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Emergency Plan of Action Preliminary Final Report

Tanzania: Population Movement

International Federation of Red Cross and Red Crescent Societies

Emergency Appeal	**Operation n° MDRTZ017**
Date of Issue: 27 November 2017	**Glide number: OT-2015-000052-TZA**
Date of disaster: 29 April 2015	
Operation start date: 15 May 2015	**Operation end date: 31 August 2017**
Host National Society: Tanzania Red Cross Society (TRCS)	**Operation budget: CHF 5,213,378** (including CHF 231,380 DREF "start-up" loan)
Number of people affected: 361,411 (of which 242,463 are Burundi Refugees[1] 2 November 2017)	**Number of people assisted:** 250,000 refugees and asylum-seekers plus 25,000 host community members
N° of National Societies involved in the operation: 421 volunteers, and at least 193 staff members.	
N° of other partner organizations involved in the operation: Government of Tanzania, United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), Tanzania Water and Environmental Sanitation (TWESA), International Rescue Committee (IRC), International Organization for Migration (IOM), World Health Organization (WHO), United Nations Population Fund (UNFPA), PLAN International, Catholic Relief Services (CRS), CARITAS, OXFAM, Médecins Sans Frontières (MSF), Danish Refugee Council (DRC) and European Commission (ECHO).	

This is a preliminary report; the final narrative and financial reports will be published on 31 December 2017.

Appeal history

- **April 2015**: Influx of Burundian refugees fleeing pre-election violence start arriving in neighbouring countries.
- **May 2015**: The Government of Tanzania officially requests international support to respond to the humanitarian needs. A 5-member IFRC Field Assessment and Coordination Team (FACT) arrives in Tanzania for 1 month. With 15,000 refugees received in Nyarugusu refugee camp and more than 30,000 refugees reportedly at Kagunga border post, an Emergency Appeal is launched for 1 million Swiss francs to assist 20,000 people, including 231,389 Swiss francs from the IFRC's Disaster Relief Emergency Fund (DREF) as start-up funding.
- **May 2015:** Mass Sanitation Module (Austrian and Swedish Red Cross) and Basic Health Care (Spanish Red Cross) Emergency Response Units are deployed.
- **June 2015**: Revised Emergency Appeal (n° 1) issued for 2 million Swiss francs for a total of 90,000 people.
- **October 2015:** Locations identified for new camps to address overcrowding in the Nyarugusu camp. The TRCS is requested by UNCHR to expand its services into the new Mtendeli camp.
- **January 2016:** IFRC deploys a Head of Emergency Operations (HEOps) as surge support to provide strategic and operational leadership and issued a revised Appeal (n° 2) for 5,245,197 Swiss francs for 250,000 people.
- **April – May 2016:** 232,315 people fled Burundi, with 126,702 refugees registered in Tanzania. Revised Appeal issued for 5,213,378 Swiss francs for 250,000 people and the Appeal timeframe extended to August 2017.
- **July 2016 –** Mid-term review report is published.

A. Situation analysis

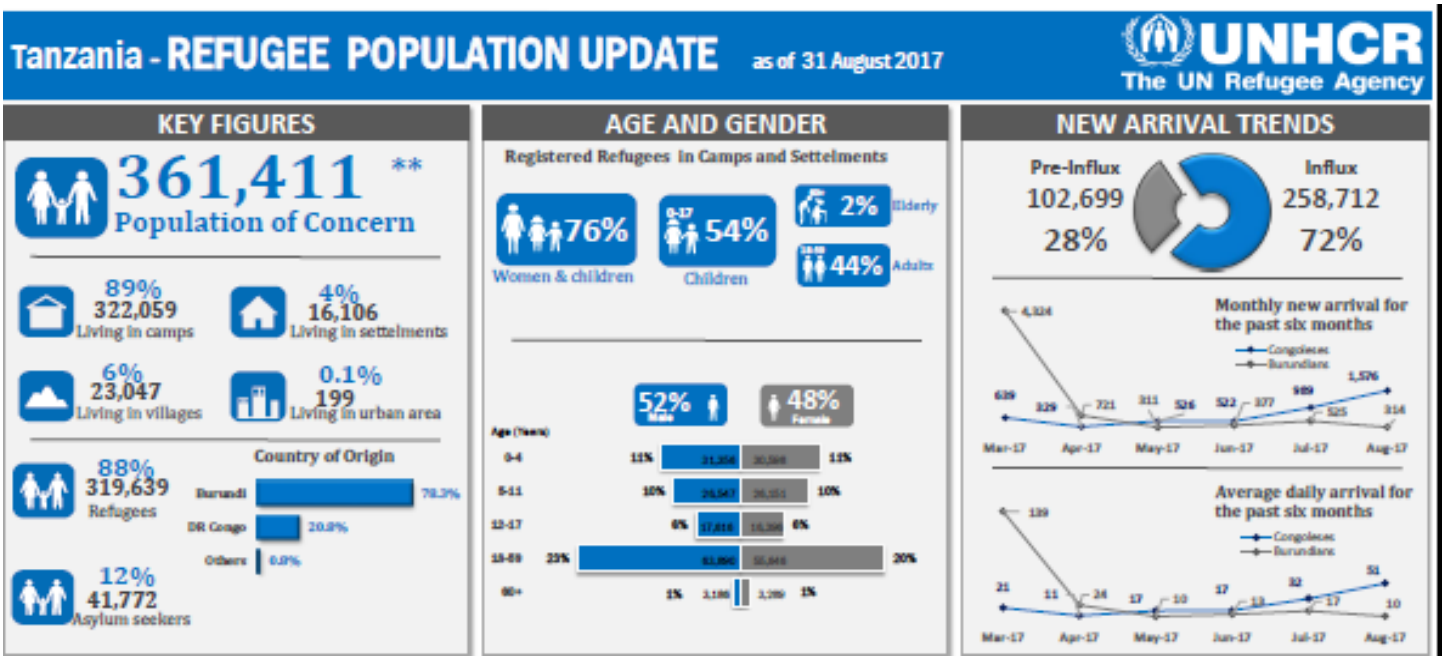
Description of the disaster

Since late April 2015, there has been on-going violence in Burundi, resulting in a number of casualties in the capital of Bujumbura and a huge population movement. Over 410,940 people[2] have sought refuge in neighbouring countries,

