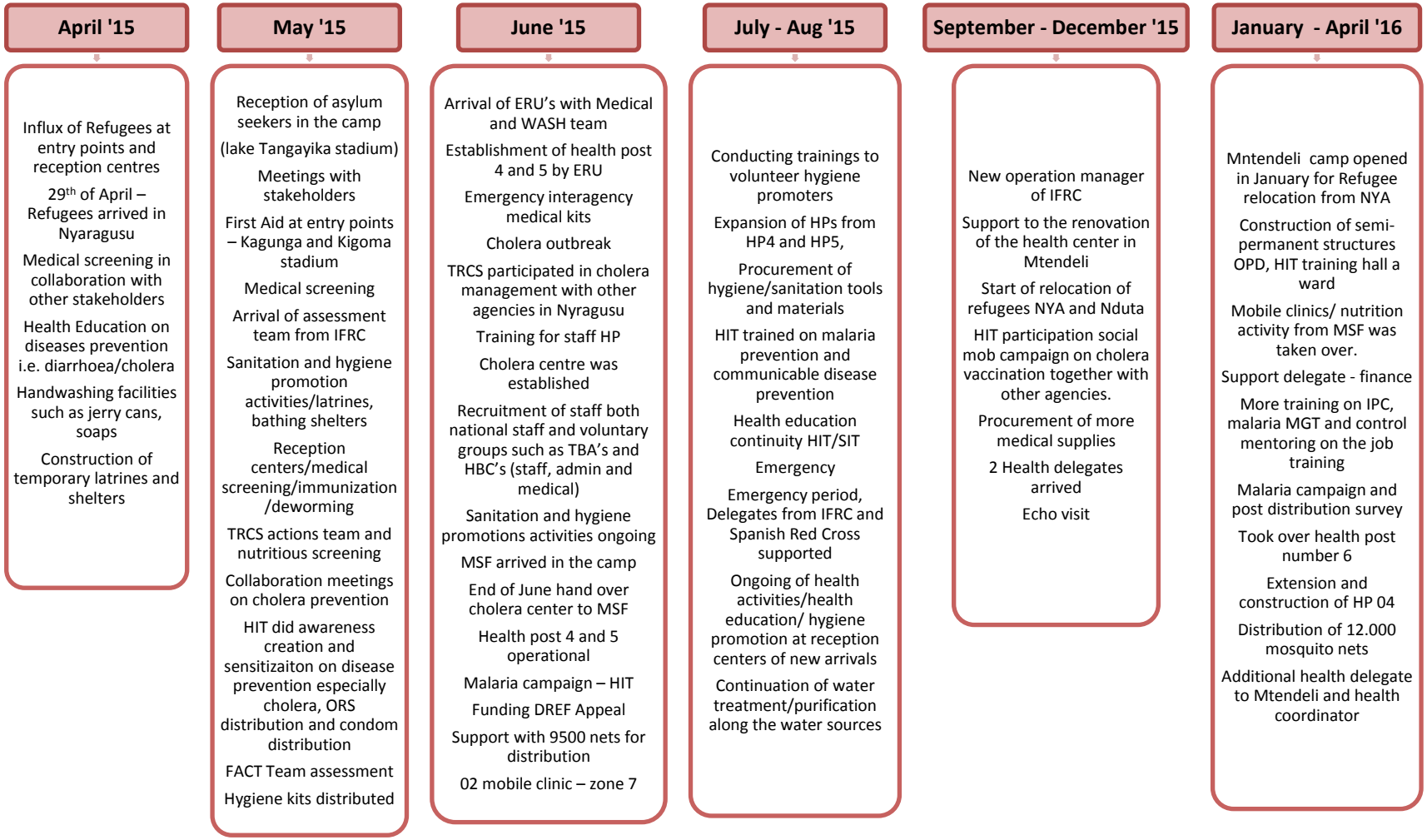
> '*May 2015 was a very busy time. The refugees were arriving with very big numbers. Sometimes there were 2000 arriving per day. The conditions in which they arrived were horrific, many had walked for days and were very sick. There were very limited facilities and there were no places to sleep. Water and sanitation was a big problem. There were around 400 people in one shelter, the place was totally congested and it was raining so heavily. Then we started having cholera cases. The situation was bad. It was a very challenging time.*' (TRCS staff during KII)

The majority of the respondents, both during the interviews, focus group discussions and lessons learnt workshop, emphasized that the start of the operation was hectic, due to the huge increase in refugees in the camps. Yet, this first phase was also seen as a phase where support was also much appreciated. The later phase of the operation has been challenging since funds have been limited, more refugees have been arriving, refugees have not been returning and needs are high.

During the lessons learnt workshop, participants were asked to map out the key events and milestones in the appeal, between May 2015 and April 2016.[5] The participants identified the following milestones:

[5] It must be noted that the image is a direct reflection of the ideas shared by the participants of the workshop participants. The ideas do not necessarily have to be strictly in line with the actual facts.

Figure 8: Population Movement Mile Stone April 2015 to April 2016



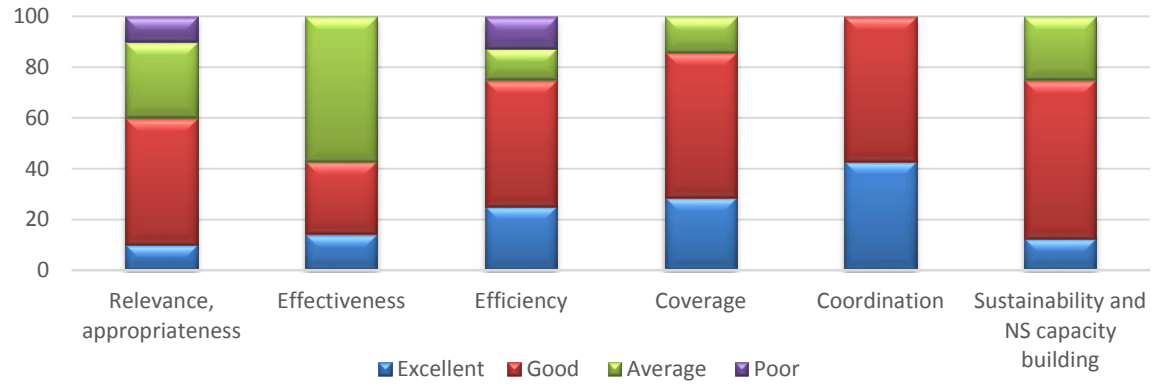
Source: MDRTZ017 LL workshop Analysis, June 2016

2.2 Overview of quality of appeal

When exploring the quality of support provided, six key areas were explored.

As visible in figure 9, during the lessons learnt workshop most satisfaction was expressed about the coordination and coverage of the appeal, followed by the efficiency and sustainability of the operation. Although generally positive, more critical remarks were made on the effectiveness and relevance of the appeal.

Figure 9: Quality Self-Assessment (N=20)



Source: MDRTZ017 LL workshop Analysis, June 2016

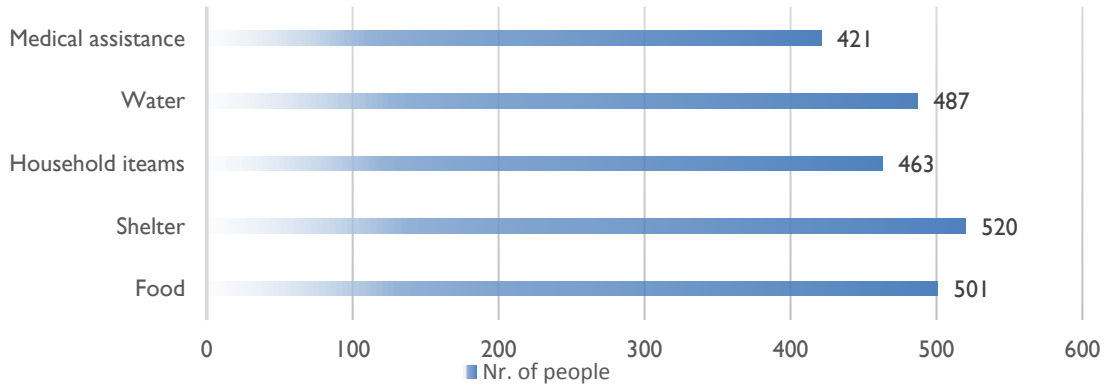
2.3 Relevance/appropriateness

The first issue to be explored is the relevance/appropriateness of the operation. To assess this, it was identified to what extent the activities planned in the appeal operation are appropriate to the needs/priorities of the affected population.