[1] UNHCR, 2 November 2017,

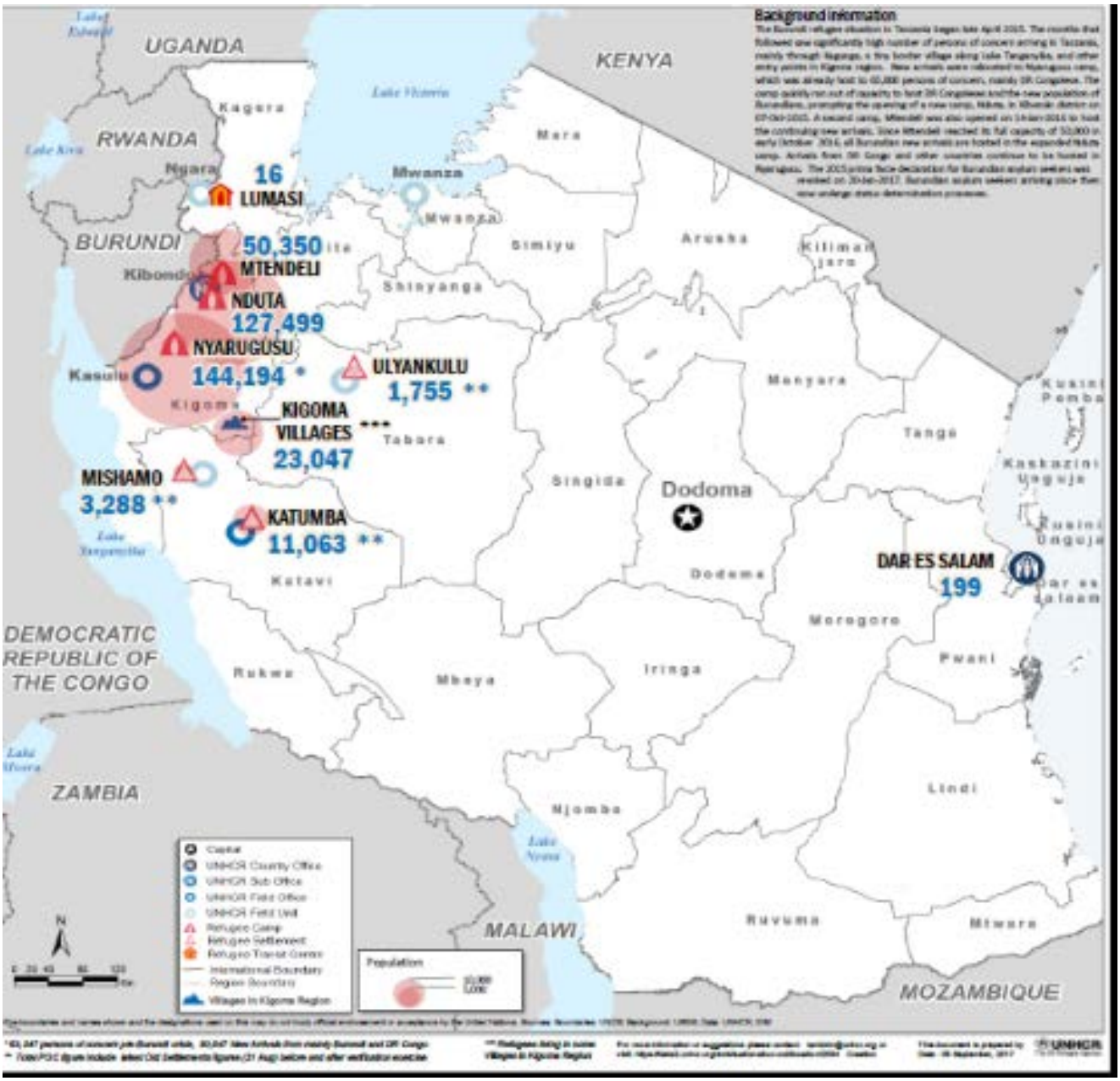
[2] https://data2.unhcr.org/en/situations/burundi
http://reliefweb.int/report/united-republic-tanzania/over-300000-burundians-have-fled-stretched-neighbouring-countries

including the Democratic Republic of the Congo, Rwanda, Tanzania, Uganda and Zambia (United Nations High Commissioner for Refugees (UNHCR, 31 October 2017). As of November 2017, 361,411 people have settled in Tanzania. [3] As visible in the refugee population update below, in Tanzania, the majority of the refugees are living in camps and are women and children. On the other hand, of the overall population, 52% is male.



Tanzania Refugee Population Update UNHCR 2017

[3] https://data2.unhcr.org/en/situations/burundi



Following the influx of Burundi refugees in April 2015, the Nyarugusu camp (Kigoma province), which was initially built in 1997 for Congolese refugees, is now rated the third largest refugee settlement in the world. Next to Nyarugusu camp, the Government of Tanzania (GoT) set up two locations for camps to address the situation, and accommodate the Burundi refugees.

As at 30 September 2017, in Mtendeli there are 50,350 refugees, and in Nduta there are 127,499. All camps are currently significantly overstretched with several thousand refugees housed in mass shelters. Tanzania continues to witness arrivals of refugees.
Throughout the whole period of the emergency appeal, the influx of refugees continued and the camps were and still receiving refugees. TRCS manages four entry points in Ngara district and one transit centre. At the transit centre TRCS has 2 health staff (one nurse and one clinical officer) who provide basic health care. In case of any medical complications, the patients are referred to Ngara district hospital. The work of TRCS and IFRC has predominantly supported refugees in Nyarugusu and Mtendeli.

Nyarugusu camp was opened in November 1996 to host Persons of Concern fleeing conflicts in DRC. Prior to April 2015, the camp hosted 65,000 DRC and 2,400 Burundian Persons of Concern. 84,961 Burundians arrived between April and October 2015 were being hosted in Nyarugusu before relocation of close to 40,000 Burundian refugees to Nduta and Mtendeli between October 2015 and February 2016 respectively. The camp continues to receive Asylum Seekers mainly from DRC, amidst a resettlement process that is mainly targeting Congolese who arrived in Tanzania between 1994 and 2005. Population figures of these camps, as of 30 September 2017 (UNHCR) for Nyarugusu are:

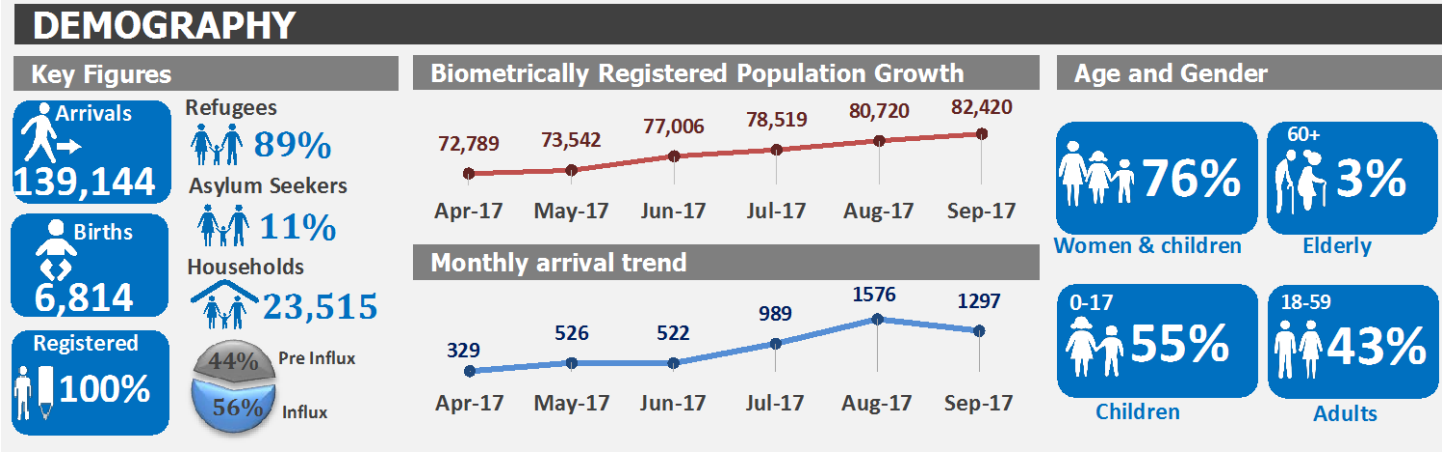


Figure 1: Demographic data Nyarugusu camp (30 September 2017 UNCHR) https://goo.gl/hkGaUK

Mtendeli camp was opened on 14 January 2016, as an emergency response to receive 40,000 Burundian Refugees relocated from Nyarugusu camp to Nduta and Mtendeli. The camp suspended relocation for short time early February 2016 due to land issue and water shortage then resumed on 8th April 2016 to stopped again in May to receive new arrivals. The camp ceased to receive new arrivals from Burundi on 3 October 2016, when the population reached 50,000 individuals. The camp is now on care and maintenance phase and water shortage remain an issue while 80% of the population is still leaving in emergency shelters.

For Mtendeli camp, the figures are currently as follows:

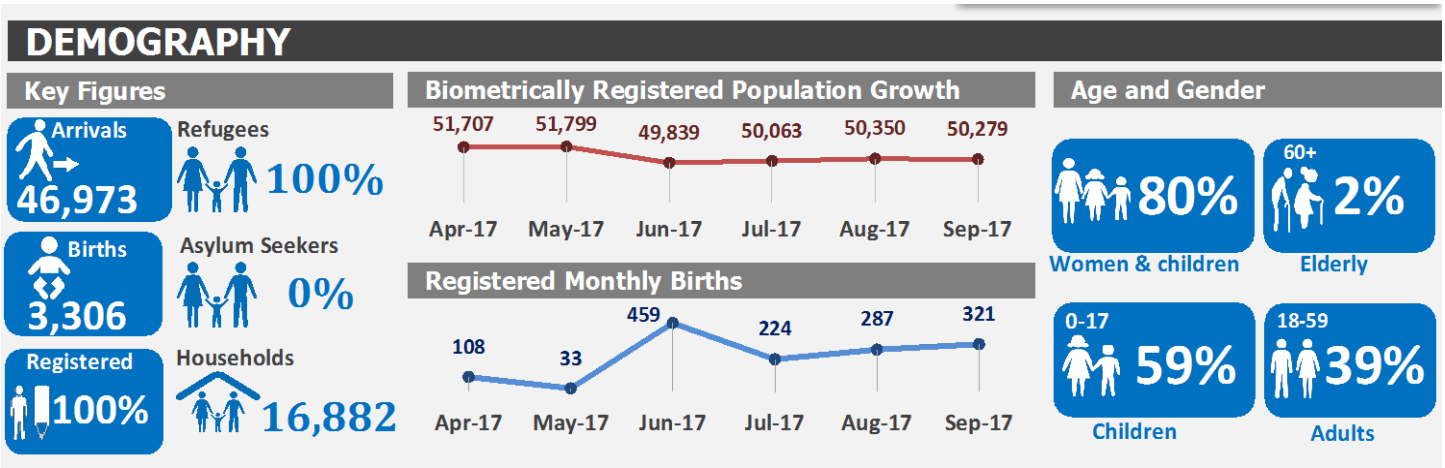


Figure 2: Demographic data Mtendeli camp (30 September 2017) https://goo.gl/55n4tY

The IFRC, on behalf of the Tanzania Red Cross Society would like to extend gratitude to the Austrian Red Cross, American Red Cross, British Red Cross, Canadian Red Cross (Canadian Government), Finnish Red Cross, China Red Cross - Hong Kong Red Cross, European Commission - DG ECHO, Finnish Red Cross, Finnish Government, Japanese Red Cross Society, Norwegian Red Cross, Red Cross of Monaco, Swedish Red Cross, Spanish Red Cross, Swiss Red Cross (Swiss Government), the Netherlands Red Cross (Netherlands Government), the United States Government (PRM) for their generous financial and in kind contributions to this operation.

Summary of response

Overview of Host National Society

Since 1993, Tanzania has been host to hundreds of thousands of refugees from Great Lakes countries including Rwandese, Burundian and Congolese refugees. Following the influx of Burundi nationals into Tanzania, the TRCS, which has been supporting the Congolese refugee population in the Nyarugusu camp for over 10 years, scaled up the assistance, specifically the provision of comprehensive health (preventive and curative). TRCS staff and volunteers in Nyarugusu, and Mtendeli camps have been assisting the arriving refugees by providing lifesaving interventions including: - first aid; medical screening for all new arrivals (immunization, treatment of common communicable diseases, and screening for malnutrition); and health education through the Health Information Team (HIT), particularly on prevention of communicable diseases).

In Nyarugusu camp, the TRCS is running eight Health Post facilities and the main dispensary. In Mtendeli, TRCS provides health services in the only health facility. The services are complemented by a Health Information Team (HIT), running health and hygiene promotion activities and disease surveillance in all zones in Mtendeli and Nyarugusu. The HIT passes messages through role play and direct communication on symptoms, prevention and control of various communicable diseases such malaria, cholera, diarrhoea, etc. Messages depend on the current campaign and the health surveillance data.

Following the launch of the MDRTZ017 Tanzania Population Movement EA in May 2015 a lot was accomplished. For updates please see operations update 1-4. Some of the examples of what has been achieved:

- Construction of Health Posts in the Zone 8 (Health Post 4) and Zone 9 (Health Post 5) to provide health and care services to the Burundian population;
- Renovated Health Post 4 (HP4) and 5 (HP5);
- Upgrading and construction in Health Post 4 has resulted in the conversion of a previously tented facility to an in-patient facility with brick & mortar buildings for OPD, a multi-function hall and office block, 2 paediatric wards, 1 male ward, 1 female ward, 1 maternity ward with 2 delivery suites, 24hr power from 2 generators, covered walkway between in-patient wards, separation fence between OPD & IPD areas, improved water storage and drainage, a waste disposal area with incinerator, placenta pit and waste pit, OPD patient toilets and a mortuary. The pharmacy, kitchen and washing area remain as temporary, wood & tarpaulin structures;
- Training of volunteers and staff in health and communicable diseases;
- Recruitment of TRCS (health, data, finance, logistics, team leaders) and IFRC staff (Health, Finance, operations manager & Logistician Delegates, FACT, ERU's and HEOps);
- Continuous monitoring and supervision from the IFRC EA-IOI office and TRCS on the evolving situation;
- Construction of Sanitation facilities with the ERU deployed at the onset of the operation;
- Construction of temporary shelters and latrines at 13 entry points;
- Provision of first Aid Services at the entry points;
- Deployment of FACT and HEOPS, which informed the development of the appeal and revision and activation of the ERU. Deployment of Head of emergency of Operations (HEOps) in January 2016 provided strategic guidance to the operation;
- Social mobilization and campaign activities e.g. malaria, measles vaccination, deworming;
- Taken over the MSF mobile clinic in Zone 12 to provide health care services and turn it into Health Post 6
- Taken over the MSF nutrition centre for severely malnourished children;
- Trained HIT to support hygiene promotions efforts in the communities and trained relevant HIT in surveillance;
- Participated in the vaccination, deworming and vitamins A campaigns (twice a year in June and December);
- Participated in the Emergency preparations contingency plan in case of outbreak lead by UNHCR; other key actors include UNICEF, WHO and the Government of Tanzania MoH.