2.3.1 The needs of the refugee population

Through the BSS the type of needs of the refugees upon arrival become clear (see graph 10 below). Upon arrival, most need was related to shelter (N=520 persons), food (N=501 persons) and water (N=487 persons).

Figure 10: Type of Assistance People Needed

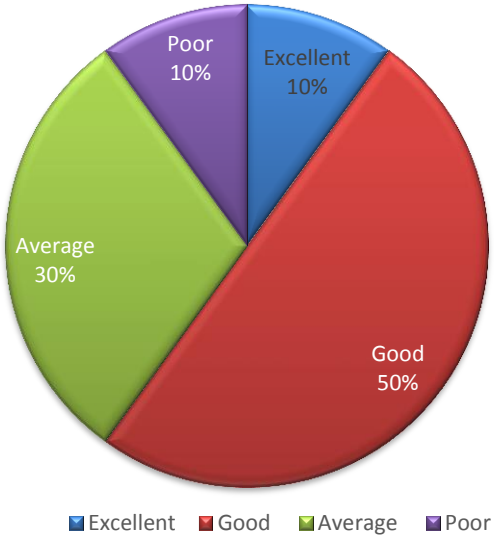


Source: MDRTZ017 BSS Analysis, June 2016

2.3.2 *Validity of the objectives and relevance of the appeal.*

Although the need for water, shelter and food was higher than medical assistance (see graph above), it was felt that validity and relevance of TRCS's focus on health was good. Within the Nyaragusu camp and at the time the newly opened Mtendeli, the TRCS is taking the lead on health issues. The majority of the respondents felt that the objectives of the appeal were and still are relevant and that it is good that the main focus of the appeal is on health. Until end May 2015, mass sanitation and basic health care activities were predominantly supported through Emergency Response Units. For TRCS to keep on supporting these various themes was felt challenging. Therefore, at the end of June 2015, the appeal was revised, the focus was narrowed down, enabling a more singular focus on health. For the future of the appeal, ensuring that high quality health care is provided to the refugees, was felt to be a key objective for TRCS in the appeal.

Figure 11: Validity of the Objectives and Relevance of the Appeal



Source: MDRTZ017 LL workshop Analysis, May-June 2016

As visible in graph 11, around 50% of the lessons learnt respondents felt the relevance of the programme was good and 10% felt it was excellent. Respondents who were less positive emphasized that there was still room for improvement related to: delays in implementation, lack of drug delivery from UNHCR, lack of good facilities and other operational shortfalls such as funding, quality of personnel, logistical challenges and poor staff welfare.

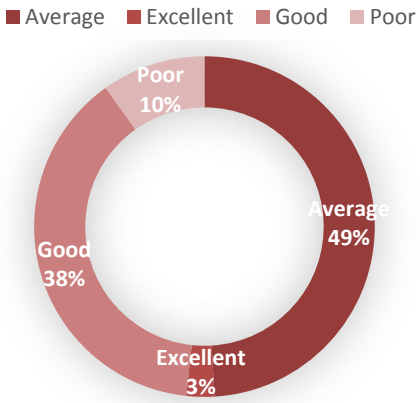
2.4 Effectiveness

The second issue to be reviewed was the effectiveness of the appeal. It was questioned to what extent the activities planned in the Appeal operation contribute to the immediate alleviation of suffering of the affected population and the objectives and outputs and accordance with recognized international standards (SPHERE). To explore effectiveness, quality/ quantity/type/timing of the support was also explored.

2.4.1 *Quality of the support*

During the BSS, the beneficiaries were asked to what extent is the support being provided was of good quality and quantity. The graphs below present the findings. Overall it can be said that the majority of the respondents rate the quality of the health services as average (49% ranks average).

Figure 12: Quality of Medical Assistance, First Aid or Health Care (N=528)

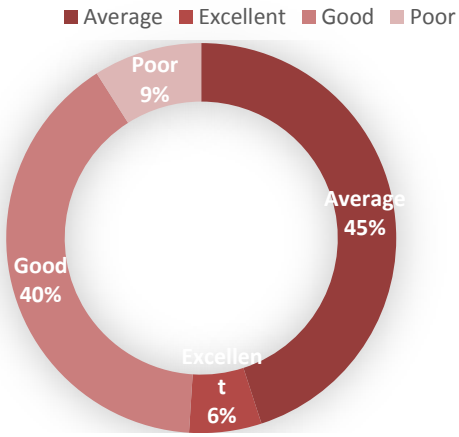


Source: MDRTZ017 BSS Analysis, May-June 2016

Beneficiaries were asked on what topics they received hygiene promotion information. The topics that were mentioned were: Malaria prevention; Hand washing; Personal hygiene; Safe excreta disposal; Water purification; HIV prevention & gender based violence; Reproductive health and Cholera. Overall, the quality of the health promotion activities were rated as average (45% rank average).

Figure 13: Quality of Hygiene promotion (N=528)

During the focus group discussions, some complaints were shared by beneficiaries on the quality of the health care. One of the male beneficiaries explains: '*When I went to the hospital, I was only given two tablets, or not give them at all.*' Others explain that there is a medical paper that they were asked to present, and if someone did not have this paper, they were left untreated.



Source: MDRTZ017 BSS Analysis, May-June 2016

Moreover beneficiaries were questioned about their satisfaction with the quality of the other services they received. Again the majority of services were rated as average. Beneficiaries were more satisfied about the water and treatment products and services (60% good or excellent) and with the quality of sanitation and waste management (43% good or excellent).

Figure 14: Beneficiaries satisfaction of quality of services (N=528)

Source: MDRTZ017 BSS Analysis, May-June 2016

2.4.2 *Quantity of the support*

Apart from the quality, the beneficiaries' satisfaction about the quantity of the services was also questioned. The following was found:

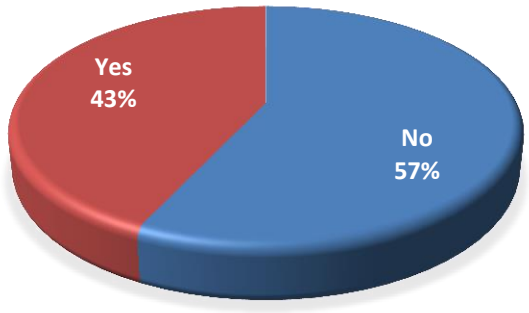
Table 3: Evaluation of Quantity of the Services Provided Scores

Quantity of the services provided	Excellent	Good	Average	Poor
Non Food Items	1%	18%	64%	17%
Sanitation & Waste Management	5%	35%	51%	9%
Water & Water Treatment Products	7%	50%	32%	7%
Shelter	0%	4%	32%	50%
Medical Assistance, First Aid or Health Care	3%	35%	51%	11%
Hygiene promotion	6%	36%	51%	8%

Source: MDRTZ017 BSS Analysis, May-June 2016

It was also questioned to what extent the beneficiaries felt that the health care met their daily requirements. 43% (N=227) of the beneficiaries agreed with this statement.