Overview of Red Cross Red Crescent Movement in country

The International Federation of Red Cross and Red Crescent Societies (IFRC) have provided assistance through its East Africa and Indian Ocean Islands (EAIOI) country cluster and the Africa regional office, which are both based in Nairobi, Kenya, and through an IFRC Operations Manager, Health Delegates, a logistics delegate and a finance delegate based in the Kigoma region.

Figure 3: Red Cross staff with patient (credits IFRC)

IFRC is and has been working alongside TRCS to predominantly be able to cope with the emergency health needs of the Nyarugusu people and to lesser extent supported TRCS in their activities in Mtendeli. The main reason for less focus was that at the time, more resources were needed to ensure quality health service provision. IFRC special link with TRCS provides the necessary collaborative structure to better manage an increasing number of consultations, drug management, consumption analysis and ordering, clinical care, staffing and training, which are all essential components of a strong and reliable health care system.

For a detailed overview of the support IFRC provided, please see Operations Update 1[4], Operations Update 2[5], Operations Update 3[6] and Operations Update 4[7] and the various revisions of the appeal. In short some of the key actions that were taken:

- On 13 May 2015, a FACT alert was published to deploy a team to carry out more detailed assessments and develop a comprehensive Emergency Plan of Action (EPoA). A second rotation FACT team leader arrived in mid-June.
- On 28 May 2015 – October 2015, a Mass Sanitation Module (MSM) ERU (Emergency Response Unit) started working in coordination with the Spanish Red Cross on water and sanitation in Nyarugusu camp. Spanish Red Cross also prepositioned a Watsan Kit 2.
- Mid-November – June 2016 individual personnel from Health Emergency Response Unit (ERU) rosters from various Red Cross (Finnish, Canadian and British) have been deployed
- January 2016, an IFRC Head of Emergency Operations (HEOps) was deployed for one month to provide strategic leadership of the IFRC operations in Tanzania
- January 2016: A Health Delegate was deployed for one week to support the TRCS in assessment of the health activities in Nyarugusu and Mtendeli camps.
- February 2016, the TRCS with the support of the ICRC increased the capacity of the volunteers responding at entry points by an additional 22 volunteers who were trained in first aid and psycho-social support.
- February 2016, a joint communication mission was performed, between TRCS, IFRC and the American Red Cross.

[4] http://adore.ifrc.org/Download.aspx?FileId=86667
[5] http://adore.ifrc.org/Download.aspx?FileId=91154
[6] http://adore.ifrc.org/Download.aspx?FileId=112121
[7] http://adore.ifrc.org/Download.aspx?FileId=131439

- April – November 2016, Canadian Red Cross and Finish Red Cross deployed nurses to support in capacity building and setting up the Emergency health kit and drugs that they sent to the field in April/May 2016.
- June 2016 – A clinical health assessment was performed on the quality of the health services
- September 2016 - A joint planning meeting was held to identify a joint plan of action.
- January 2017 – Finalization of remaining budget, reallocations for additional activities for the last 6 months
- March 2017 – Procurement of 2nd generator for Health Post 4, enabling 24hr power for inpatient wards, OPD, Pharmacy and Laboratory
- April 2017 – Construction commences of covered walkways at Main Dispensary and Health Post 4
- May 2017 – All clinical colleagues issued standardised staff uniforms, as per Ministry of Health guidelines
- June 2017 – Final review

ICRC is and has been supporting the TRCS to heighten its Restoration of Family Links (RFL) and First Aid response. With the support of ICRC, TRCS is providing RFL services including "safe and well" phone calls in Nyarugusu, Mtendeli and Nduta camps.

Spanish Red Cross in collaboration with TRCS started a community health project in the host community which will run for 3 years and started in 2016. The project focuses on capacity building for Laboratory staff in 3 dispensaries: Kasulu District Hospital, Kiganamo HC and Makere Health Centre. American Red Cross were supporting the TRCS in Nyarugusu camp for the last 12 years. The American Red Cross has handed over its supported activities in Mtendeli and Nyarugusu to TRCS and IFRC, with previous activities funded by the US Bureau of Population, Refugees, and Migration (BPRM) as a main donor.

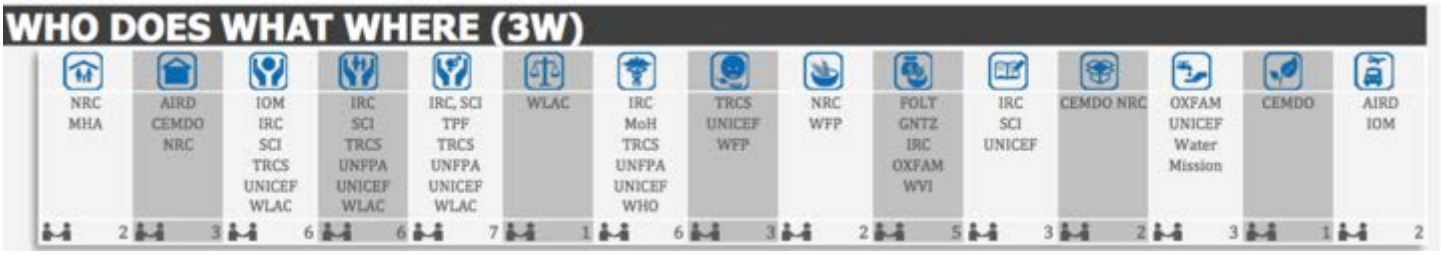
Overview of non-RCRC actors in country

The Government of Tanzania (GoT) through the Ministry of Home Affairs (MHA) and UNCHR are coordinating the influx of refugees. TRCS Staff and volunteers in the camp collaborate with various health agencies, e.g. MSF or UNHCR and TRCS staff attend coordination meetings in health, shelter and WASH sectors. TRCS field staff are in regular contact with the TRCS disaster management department at the national headquarters (NHQ) to provide situation updates. For more details on actors, please see the last revised emergency appeal document. In the summary, the agencies involved in the response are the following:

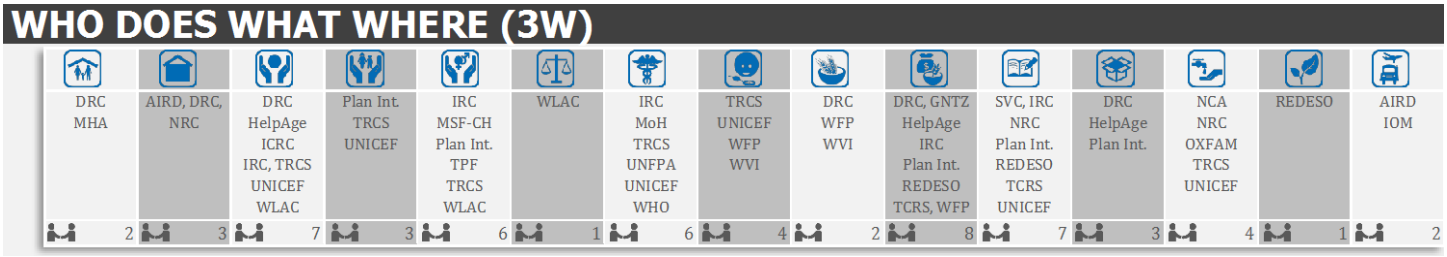
Table 1: Summary of agencies involved in the response

Partner	Sector	Area of focus
Médecins Sans Frontières (MSF) Swiss	Health and Psychosocial support	Three mobile clinics in the Nyarugusu camp as well as support to TRCS paediatrics' ward. Lead medical agency at NDUTA with full services.
International Rescue Committee (IRC)	Maternity services/Protection	Antenatal, postnatal and SGBV psychosocial care. Community services (protection and education)
UNHCR	Health	Provides drugs/medical supplies to the clinics. Supports medical and operational staff costs. Provides Technical support. Shelter Protection
UNICEF	Nutrition/ Child health	Supports in capacity building of Staff in data management and vaccination campaigns and health campaigns
UNFPA	Reproductive health	Maternal child care and capacity building for reproductive medical staff. Provides equipment that relate to maternal care.
WFP	Nutrition	Food and supplementary feeding
World Vision	Nutrition	Food distribution. Management of Moderate Malnutrition.
IOM	Migration	Provides logistics support to reallocated and settlement of refugees
TWESA and OXFAM	Water and sanitation	Provides water to the refugee population.
Community Environmental Management and Development Organisation (CEMDO	Environmental	Environmental concerns in the camps in coordination with UNHCR

The following overview of UNHCR shows the key actors per sector in the Nyarugusu (September 2017), https://goo.gl/hkGaUK



The following overview of UNHCR shows the key actors per sector in the Mtendeli (September 2017), https://goo.gl/55n4tY



Needs analysis and scenario planning

Risk Assessment
The major risk foreseen was the potential for an abrupt upsurge in the number of arriving refugees due to the unstable situation in Burundi and the Democratic Republic of Congo. This increase could overwhelm the on-going humanitarian assistance and lead to a deterioration in the security situation in the camps. UNHCR and other Humanitarian agencies on the ground have hold preparedness meetings to prepare contingency plans for the repatriation of the refugees.
(https://data2.unhcr.org/en/documents/download/60307)

In short:

- Total of 1,630 individuals assisted to repatriate voluntarily
- 104 (6%) of total were persons with specific needs
- 4 return convoys (26 & 28 September and 3 & 5 October)
- Areas of return: Karuzi, Kirundo, and Ngozi provinces

As an ongoing concern, the GoT is keen to ensure that the security situation at all entry points and reception centres is calm, under control out of the population in the camps.

Outbreaks of communicable diseases have been highly likely due to overcrowding if timely preventive measures are not put in place. Cholera always remains a high risk due to the ongoing outbreak in some parts of the country. There has therefore been a need to ensure a strong epidemiological surveillance including capacity building of TRCS volunteers and staff as well as reviewing epidemics preparedness and response plans which the UNHCR and other health actors are doing.

Mitigation strategies have been founded on ensuring clear communication and information sharing, as well as mutual support and partnership, between TRCS, IFRC, UNHCR and other health actors in the wider operation. Contingency plans for communicate disease outbreaks are kept valid and up to date, with isolation areas, triage and monitoring actions agreed and in place.

Additional risks have arisen from clinical concerns regarding the availability of medicine and medical supplies, IFRC have supported the procurement of emergency stocks of medicine and supplies, however the responsibility for providing WHO Essential Medicine and agreed essential medical supplies lay with UNHCR, who have the mandate to ensure adequate supply to all health facilities in Nyarugusu and Mtendeli Camps. TRCS provide weekly stock updates and medical requisitions to UNHCR, based on consumption and forecast data.

B. Operational strategy and plan

Overall Objective

Immediate survival and basic health care needs of 250,000 Burundian refugee population are met through the provision of essential emergency health.

Proposed strategy

The emergency appeal continuously incorporated the recommendations from assessments carried out by the International Federation of the Red Cross (IFRC) and Tanzania Red Cross Society (TRCS). To ensure quality support to TRCS to provide emergency health care services in Nyarugusu camp, was a core focus of the emergency appeal operation. Moreover, thanks to the support of PRM, the operation incorporated the main dispensary of Nyarugusu camp. IFRC and TRCS have received a new round of funding from the PRM and is currently identifying suitable partners to hand-over the appeal activities.

Update on health situation

As at October 2017 for Nyarugusu Camp:

An Active Surveillance system set up by WHO and the Ministry of Health is in place and functioning well. No eruption of epidemic diseases observed such as cholera, meningitis, yellow fever, fever rash illness or neonatal tetanus. Also, no outbreak of potential epidemic disease in Kigoma region.

OPD Burundian October 2017

Months	**August 2017**		**Sept 2017**		**Oct 2017**	
	Total	< 5 yrs	Total	< 5 yrs	Total	<5yrs
Consultations	11,921	2,084	10,790	4,143	1,1627	3,325
Morbidity	15,450	2,966	13,771	5,288	14,122	5,986

OPD Host community October 2017

Months	**August 2017**		**Sept 2017**		**October 2017**	
	Total	< 5yrs	Total	< 5yrs	Total	< 5 yrs
Consultations	1,295	518	946	405	1,141	468
Morbidity	1,865	829	1,381	591	1,833	815

Common causes of OPD Morbidity for Burundian Refugees as % of total morbidity October 2017

Nyarugusu Camp	**Nyarugusu**		
Month	August 2017	September 2017	**October 2017**
Total morbidity	15,450	13,771	**11,627**
% of total pop. /day	0.06%	0.05%	**0.47%**
Confirmed Malaria	3135	3,033	4,017
% of morbidity	20.2%	22%	34.%
URTI	2781	2,358	2,310
% of morbidity	18%	17%	19.8%
LRTI	1729	1729	1,658
% of morbidity	11.1%	13%	14.2
Skin diseases	545	547	228
% of morbidity	3.52%	3.53%	1.9%
Eye disease	250	117	88
% of morbidity	1.6%	0.74%	0.75%
Dental conditions	67	45	55
% of morbidity	0.43%	0.28%	0.47%
Intestinal worms	980	640	621
% of morbidity	6.34%	4.1%	5.3%
Watery diarrhoea	669	411	332

% of morbidity	4.3%	2.6%	2.8%
Blood Diarrhoea	19	24	25
% of morbidity	0.12%	0.15%	0.2%
Tuberculosis	0	0	0
0% of morbidity	0%	0%	0%
AFP/Polio	0	0	0
% of morbidity	0%	0%	0%
Measles	0	0	0
% of morbidity	0%	0%	0%
Meningitis	0	0	0
% of morbidity	0%	0%	0%
HIV/AIDS	0	0	0
% of morbidity	0%	0%	0%
STI(non-HIV/AIDS)	32	17	33
% of morbidity	0.20%	0.10%	0.28%
Acute malnutrition	1	0	7
% of morbidity	0.06%	0%	0.06%
Anaemia	44	27	24
% of morbidity	0.28%	0.17%	0.20%
Chronic diseases	26	19	17
% of morbidity	0.16%	0.11%	0.14%
Injuries	83	32	38
% of morbidity	0.53%	0.20%	0.32%
Schistosomiasis	41	33	21
% of Morbidity	0.26%	0.20%	0.18%
UTI	1508	1469	1473
% of morbidity	9.7%	9.4%	12.6%
Gastritis	522	466	382
% of morbidity	3.3%	2.9%	3.2%
Others	2992	2750	2755
% of morbidity	19.3%	17.7%	23.6%

Burundian caseload malaria was the leading cause of OPD morbidity by 40.3% followed by URTI by 10.9%. HITs will distribute LLITN according to national policy that is 1net/2 person.