Figure 15: Fulfilment of Heath Care for Daily Requirements (N=528)

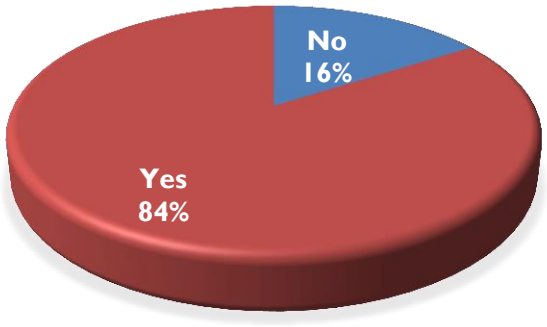


Apart from health care, non-food items were also distributed. These included: buckets, basic hygiene Kits, Jerry cans, Basic hygiene items (laundry soap, bathing soap etc), and water purification chemicals Medicines, Mosquito nets and Blankets.

Source: MDRTZ017 BSS Analysis, May-June 2016

Figure 16: Noon Food Items Distribution (N=528)

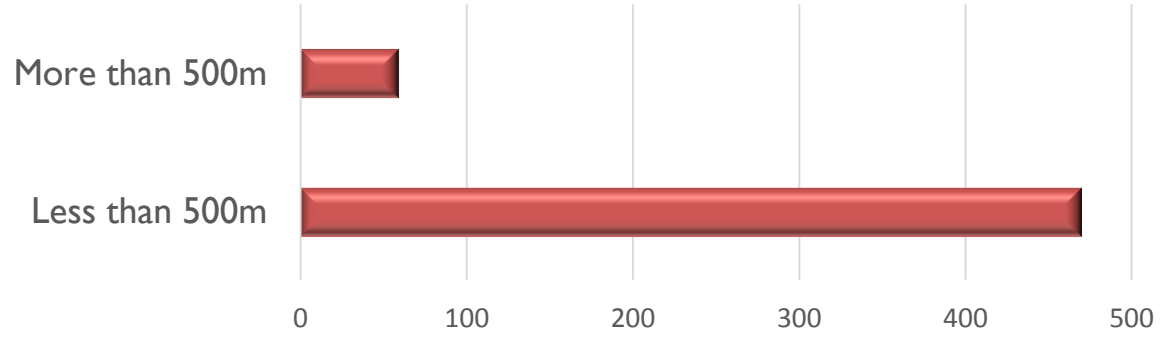
When questioning if the NFI's were enough for the household 94% (N=494) of the beneficiaries identified they were not. Interestingly, 16% (N=84) of the beneficiaries identified they did not use the NFI's that they received (see graph below).



Source: MDRTZ017 BSS Analysis, May-June 2016

Finally the quality of latrines was questioned. As visible below, for the vast majority of the households, a latrine was based less than 500 meters from their shelter.

Figure 17: Distance between Shelter and Latrines (N=528)



Source: MDRTZ017 BSS Analysis, May-June 2016

In addition, the majority of the beneficiaries, namely 68% (N=360 persons) felt that the latrines were safe to access.

2.4.3 Timeliness of the support

The beneficiaries were also asked about the accessibility of the health care. The table below shows the findings from the survey

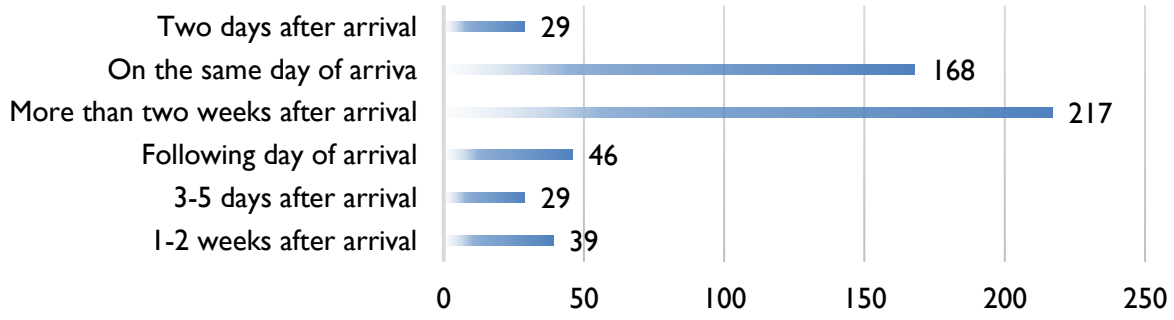
Table 4: Access to Health Care

When Did You Receive Health Care?		
1-2 weeks after you needed it	26	5%
3-5 days after you needed it	25	5%
Following day that you needed it	54	10%
More than two weeks after you needed it	67	13%
On the same day that you needed it	329	62%
Two days after you needed it	27	5%
Total	528	100%

Source: MDRTZ017 BSS Analysis, May-June 2016

During the focus group discussions with the beneficiaries, it was raised multiple times that beneficiaries went to the hospital were told to return at a later moment or had long waiting hours. As visible in the table below, the majority of the beneficiaries (N=217) received the non-food items more than two weeks after their arrival.

Figure 18: Distribution of Non-Food Items (N=528)



Source: MDRTZ017 BSS Analysis, May-June 2016

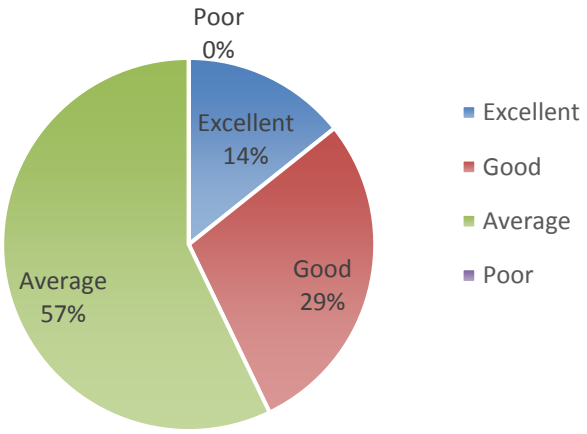
Various respondents during the interviews and the FGD emphasized that there are often delays in the implementation. This is both on the side of TRCS and of IFRC. A TRCS staff comments during a

KII: '*IFRC staff needs everything quickly, but they delay with sending us money, so they can then not expect us to get things quick'.*

2.4.4 Achieving effectiveness

During the lessons learnt workshop, those people who were satisfied (43%) about the effectiveness of the operation emphasized that things have gone according to the expectations. As example it was mentioned that consultation rates are now within the standard of around 50 consultations per clinician per day, whereas this was 130 consultations per clinician per day at the start of the influx.

Figure 19: Effectiveness of the Operation



Source: MDRTZ017 LL workshop Analysis, May-June 2016

During multiple key informant interviews and the lessons learnt workshop it was emphasized that a key reason that the provided health and care was not always sufficient, is because TRCS was initially overwhelmed by the influx of refugees in the camp. TRCS had a set-up in the camp to tailor for the health care needs for the Congolese refugees and was not equipped to attend such huge amounts of people. A health partner explains during a KII:

'Things have stabilized now because everyone was initially so stretched. With 60.000 Congolese refugees in the camp things were going fine. But when another 80.000 persons quite suddenly were added, things were strained. There were not enough drugs, long waits, poor follow-ups.'

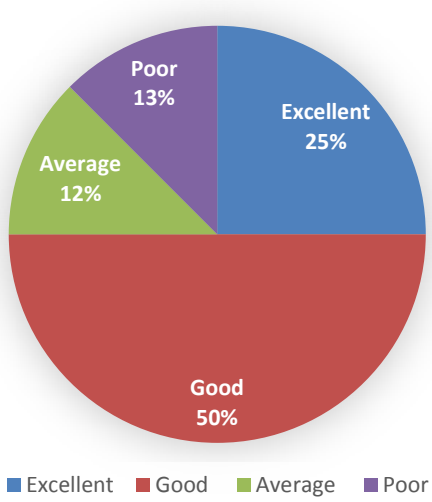
In addition, just before the influx of refugees arrived, the TRCS just like UNHCR had been scaling down, the system was being dismantled, staff numbers had been decreasing/staff were being declared redundant and a lot of materials were not in stock. Materials and man-power needed to be restarted again to tailor for the huge influx. One TRCS staff during a Key Informant Interview emphasized: '*no one had thought of keeping stock for in case an expansion of the refugee population would occur*.'

Others who were less positive emphasized the delays. For example the delays in the renovation of the health post structures and the delayed implementation of other activities. In addition critical remarks were made on the delays due to late arrival of IFRC's technical support such as the health delegates.

2.5 Efficiency

The efficiency of the appeal was identified by reviewing if the planned activities in the Appeal operation maximized the resources that are available and are cost effective.

Figure 20: Efficiency of the Appeal



When discussing the extent the appeal is being managed in an organized and competent way, and if enough NS capacity building was provided, critical remarks were shared.

A major and recurring theme was Human Resource (HR) issues. This included the re-organisation that TRCS is currently under-going. This most definitely influenced the leadership related to the appeal. In addition it was noted that there is a high turnover of staff and that TRCS staff is often either very young (just graduated) or close to retiring.

Source: MDRTZ017 LL workshop Analysis, May-June 2016

Also one of the partners explains their perception during a KII:

> *'I feel TRCS could do more. The biggest gap is budget. (…) But when you come to specifics, it comes to human resource capacity. They are lacking the HR to address many needs. Some of the staff are not well experienced to address the needs. Usually new graduates or people who have just retired are working in the clinics. This last group feel complacent with where they are. Once the newly educated get new opportunities, they leave. The salary structure is not in place.'*

One of the TRCS staff emphasizes during a KII that the quality of services in influenced by the lack of staff:

> *'Thanks to IFRC we have employed many staff. The challenge is the high staff turnover. We recruit them and then they go. It is the package. It is not convincing. This is why things are going 'slowly slowly', because everything goes by funds.'*

The majority of the interview respondents mentioned the living conditions in the Makere compound as a major problem and one of the reasons that staff is leaving:

> *'We have 3 or 4 people sharing one room in the living compound. They are grown up people, they need space. Maybe this is why they are running away,'* (TRCS staff during KII)

Other HR issues mentioned were the lack of sufficient and qualified health staff. Finally management were often felt to be related to insecure funding. One of the TRCS staff emphasizes:

> *'When you first see the IFRC budget it seems a lot. But this is a problem because we do not have a full coverage of the budget. This makes it very difficult.'*

Those who felt that the operation was poor, identified this was based on:

- Complaints from beneficiaries
- Complaints from staff
- Complaints from donor such as ECHO, who were not always satisfied during monitoring visit
- Lack of government supportive TRA
- Import clearance of goods

During the focus group discussions, multiple volunteers and staff expressed that they were happy with the training they received. However, multiple volunteers expressed that they would have liked to have received more training and on-the job coaching. One male volunteer during a FGD states: *'I gained no new skills except tiredness'*.

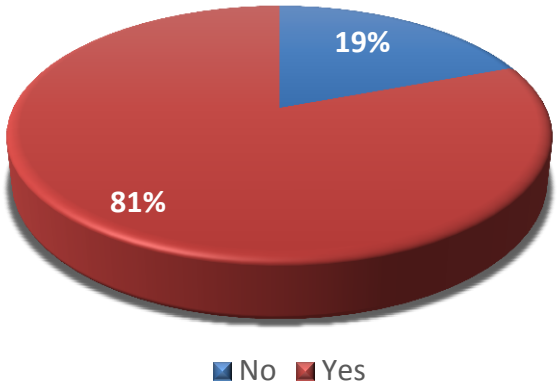
2.6 Coverage

To explore coverage it was mainly questioned to what extent the appeal operation is able to reach the populations/areas most at risk by the crisis?

2.6.1 Beneficiary perception on the coverage of Red Cross

Figure 21: Beneficiaries Perception of Tanzania Red Cross

Through the BSS it was questioned if the beneficiaries had received information about the Red Cross since they arrived in the camp, which was the case for 81% of the respondents (see graph below).



Source: MDRTZ017 BSS Analysis, May-June 2016

Table 5: Source of information about Red Cross

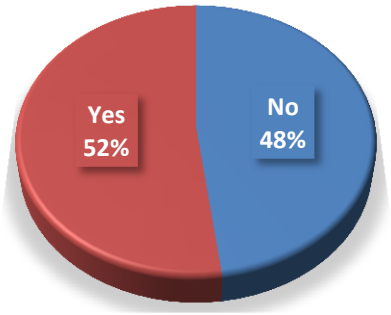
Source of information about Red Cross	
A neighbour	139
A friend	139
Pamphlets/flyers/banners	186
Red Cross Volunteers	396

It was also queried where they had heard about the assistance provided by the Red Cross. The table below shows that the vast majority had heard of the Red Cross through their volunteers.

Source: MDRTZ017 BSS Analysis, May-June 2016

Subsequently it was questioned, if the beneficiaries had been questioned about their needs which was the case for 52%.

Figure 22: Information collected Regarding Needs (N=528)



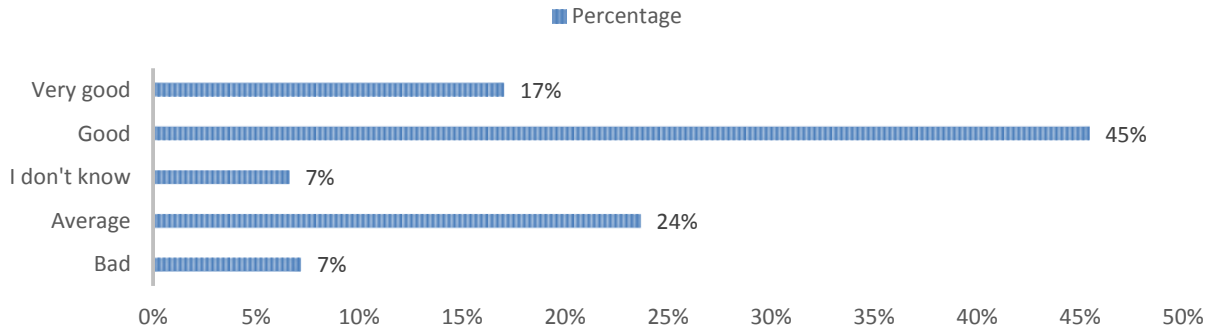
If they were asked about their needs, in total 33% (N=175) of the beneficiaries identified that this was done by the Tanzanian Red Cross Society. Others who asked about their needs were the camp authorities, the government, neighbours and others living in the camp. In total 42% (N=220) of the beneficiaries knew they were selected to receive support and of this group 40% knew why they were selected.

Source: MDRTZ017 BSS Analysis, May-June 2016

In total 30% (N=158) of the beneficiaries identified to have been asked about what assistance they preferred. And 33% (N=172) of the beneficiaries knew when the assistance was going to be provided.

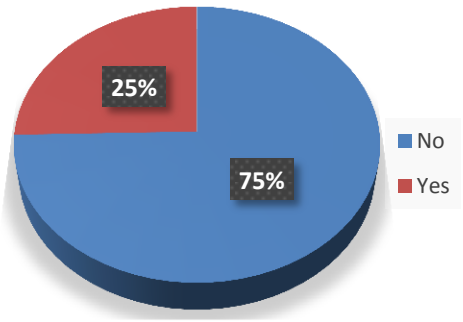
Finally the behaviour of Red Cross staff and volunteers was queried. As visible in the graph below, 45% of the respondents felt that this was good. Although only 7% and often referring to the Health Services provided in Mtendeli, various stories have been reported (i.e. Clinical Health Analysis Report, July 2016), on the breach of the code of conduct by TRCS staff towards their patients.

Figure 23: Perceptions of beneficiaries on behaviour of Red Cross staff and volunteers (N=528)



Source: MDRTZ017 BSS Analysis, May-June 2016

Figure 24: Knowledge on how to make a complaint (N=528)



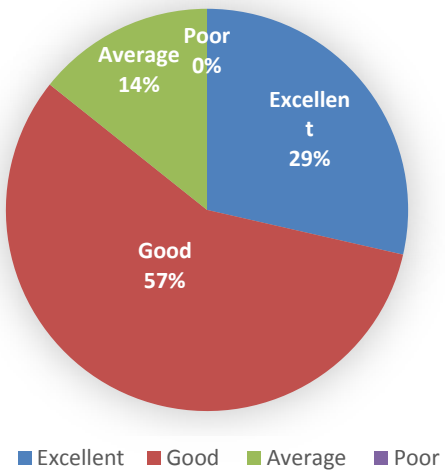
The beneficiaries were also asked if they were aware about how they are able to make a complaint. The vast majority, namely 75% identified to not know.