Based on this, the strategy of the Revised EA includes the following objectives/activities:

Health and care
The IFRC Health Delegates have been supporting the capacity building and conduct daily coaching of clinical staff for instance examination, diagnosis and treatment skill, patient (admin-record) management, medicine management.

Figure 4: The Red Cross health care facility in Nyragusu (source IFRC)

Health facilities

- In total, the appeal supported 120 TRCS staff in health facilities in Nyarugusu Camp
- Management of Health Posts (HPs) in the Nyarugusu camp –HP 4 and 5 and 6 are and have been supported through the EA with other partners supporting the National Society with the running of the remaining HPs. Given the increasing caseload that is being received at these facilities, the structures in HP 4 will be now extended (from temporary to semi-permanent structures) and HP 6 (which has been established). Basic Health Care activities provided from these structures comprised both the management of existing illness and injuries, as well as prevention of further disease spread and violence. Basic outpatient clinic services, maternal-child health (including uncomplicated deliveries), community health outreach, immunization and nutritional and epidemiological surveillance to support strengthening of health information and surveillance systems, standardized tools will be developed and instruments, and which are essential components of the information building blocks.
- Following the health assessment report (Jan 2016), capacity building of staff and volunteers stationed at the structures in both the Mtendeli and Nyarugusu camps, which was initiated with the support of the Basic Heath Care ERU as well as IFRC Health Delegates, and was continued to ensure the delivery of quality health services to meet the sphere standards. It included the training of staff and volunteers on: clinical treatment guidelines and drug management, trainings of volunteers as Health Information Teams (HIT), on epidemiological surveillance, prevention and health education messages, IPC and management of fever cases, Community and clinical Integrated management of child illness
- As per the recommendations of the health assessments, the infection prevention and control measures were taken up and staff will be trained on the steps. The steps were displayed in the IPC rooms. In addition, strengthening the health systems remained a key priority.
- Efforts were done to strengthen the data management and reporting system, to include facility based data: from censuses, household surveys, civil registration data, public health, surveillance, medical records, data on health services and health system resources. On a weekly basis, the HIS were analysed interpreted and reported highlighting trends as well as documenting progress and best practices. This is done by trained data clerks, this is also done with the support of UNICEF.
- The case history of patients will be documented through the outpatient books and in-patient cards. This will enable the clinical officers trace the treatment management

Figure 5: An inpatient ward at Health Post 4 in Nyarugusu Camp Zone 8 (source IFRC)

Figure 6: The new Incinerator, Waste Pit, Placenta Pit at Health Post 4, TRCS facility (source IFRC)

Social Mobilization

- TRCS staff (both Tanzanians and members of the refugee population) were stationed at the HPs and equipped with items such as boots, IDs, jackets, rain coats, scrubs and uniforms. Procurement and distribution of items required for the running of the HPs will also be carried out, e.g. medical equipment, cleaning consumables, stationery, etc.
- All the volunteers were equipped with items, such as bibs, boots, rain coats, as well as megaphones. Following the trainings, the volunteers were mobilized to conduct social mobilization and health education, including on hygiene and sanitation practices, immunisation, HIV/reproductive health supplementary feeding, and sexual and gender based violence (SGBV).
- In addition, the HIT volunteers carried out epidemic surveillance through a task force which includes the MoH, TRCS, UNHCR, and other health actors on ground. Beneficiary communication and disaster risk reduction activities will be streamlined throughout to improve social mobilization activities. This team worked with MSF health Education team in Nyarugusu camp.
- Vaccination campaigns for polio and measles were carried out in coordination with local government, MoH, and UNICEF working with vulnerable groups (children under 5 years).
- TRCS/IFRC continued to train Health Information Team (HIT) on different communicable diseases including yellow fever. The trained HIT will conduct health promotion and education to refugees through household visit and community gathering/meeting.

Figure 7: TRCS capacity strengthening through training (Source IFRC)

National Society capacity building / Disaster Preparedness

TRCS plays its auxiliary role to the government during emergencies. It was paramount to support TRCS in areas particularly pertaining to its volunteer management, as well as enhancing the capacity of its Health and Finance programmes. These actions will ensure the sustainability of TRCS Human Resources and increase its efficacy to prepare and respond to emergencies and to promote quality implementation of ongoing activities. This can be achieved through training and mentoring programs, in addition to financial support to newly recruited staff to help guarantee the quality of the operation.

TRCS will continue to strengthen the health systems and routine health information system through data collection, analysis for programme improvement, as this is essential for the provision of quality services in the camp. Surveillance of malaria, diarrheal and other preventable diseases both by clinical and community based surveillance will continue to minimize risks of outbreaks.

TRCS will guide in the development of an epidemic preparedness and response plan clearly outlining the case definition, early warning and response mechanism in case of an outbreak in addition to stock piling of essential drugs and supplies. Health information systems will be strengthened to ensure close monitoring/surveillance as well capacity building of HIT staff. TRCS will identify spots that will serve as cholera treatment centres and oral rehydration posts set up in case of outbreaks.

TRCS will continue to improve the living conditions for the staff in the camps. They plan - funding dependant – to connect to national grid electricity, improve water supply in all locations, and improve accommodation through construction of additional houses for health staff in both camps.

TRCS will continue to provide psychosocial training, Code of Conduct and Sphere standards for all staff engaged in the refugee program in both locations. This will contribute to better understanding of Red Cross Ethics and indicators and well as staff wellbeing.

IFRC will support the TRCS in strategic thinking and planning as per the (HEOps report Jan 2016) recommendation below:

- Develop a joint Resource Mobilization plan (including a strong communication and advocacy plan) for the crisis to support to ensure the support for human, material and financial resourcing as well as structure.
- Support the Tanzania Red Cross prepare for a possible protracted refugees situation and the long-term humanitarian consequences with the best support possible from the Red Cross Movement.

Repatriation of the refugees back to Burundi
The appeal was aligned with the 3 pillars identify in Tunis meeting related to migration: response, protection and advocacy.
In view of the appeal guidelines, TRCS and IFRC planned to move the emergency response operation to a longer-term, development focus programme. This has been achieved through the follow-on operation, setup as a DOP with PRM funds with a plan to move in 2018 to a PNS-supported programme.

Operational support services

Human resources (HR)

To ensure health services are in line with the Sphere Standards, a number of IFRC, TRCS staff and volunteers were supported through this appeal. This included medical doctors who provided consultations and Health Information Teams who provided the community health services and early referrals in the facilities supported by IFRC.

- The EA funded the following staff and volunteers, which was a mix of full time staff, refugee incentive workers, people based in Nyarugusu, NHQ of Kigoma Regional Office:
- 66 TRCS staff posted at HP 4 & 5 in Nyarugusu
- 84 refugee staff posted HP 4 & 5 in Nyarugusu
- 120 HIT volunteers
- 64 volunteers (TRCS) for 1st aid at entry points
- 10 volunteers to monitor treatment and storage of water through household (sampled) water quality tests
- Finance officer (NHQ)
- Finance officer (Branch)
- Logistician (Branch)
- Security Supervisor
- Radio operator
- Logistic Assistant
- 7 Drivers
- Recruit Warehouse/storekeeper
- Plus, differing % contributions to salaries of 6 other TRCS staff

Volunteers/incentive workers received per diem as per the TRCS volunteer policy revised on 20 May 2015. The rates might be reviewed by TRCS headquarters. The per diem supported the volunteers with the implementation of activities planned and for their sustenance. Every two months NHQ staff assisted and/or monitored the operation at the branch and/or at field level.