Source: MDRTZ017 BSS Analysis, May-June 2016

2.6.2 *Partners and TRCS Staff Perception on the Coverage of Red Cross*

Figure 25: Perception of the Coverage of the Appeal

The majority of the TRCS staff and partners (57%) felt that the coverage of the appeal was good. It was emphasized that they reach out to the affected population and in doing so, no distinction is made between the aid provided by the TRCS. Moreover their efforts to target the most vulnerable were acknowledged. Those who felt it was average, emphasized that there are still gaps that need to be addressed to really reach out effectively to the most at risk in terms of additional health post, health information, community outreach etc. During interviews some respondents emphasized that although TRCS is the main health provider together with MSF, more can be done to improve visibility. Moreover, various respondents mentioned that the fact that the camp is hosting both Congolese and Burundi refugees and the Red Cross has staff from Tanzania, Democratic Republic of Congo and Burundi, at times is complicated. This includes language related barriers.



Source: MDRTZ017 LL workshop Analysis, May-June 2016

2.7 Coordination

One of the important roles of the IFRC secretariat is to coordinate the activities of Red Cross Red Crescent partners. In order to measure if this role is fully satisfactory the TRCS/ IFRC internal review team explored the **extent to which coordination is occurring with the key stakeholders during the appeal operation. This also includes visibility and cooperation with other stakeholders.**

Table 6: Organization Support in the Camps

Which Organisations are Providing Support?	
Camp Authorities	135
Government	332
Tanzania Red Cross Society	493

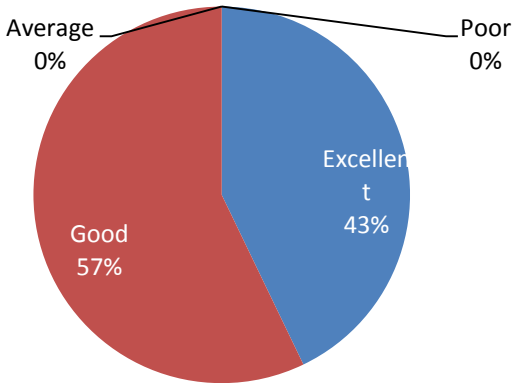
Beneficiaries were asked what organisations are providing support in the camp. The findings are visible in the table below.

Source: MDRTZ017 BSS Analysis, May-June 2016

The vast majority identify the government and TRCS as key actors. Other organizations that were mentioned by a high share of respondents, as being involved with providing emergence services are:

- IRC
- UNHCR
- SAVE THE CHILDREN
- TWESA
- OXFAM
- MSF

Figure 26: Organisations Coordination in the Operation (N=20)



Source: MDRTZ017 LL workshop Analysis, May-June 2016

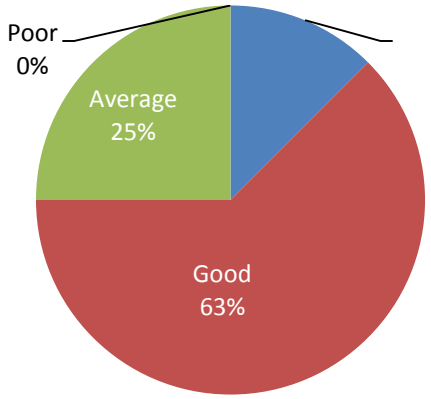
During the lessons learnt workshop, 43% of the TRCS and IFRC staff identified that the coordination was excellent. Reasons mentioned during the LLW were: *'This is because they work closely with partners'* and *'TRCS is very cooperative when it comes to coordination'*. Respondents also emphasized the good participation of TRCS during coordination meetings and that there was often representation of Red Cross during meetings.

57% felt it was good and not excellent and explained that: *'Because for example during handover of Health Post 6 and nutrition programme there was lack of proper communication with UNHCR.*

2.8 Sustainability and connectedness

The main question to be answered in this section was the extent to which the activities planned in the Appeal operation contribute to building the capacity of the NS and the level of sustainability of the interventions.

Figure 27: Sustainability and Connectedness



Source: MDRTZ017 LL workshop Analysis, May-June 2016

As visible in the graph below the majority of the respondents (63%) felt that the sustainability of the operation was good. This was explained to be related to the sustainable skills and training that was provided and which TRCS staff and volunteers is now able to use in the community.

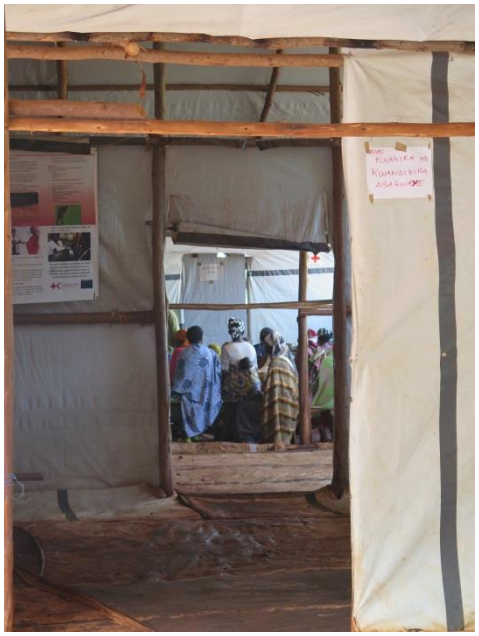
However it was also emphasized that more support is needed to do other activities like:

- Training to staff
- Permanent building
- Community awareness and sensitization i.e. training/meeting/FGD for target

However, in terms of sustainability questions can be posed and it was emphasized during the LLW that 'there is more room for capacity building to ensure sustainability'. During a KII a respondent explains:

'The efforts were initially well meant, but we really need to start thinking to be working more longer term. Only planning for three months is very expensive and not sustainable at all. If we put down buildings and other issues we also need to budget for repairs. Because from where should TRCS get the money to keep on repairing temporary and low quality short term materials and structures that have been put in place? For example the temporary health clinic 5: the ERU built it quickly and for three months, that was great. Now

they are a great expense. We keep on needing to change the floors of health post 5. It is a huge expense which has not been budgeted for. This short-term thinking is not realistic anymore, in a situation that is likely to stay for a long time.'
(TRCS staff during Key Informant Interview)


Picture 3 Floors of Health post5

The room for improvement in terms of sustainability also becomes evident during a KII a TRCS staff member notes: *'IFRC should continue working with TRCS until the refugees go home'* (TRCS staff during KII). Another TRCS staff member notes: '*We are not sure how to continue after IFRC leaves'*.

Chapter 3: Key Lessons Learnt

During the mid-term review, it was explored what the strengths and challenges were of the main services provided including health and care, water/sanitation and hygiene promotion, shelter and household items and finally national society capacity building. Moreover the strengths and challenges of IFRC's operations support were reviewed. The following chapter presents the main findings.

3.1 Key strengths

The following section presents the strengths related to the main appeal outcome areas.

3.1.1 Health and Care

During the interviews and the lessons learnt workshop the main strengths of the health care services and health promotion were discussed. The participants mentioned that the strengths were that although quality is not always as wished, TRCS at least aimed to support holistic health services to the beneficiaries. This includes both preventative and curative services. Moreover, they have made both Burundi and Congolese staff available in their facilities in the camps.

As for the health education and promotion, staff and partners felt that the refugee community have been responding positively to health education and awareness provided by HIT and hygiene promotion. Moreover, HIT members have been able to build their capacities on different aspects on health. Referral system on different health issues from household to health facilities improved and followed-up. For example malnourished children chronically ill patient care of bed-ridden patients Finally, it was identified that early identification/detection of diseases in community level has improved by Health information.