The IFRC EAIOI regional representation's operations unit and finance unit provided technical support to ensure that the operation is implemented in accordance with the Emergency Plan of Action (EPoA), and agreed conditions of the operation. Numerous IFRC Staff were deployed to the operation, including: Operations Manager, Finance Delegate, Health Coordinator, Health Delegates (6), logistics delegates.

Logistics and supply chain

Supply chain planning plays a critical role to ensure that the products needed by the operation are delivered at the right locations, at the right time, in right quality. An ERU Med-log was deployed short term and an IFRC logistics delegate was deployed for four months, based in the Kigoma region, to support the National Society with additional capacity to carry out the procurement, warehousing, transport and fleet management needed for this appeal.

Procurement of goods and services was carried out by the National Society (TRCS logistics unit in NHQ in collaboration with TRCS branch level) and supported by the IFRC (via the Logistics Delegate in-country, the Regional Logistics Unit for Africa and Logistics Management Department in Geneva).

- Medical items: UNHCR is responsible for providing all WHO Essential Drug List items for Adults and Children, and essential medical supplies. UNHCR have aimed to ensure a 3-month buffer to avoid any supply disruption, however, this has always not been possible. In cases of critical shortages in country, IFRC has procured goods internationally and from within Tanzania (from Ministry of Health approved pharmacies and distributors).
- Non-medical items purchased for this operation included non-food items (blankets, mosquito nets, hygiene kits, buckets, tarpaulins, family tents) dignity kits, menstrual hygiene management kits (MHM kits), water treatment tablets, hospital beds, generators, mobile storage tents, and IT equipment. Because of the lengthy import process, goods were sourced nationally instead of tapping in the option of deploying relief items from the IFRC regional stockpile in Dubai.

To create enough warehousing capacity, 2 mobile storage tents were mobilized for the operation and erected in Nyarugusu and Mtendeli camps.

Communications

TRCS, with support from IFRC regional communications teams in Nairobi, aimed to coordinate various awareness and publicity activities, to sensitize the public, media and donors on the situation on the ground and the humanitarian response.

A regional RC/RC Movement communication strategy including Movement tools was created with the support of the American Red Cross to support the EA; and was adjusted based on the needs identified through the Revised EA. Communications expertise was sought from within the IFRC as well as interested RC/RC Movement partners to ensure that this strategy is delivered on.

Communication continued on an internal Movement level, and an external level, targeting donors, media, the general public, decision makers, governments, and the humanitarian community. A dedicated web page www.ifrc.org/burundi-crisis was created to profile the on-going situation.

An example of a communication event (17 December 2016) was, in cooperation with the Swedish Red Cross, and included a live stream broad case of the operations manager in base camp. For the interview please follow: https://www.facebook.com/rodakorset/ and http://www.redcross.se/

Security

Security management was a vital element of the operation to ensure security of personnel, assets and programs. TRCS and IFRC continuously monitored the security environment and responded to changes in the threat and risk situation, if any, by implementing adequate risk reduction measures. This included measures related to safety-related threats and risks, e.g. road traffic accidents, fire safety, and health-related concerns. All personnel were checked to confirm the successful completion of the respective IFRC Stay Safe courses; *Stay Safe Personal security* is mandatory for all personnel and *Stay Safe Security Management* is mandatory for all managers.

The IFRC Operations Manager was the Security Focal Point for all IFRC people, assets and missions in-country, whether in-country as part of the Population Movement response or not.

Planning, monitoring, evaluation, & reporting (PMER)

There was on-going and continuous monitoring of the operation. TRCS/ IFRC conducted a detailed health assessment with the support of a Health Delegates from Nairobi and the field health coordinator in January and in June 2016. The needs and recommendations were taken up to improve the health indicators and ensure the services provided meet the sphere standards. A mid-term review was performed in May 2016 and recommendations were integrated and followed up in the planning event in September 2016. Follow link for the mid-term review report.

TRCS HQ and branch staff were deployed to support the ongoing monitoring and supervision of the operation. The IFRC EAIOI regional representation's Disaster Management and PMER units are providing technical support, and ensure that monitoring and reporting structures are established.

At the end of the operation, the IFRC and TRCS conducted a final evaluation of the operation which included capturing and lessons learned to identify the effectiveness and outcomes of the operation. Two beneficiary satisfaction surveys were carried out. The evaluation was done with the support of Partner National Societies and the IFRC EA-IOI operations team and TRCS PMER staff.

C. DETAILED OPERATIONAL PLAN

Early warning & emergency response preparedness

Early Warning & emergency response preparedness

Outcome: The TRCS is prepared to respond to an increase influx of refugees

Output: National Society volunteer and staff response capacity strengthened in Mtendeli and Nyarugusu

Activities:

- Training in WATSAN NDRT to continue the sanitation and hygiene promotion after departure of MSM ERU
- Training in Health NDRT to continue with the Health Posts after departure of BHU
- Preposition of WatSan Kit 2 as a contingency plan for the NS (supported by Spanish RC)
- Installation of two rub halls (base camp and Mtendeli camp) and rehabilitation of TRCS base camp warehouse
- Allocation of emergency funds for the top ten essential drugs to ensure there is no stock out in the facilities.
- Stocking of essential NFI items in case of an influx

Achievements

- All planned training was completed with TRCS staff
- Preposition of WatSan Kit 2 as a contingency plan for the NS (supported by Spanish RC)
- Rub halls and warehousing at Ngaraganza and Mtendeli have been installed and handed over to TRCS direct management

Challenges

None

Lessons Learned

- Enhance advocacy and humanitarian diplomacy on all levels
- Adequate funds for example for the expansion of the operation theatre, laboratory and maternity ward
- Technology:
    - Move towards collecting in soft copy – excel
    - Mtuha – further advance on the roll out.
- More education and awareness raising amongst refugees, for example on drugs and colour coating (for example white pills can be a lot more than paracetamol). HIT should have a flexible agenda to add new topics to their agenda
- Ensure regular feedback to the community
- Strengthen the cooperation with the Ministry of health.

Quality Programming / Areas Common to all Sectors

Needs assessment

Outcome: Continuous assessment, analysis, and final evaluation is used to inform the design and implementation of the operation

Output 1: Initial needs assessment are updated following consultation with beneficiaries; and Emergency Plan of Action is updated and revised as necessary to reflect needs during the timeframe of the EA

Activities:

- Deployment of Field Assessment and Coordination Team
- Conduct needs assessment in the Mtendeli and Nyarugusu camps to inform design of the Emergency Plan of Action
- Continuous NHQ/field level monitoring and documentation of the activities planned in the EA; as well as refugee influx
- Continuous updating of the Emergency Plan of Action for the EA; based on monitoring information
- Preparation of reporting as required (including Operations Updates)
- Initial orientation and information meetings are held with the community to provide information on the mandate of the National Society/IFRC etc.
- Establish beneficiary complaints and feedback mechanism in the areas of implementation
- Programme information on the implementation of the EA is communicated regularly and through appropriate channels
- Deploy IFRC Head of Operations surge support to provide strategic and operational leadership

Output 2: The EA operation is reviewed to inform lessons learned and future operations

- Conduct beneficiary satisfaction survey
- Conduct final evaluation and lessons learned
- Develop an exit strategy workshop as per the appeal guidelines.