3.1.2 Water, sanitation, and hygiene promotion, shelter and household items

Although the support provided on water, sanitation and hygiene promotion, shelter and household items was less than health care, that following things were felt to have gone well:

- Hygiene promotion with HIT
- The trainings that were provided on the different activities
- Staff and volunteers felt their skills were usable and that the skills have been sustainable.
- Hygiene kits and other NFI's have been well received

- All the WATSAN donations and equipment that has been given, NFI's to work, construction materials have been very valuable.
- Vector control equipment and training went very well.
- In terms of shelter, the set-up of shelter at the boarder went really well. At 7 out of 13 entry points shelters were set up.

3.1.3 National society capacity building

'Thanks to IFRC, I gained an experience that I could not have when I make a comparison with other donors. The support was different. I can now make a Budget Variance Analysis and I am proud of that.' (TRCS finance staff during KII).

As visible in the quote above, in terms of National Society capacity building, numerous staff expressed that they were happy with the various types of training and on the job support which they received. They felt that there had been an increased visibility from government and public and that they support had helped to be able to provide better services. Finally, the majority of the respondents emphasized the hard work the volunteers had been doing. TRCS's good volunteer base with dedication is applauded. Finally it was emphasized that the group of staff are also very dedicated as they are willing to stay in the camp in difficult circumstances.

3.2. Key Challenges

The following section presents the challenges related to the main appeal outcome areas.

3.2.1 Health and Care

When ranking the quality of the health facilities during the LLW, it was identified to be average as it was felt that there is still a lot to be done.

When exploring what the challenges are the following issues were noted:

- Frequently it was emphasized **that funding for the operation is insufficient**

The amount of refugees and their needs for health care are high. All humanitarian actors in this refugee operation are stretched with inadequate funding and a lack of mobilised resources. This has tremendous impacted on TRCS, i.e. on payment of staff salaries, access to adequate materials and maintenance of facilities. The appeal is total of CHF 4,270,197 and only has a coverage of 54%. Due to the funding gap, full implementation of the proposed emergency plan of action is hindered.

- **Health service infrastructure and resources** were not felt to be sufficient

As also mentioned in chapter 2, in various occasions it was emphasized that the operation is underfunded and that there is not sufficient infrastructure, fuel, equipment and materials to work efficiently.

- **Staff welfare was identified to be poor**.

Multiple complaints were put forward in terms of the staff welfare and living conditions. Living quarters are extremely crowded, with staff members sharing tents and having little to no privacy during time off. Showers and latrines are insufficient, (4 latrines for 100 staff members, only 2 stalls for showering), water is not reliable and electricity (from generator) is available only part time. In Nyarugusu, there is no land available for expansion in the existing location; alternative solutions will need to be sought.

- **Drug supplies and drug management**–shortage of drugs.

The TRCS drug management has been challenging and worrisome due to a near break-down of annual medicines supply stocks from UNHCR. Although a request was submitted in July 2015, the UNHCR global supply chain has not been able to provide essential medicines for the first semester of this year and no consignment has been received to date. Although this has mainly been beyond the control of the Red Cross, the implication of this situation is huge. Moreover, there has been critique towards the way in which TRCS is managing their drugs. This has been felt to be problematic and is firstly felt to caused by the lack of well-managed pharmacy facilities. It secondly is felt to be due to TRCS health posts lacking adequate drug management systems, staff lacking skills and the frequent lack of daily consumption reporting and medicines controls. Thirdly it derives from various more operational issues such as limited data collection, limited drug management tools and faulty prescriptions of drugs.

- **HR issues.**

In terms of HR, several issues were highlighted. As mentioned before, respondents identified that there is an inadequate amount of staff. Moreover the staff turnover is high which is also caused by the fact that staff are either fresh from school or often waiting to get government employment, or more senior and nearly about to retire. This last issue makes capacity building activities challenging too.

- It was felt that there were only **few delegates** to support the operation

It was mentioned several times that there were too few IFRC delegates to support the operation. Moreover, it was felt that the delegates that support this operation in the future, should remain for a longer period of time. The short missions were deemed helpful but not sustainable. It was emphasized multiple times that support needs to be more longer term.

- **Breaching of code of conduct**

During the TRCS medical staff has been reported to perform miss conduct to refugees whom seek health services in a few cases. The complaints include verbal and physical harassment. Although not part of the MDRTZ017 operation, there was a case reported by a refugee during the mid-term review about sexual harassment at the hospital. IFRC health team has reported cases to both TRCS and IFRC management; it was followed by continuous advocacy to address the issues. As a result, the respective staff were laid off or replaced from the job.

The challenges that were mentioned related to the health promotion activities were the following:

- Maternal health, child illnesses and communicable diseases are a challenge and that more training is needed on this topic.
- It was felt that there were an inadequate amount of HIT members to cover all the population.
- Language barrier of National leaflets, are created in Swahili instead of Kirundi.
- Lack of transportation to reach the community. The HIT teams need bicycles
- Currently there are no community health committees and more cooperation should happen with community leaders. During campaigns they can play a key role.
- Lack of training to community volunteering groups for example TBA's (Traditional Birth Attendance) and Home Based Care (HBC).

To the question what should be done differently the following was replied:

- More financial and technical support
- Advocacy for better refugees housing, as it can cause illness
- Increase awareness and prevention campaigns.
- International advocacy for Burundian influx. It was not advertised internationally. Middle east and Syria received more attention

The following was suggested in terms of what can be done to improve health and care results?

- Increase the number of delegates for capacity building
  - Specifically improvements could be made in terms of continuity and type of delegates which should include doctors – health practitioners and health experts.
  - Increase program support services related staff – admin, finance, logistics
- Advocacy to UNHCR, IFRC for staff residence/housing and increase of salaries
  - . Improve facilities and move the staff to Ngaraganza compound
- Improve funding by diversifying the donors.
- Renovation of hospital
- In the health posts old medical equipment needs to be replaced
- To address drugs supplies it was suggested to:
  - Increase talks with the government to include TRCS in their program and to allow TRCS passage of drugs at the boarder for this operation. I
  - Increase talks with UNCHR to speed up the process.
  - Advocate to include the refugee program to be included in the National Health program.

3.2.2 Water, sanitation, and hygiene promotion, Shelter and household items

For water, sanitation and hygiene promotion and shelter and household items feedback was limited as a lot of the activities went well and had been completed and handed over. Generally it was felt that people should have received more food and items for cooking upon arrival. In addition, it was felt that more hygiene related items should have and still need to be distributed. Finally, vector control management was a challenge at the time of the influx and was felt to be more under control now.

3.2.3 National society capacity building

In terms of capacity building of the National Society a few issues were raised.

- **Quality and capacity of staff and the delivery of objectives.**

It was felt that more could be done to improve the skills and quality of the staff. As a TRCS staff mentioned in a KII: '*We are delivering but sometimes lacking quality*.' It was identified to be a challenge to find qualified health staff; this was explained in part due to the low salaries offered by the TRCS as well as the poor living conditions provided to staff.

- **Human Resources**

As mentioned previously and in various other assessment reports, HR in HQ and in the branches and the camps is a challenge. Leadership, management and systems, are identified to be a cross-cutting challenge throughout the organization. One of the key reasons for this challenge is that TRCS is currently going through a re-organisation/restructuring.

In a KII a TRCS staff explains: *'Unfortunately TRCS is in transition period. Including government. Most of the procedures have been changed. In the government you can find now someone is new. Permits for example, were very easy. They knew red cross. It would be fast. Now they are changing person, they are not familiar with the procedures. So it has slowed things down. HR has to do permits. Now there is transition. Some are going to retire, so also internally we have changes. Everything is pushed to logistics. Logistics, normally involved in procurement, transportation of materials, welcome support, pick-up people from the airport'*
This implies a general shift of key senior leadership exiting the organisation by the end of this year (2016). These big organizational changes and challenges are having a direct impact on the programs and operations that TRCS is running, including the IFRC operations. Currently 15 of the most senior staff at HQ level as well as in the regions are going to move out (retire) and be replaced. These jobs are currently published in national newspapers.

On a field level (Kigoma and Kasulu/Makere) there are also challenges. Key decision-making staff are over-stretched and working under a lot of pressure. Since the influx started in May 2015, the operation has grown exponentially and there has been as structural lack funding for this emergency. In addition, although numbers have stabilized, the influx and amount of refugees in the camps, is large. Initially the refugee influx was 30,000 in Nyarugusu camp which TRCS was managing well. Now agencies are dealing with 133,110 refugees in three camps (Nyaragusu, Mtendeli and Nduta camp) and are still receiving around 100 refugees on daily basis. [6]

Further HR issues include the recruitment of national staff, their staff well-fare conditions, salary grading which is leading to high staff turnovers. Also, it seems that some key staff is not up to standard and lack RC/RC knowledge leading to breaching of code of conduct. The shuffling of health staff between health service locations and programs, has been noted as a factor contributing to a lack of accountability in the various locations and poor quality of patient care. Other issues that have been noted include the fact that TRCS staff paid by IFRC are lacking contracts, those paid by UNHCR have not been paid, refugees are considered 'volunteers' but at times are in positions higher than Tanzanian staff, individuals often do not show up for their shift or show up late and face no repercussions etc.

Finally it is important to note that TRCS field staff acknowledge short-comings. However, part of the criticism is beyond their control. External factors have also impacted on TRCS's ability to respond adequately and thus been partially beyond their control.

- **Finance**

An assessment on the finance system was performed, to explore what kind of finance development is needed. A new financial system needs to be introduced. Currently TRCS has the software, but the licences fees have not been paid for years. One of the interviewees explains: '*You need to have the system. It's like giving someone driving licences and not the car.'* Once this is in place, this will also be of great benefit to perform the budget variance analysis. Currently, this is done manually by every program manager. However due to lack of software it is often not done because it is a huge amount of work. Finance is not updating the data. In addition there is no compatibility with the IFRC system.

[6]For more statistics on refugee influx see UNHCER: http://data.unhcr.org/burundi/country.php?id=212

3.3 IFRC Operational Support Services

The perceptions of the support that IFRC has provided to TRCS have been dual. On the one hand they have been applauded as the following TRCS staff explains in a KII:

> *'When the influx arrived, I was here and this was the time when IFRC and ERU's arrived. We were very happy. We were very impressed. When we started health post 4, then we felt so proud that we can do something. We put up tents, constructed latrines. It was only temporary, but the people started to know, Red Cross is here on the Burundi side'. (..) The ERU's all worked as men, even the women. We worked very closely'.* (TRCS staff during KII)

The cooperation and coordination was generally good and especially the on the job support and the training that was provided was numerously mentioned as being highly valuable. IFRC was also seen to be a window of opportunity for the TRCS to get increased funds:

> *'Having delegates in the field is good. They help us and they can talk directly to Nairobi and Geneva to get more funds and to get things done*.' (TRCS branch staff during KII)

However, challenges have also been highlighted. During a KII a TRCS staff explains:

> *'When the ERU's left, we thought we would collapse. Especially in health we missed the people. Then when they came again, we worked together again, but the strength was a bit lower. Maybe because of the limited budget. They needed to go and find new funds. Things came slowly, slowly. When I saw they came I thought they would come and do each and everything but there were limited resources'. (TRCS staff during KII)*

Issues that are mainly challenging for IFRC include: HR, funding/finance and a clear strategy/plan on how to move forward with TRCS on this operation. In addition the lack of a strong operation leader to support the IFRC and strategically liaise with TRCS on how to move forward has been missing.

- **Human Resource**

Underlying reasons are HR issues related to IFRC. Although around 4 delegates (an operations manager, a health coordinator, a health delegate, a finance delegate) are based in the field, these positions are not always filled and funded. Recruitment for these positions has proven challenging. Although the ERU missions were highly valued, it was also emphasized that there needs to be more focused on longer term contracts and relationship building. Consistency in IFRC contracts was also raised as an issue of concern. Especially longer term medical, financial, medical logistics staffs and a strategic operations manager were felt to be of most value. Some challenges were also noted concerning the cooperation between some of the delegates and the TRCS.
During a KII one of the staff mentions: *'Sometimes it feels like we are playing cats and rats, IFRC is the cat, chasing TRCS the rats.'* (TRCS staff in KII)

- **Finance & PMER**

The IFRC support through a financial delegate was highly appreciated. Apart from the underfunding of the appeal, several other challenges were mentioned which all cause delays in the flow of funds. Firstly, the flow of funds from Geneva, Nairobi, Dar es Salaam, Kigoma to the camps was seen to be full of bottle necks. During a KII a staff member explains: *'The money needs to go through many different layers and often gets stuck on the way. It goes from Nairobi to Dar es Salaam to Kigoma and only then it goes to Kasulu. This causes many delays.'* At times, delays are also caused due to returns getting stuck or being slowly processed in the IFRC office in Nairobi. Finally, TRCS is on a working advance system which in the beginning was not well understood by the NS. In addition, the budget holder signing process in a mission where staff is geographically so widely spread so has proven challenging. Finally, there is still room for improvement in terms of cooperation between IFRC and TRCS on

planning, monitoring and reporting. There are not enough strong links between the flows of information from the field and HQ/Nairobi level. Also the links between financial and narrative reporting could be improved.

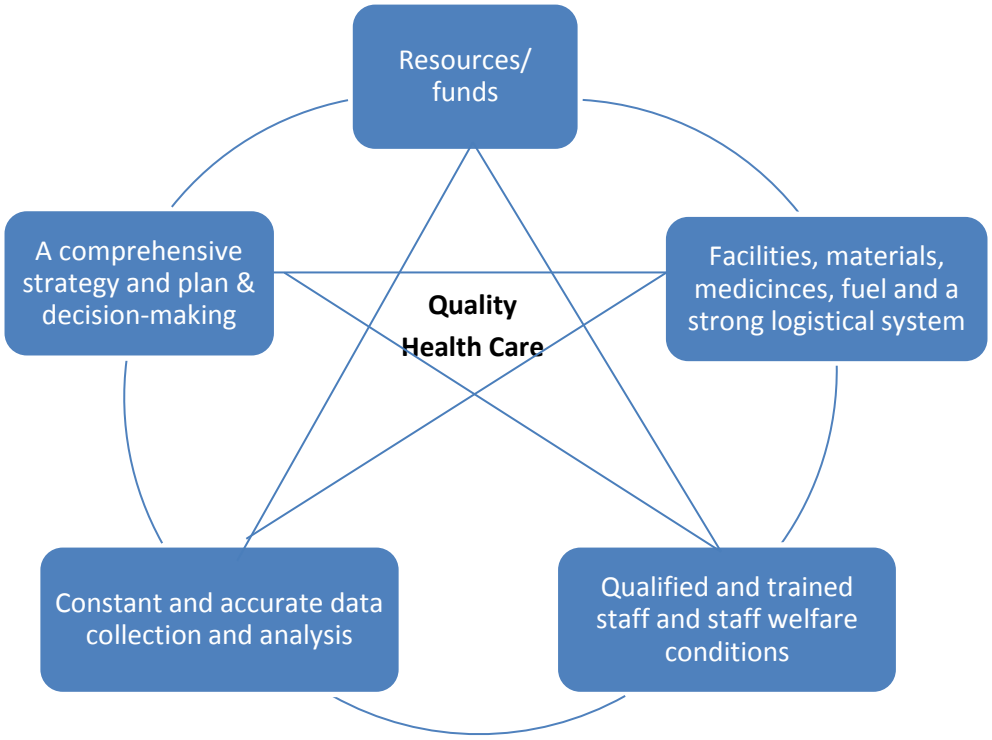
3.4 Summing up the lessons learnt

'If you fail to plan, you plan to fail'. (Red Cross Staff during KII)

The sections and chapters above have made it evident that the quality of the support provided by the TRCS and IFRC has many strengths but that there are also numerous challenges related to the services provided. Especially the main services provided by the TRCS, health care services, has room for improvement.

The analysis shows that the **strengths, weaknesses, opportunities and threats all revolve around several key issues**. Various are short term and others are longer-term organisational development issues. The identified key factors that influence achievements, especially in the field of health and care are (the lack of): **resources/funds** leading to: lack of **facilities/material/fuel** and a **strong logistics/procurement**, lack of **staff and staff welfare conditions**, over-worked staff, a decrease in motivation leading to a decrease in quality health care. Three fundamental issues are the (lack of) a **comprehensive strategy/plan,** (over-stretched) **leadership/decision-making** and the (lack of) constant and accurate **data collection and analysis**.

Figure 28: Key factors influencing quality health care



Source: MDRTZ017 LL workshop Analysis, May-June 2016

Chapter 4: Conclusions and Recommendations

Based on the findings, some key conclusions can be drawn and some recommendations are presented.

4.1 Main conclusions

Based on the review of the effectiveness of the MDRTZ017 operation in terms of meeting the planned objectives and outputs in the EPoA the following can be concluded.

Relevance:
The emergency appeal main focus on health and care suited the priorities of the affected population. However, the findings show that, especially on this outcome area, if more funding would be available, more could be done.

Effectiveness
Although to a certain extent, the appeal operation was able to meet its intended objectives and outputs, especially on health and care, multiple respondents questioned if the care was always in accordance with recognized international standards. The vast majority felt that the quality of the health care was average.

Efficiency:
Although it was assessed fairly positively, the fact that the appeal operation was not always managed in an organized and competent way mainly was explained to be due to lack of funds and enough staff (both from TRCS and IFRC).

Coverage:
Generally it was felt that the appeal operation is able to reach the populations/areas most at risk by the crisis.

Coordination:
Both partners and TRCS staff felt that the cooperation with other key stakeholders was productive and happening on a frequent and constructive manner.

Sustainability & Connectedness
The review showed that more needs to be done to ensure that the outcomes of the operation will be sustained (where relevant); particularly in relation to capacity and learning gained through the interventions (National Society capacity); and that they need to be integrated within contingency planning activities and future new activities being carried out by the TRCS.

The key factors identified as hindering achievements in terms of providing quality health care are: the lack of resources/funds leading to: lack of facilities/fuel/tools, lack of sufficient staff and (quality) staff welfare conditions, leading to over-worked and less motivated staff which has been leading to a decrease in quality care. Having IFRC delegates based at Kigoma level was felt to be beneficial, however longer-term commitment and missions were felt essential for the support of the IFRC to increase the quality and longer-term effectiveness of the operation.

4.2 Recommendations

Based on the successes, challenges, lessons learned from the MDRTZ017 operation review, the following key recommendations are suggested. In addition, a list of outcome specific recommendations were also developed based on the lessons learnt workshop and KII.

This list can be found in annex II.

Based on the review the key recommendations are:

Based on the review the key recommendations are:

1. More emphasis and efforts should be put towards resource mobilization for the appeal/ situation
2. A strong (health) strategy needs to be developed for and with TRCS and the health partners
3. Funds should especially be identified to be able to address the staff welfare conditions, fuel and other key assets. Funds should also be made available to ensure maintenance of infrastructure and equipment/assets.
4. Jointly, TRCS and IFRC should liaise with the government to facilitate operation related logistics such as medicines, import taxes, working permits/visas
5. A strong HR plan and overview needs to be developed and implemented, both for TRCS and IFRC. Preferably and if funding allows, longer-term IFRC delegates are to support the operation.
6. Increased clinical/medical on-the-job support and training needs to be provided and it needs to be ensured that there is a strong PMER system in place. This will allow a clear picture on the patients and care, through accurate collection of data and analysis of the situation.
7. More regular coordination meetings need to be held, during which clarity is provided on the financial situation of the appeal (funding that has been received and funds that have been spent).
8. To prevent delays in implementation, returns need to be processed as fast as possible on all levels (including field, Dar es Salaam and Nairobi).
9. Clarity on the procurement plans and requirements of TRCS systems and IFRC supported appeals and further on the job medical logistics support needs to be provided.
10. Drug procurement, logistics and distribution needs to be tightly managed
11. TRCS and IFRC should maintain close contact and cooperation with UNHCR to ensure the procurement and delivery of drugs is ensured
12. The visibility of volunteers and TRCS staff should be increased, by ensuring TRCS materials are widely available (bibs etc.)
13. Given that health services are the core focus of the appeal and they were rated as being of average quality, increased attention needs to be put on ensuring quality control of the services.
14. Since funds are limited, it is recommended to focus efforts to ensure quality health service is provided.
15. Jointly, TRCS and IFRC should further develop a contingency plan, identify where they will focus their efforts and IFRC should develop an exit strategy.

Annex I Map of Nyarugusu camp

Annex II Outcome specific recommendations

The following recommendations were **provided participants of the review, during the lessons learnt workshop and during interviews**:

Recommendations health and care

- More cooperation should take place with community leaders for information campaigns in the communities.
- Improve health information to the community (refugees) by:
  - Providing enough ICE materials, megaphones, tools to reach out, improved mobility
- Formation of community health committees
  - Use community leaders, use famous people in the community
- Increase funds on capacity building, community messages IEC (Information, Education and communication) in both language's
- Increase incentives workers according the standards.
- Community involvement on Health exhibitions such as AIDS day, malaria
- Community leaders, media, radio, have different groups, women groups, youth groups, departure centres.
- Have a reliable means of transport to carry patients from community
- More donor on health information activities
- Improve Adolescent Sexual Reproductive Health (ASRH) health information
- Strengthen community Behavioural Change and Communication (BCC) on different health aspects

Recommendations on WASH and Shelter

- Need for long-term delegates, especially in WASH
- More NFI's especially esllection.
- Higher volume of the non-food items (6000) and items for the collection of water
- Aqua-tabs, we might need to give more. It is simple and easy for families to use.
- Move from temporary to more permanent structures, latrines and living
- Both at the entry points, at border, move from temporary shelter and permanent building. Same for latrines, check at waterpoint.
- More checks at the water points. Although we do not do that, it would be good to increase
- Expat team to stay longer, especially mass sanitation. The sustainability is not happening because we are lacking adequate staff. Capacity building is not enough. Capacity is still minimal in regard to the incoming refugees.
- Training of trainers. Due to staff turnover, skills should get handed over.
- They have been trained technically
- More on the job training.
- Maintenance and monitoring of what TRCS have put in place
- WASH and health go together is a weakness. We have pushed health but not WASH. Usually they deploy together and longer term.
- Increased resource mobilisation and awareness of the operation here.

Recommendations on NS capacity building

- Improve resource mobilization – increase visibility, increase trust in partners, be able to plan ahead, before disaster happens so we can plan ahead.
  - NS need support to do resources mobilisation.
  - We need to be able to show the public what we have done (narrative and finance)
- Warehouse management, preposition of materials, quality of volunteers (trained)
- Tools/policies development need to be improved. Finance, HR, logistics, audit, management system etc.
- Empowering the people, we need have well trained staff and personnel.

Recommendations on logistics

- Establish strong systems for logistics and improve the link between the field and head quarters to make sure logistic issues run more easily.
- Ensure clarity on the procurement plans and requirements of TRCS systems and IFRC supported appeals
- Have strong monitoring system for stock management in place
- Ensure relevant trainings of field staff in distributions and logistics management.

Recommendations on planning, monitoring evaluation and reporting (PMER)

- A Monitoring and Evaluation plan needs to be developed that is:
  - Realistic
  - Relevant
  - Easy to use
  - Timely
- The tools should be developed in cooperation with TRCS and from the beginning of the operation it should be clear who is responsible for collecting the various types of information.
- There should be strong links between the flows of information from the field and HQ flows
- There should be strong links between financial and narrative reporting