Achievements

- FACT and ERU deployed at beginning of crisis for immediate support to TRCS
- Clinical, OD and staff assessments completed to identify needs and priority areas for support
- EPoA updated throughout operation, based on assessment on facts on the ground and changing context in each camp
- End of Operation Review, beneficiary survey and Operations Update completed
- Lessons learnt drawn from End of Operation Review, staff survey, beneficiary survey and clinical services assessment
- IFRC HEOps was deployed at start of operation as planned

Challenges

- Inadequate clinical management
- Inconsistent professional ethical standards
- Mid-term Joint management review between IFRC and TRCS did not happen
- Regular budget management communication at all levels was inadequate
- Unstandardized incentive payments

Lessons Learned

- Information sharing maintaining chain of communication
- Creating platforms for sharing concerns and information to staff and volunteers. For example, suggestion/question box.
- Need to standardize payments
- In terms of keeping HR structure strong, it is a necessary to consider more strongly experience and skills of the health staff for retention.
- Performance management and adherence to HR policy, R&R and job descriptions
- Bi-weekly meetings
- Show casing achievements
- Visibility should be everywhere.

Health and Care

Health and Care

Outcome 1: Immediate risks to the health of the target population are reduced at the entry points and in the Mtendeli and Nyarugusu camps, for a period of 15 months

Output 1.1: Basic health care access is provided for the target communities living in the Mtendeli and Nyarugusu camps to enable to rapid medical management of injuries and diseases (Target: 300,000 people)

Activities:

- Deploy Basic Health Care ERU (Nyarugusu)
- Deploy Health ERU HR (Logistician, Head Nurse)
- Provide on the job skills building sessions for staff in Mtendeli and Nyarugusu camps
- Install HPs in the Nyarugusu camp (New Target: HP 4 & 5, and through the Revised Emergency Appeal - HP 6)
- Temporarily reinforce HP 4 and 5 in the Nyarugusu camp
- Reinforce semi-permanent structures at HP 4 in the Nyarugusu camp
- Rehabilitation/installation of the Basic Health Care service facilities in the Mtendeli camp (including clinical inpatient/outpatient services (100 bed ward), pharmacy/dispensary, and refrigeration of blood pouches etc.)
- Procure/transport buffer stocks of essential medicines for Basic Health Care in the Mtendeli and Nyarugusu camps
- Procure equipment for staff posted to the Basic Health Care services in the Mtendeli and Nyarugusu camps
- Procure medical equipment required for the running of the Basic Health Care services in the Mtendeli and Nyarugusu camps
- Training of Local Tribunal / Community Leaders on the Importance of Early Reporting of GBV/Rape within 72 Hours
- Clinical IMCI Training
- Community IMCI Training
- Providing training of health workers on clinical treatment guidelines (Target: 50 volunteers)

- Management of Acute Severe Malnutrition
- Provide training for volunteers on drug management (Target: 36 volunteers)
- Provide referral services

Output 1.2: Epidemic prevention (focus on malaria and cholera) and control measures are carried out with target communities living in the Mtendeli and Nyarugusu camps diseases (Target: 250,000 people); including distribution of mosquito nets (Target: 6,000 households)

- Procure/distribute mosquito nets to target population (Target: 12,000 mosquito nets / two per beneficiary); and demonstration on their use
- Provide training of Health Information Team volunteers (including on cholera; malaria, nutrition, reproductive health, preventions and vaccination messaging) (Target: 120 volunteers)
- Providing training for volunteers on epidemiological surveillance (Target: 120 volunteers)
- Provide orientation for volunteers on IPC (Target: 100 volunteers)
- Provide training for volunteers on IPC (Target: 100 volunteers)
- Provide training for volunteers on the management of fever (Target: 50 volunteers)
- Conduct social mobilization and health promotion (including on HIV prevention and sexual violence and gender-based violence; supplementary feeding to children, to pregnant and lactating mothers as well as by promote good breastfeeding)
- Community awareness raising through mobile cinema campaign
- Conduct epidemic surveillance through a task force with official information (government/others) and local community-based information (through the HIT volunteers)
- Provide first aid/referral services at entry points
- Conduct vaccination campaign in collaboration with UNICEF/MoH
- Identify a possible site for isolation and treatment if an outbreak occurs. (CTC, ORP, CTU)
- Strengthen data management and reporting system
- Develop/review diseases outbreak preparedness and response contingency plan. (Task force meeting each month)

Achievements

- Nyarugusu - At Health Post 4, five new permanent in-patient wards have been constructed, inaugurated in early 2017. 2 paediatric wards, 1 male ward, 1 female ward and 1 new maternity building (antenatal ward, delivery suite, post-natal ward) provide approximately 100-bed capacity for patients
- Nyarugusu - At Health Post 5, a partnership with MSF has seen the two health facilities become conjoined, with the facility handed over to TRCS with TRCS providing OPD services, with overflow isolation facilities availability as part of epidemic outbreak contingency planning
- Out-Patient and In-Patient books are in use, provided by UNHCR & IFRC, and patient records managed by TRCS at every health location. Standardised approach is in place, supported by IFRC. System is paper based.
- Every TRCS health facility has a handwashing station at every entrance/exit, toilet, OPD and ward. Cleaners are employed for every facility, with ample supply of mops, brushes, buckets and bleach. However, Health Post 5 and Health 6 have mud or plastic floors, not sealed concrete floors. Wards and OPD in Main Dispensary have sealed floors, although uncovered mud paths, dirt roads and untreated **walkways are the norm in every location.**
- A colour-coded triage system based on international practice is in place at every health facility.
- Health worker skills and knowledge have been increased through training provided by IFRC, WHO, UNFPA, UNICEF and MSF. Clinical experience and practice is meeting Sphere Standards and comparable standard to TanGov levels in most areas
- There are some vacancies for clinical staff, however, over the past 6 months staff levels have stabilised and a cadre of colleagues have been in place for over 12 months now. Most clinical staff are either at the beginning of their careers, or are aged over 50, so the 'middle' group of experienced staff, who may have trained overseas with strong management and clinical practice experience, remain elusive to TRCS due to salary level, living conditions and T&Cs for employment.
- Handwashing stations are at every toilet, OPD, entry/exit point and ward. Latrines are either housed away from the OPD/waiting area, or, are in a dedicated block.
- All health facilities have basic equipment such as stethoscopes and weighing scales, but procurement of newer equipment such as oxygen concentrators, pulse oximeters, examination beds and lab equipment have been planned for in-patient facilities.
- Health Posters in local languages are required for all health facilities. Health promotion work is sometimes by HIT colleagues and Clinical Officers whilst patients ***wait to be seen***
- Drug management has improved, including the use of standardised requisition books, medicine usage books, inventory recoding spreadsheets and waybills for transportation

Challenges

- There was inconsistent supply of medicines

- Overcrowding of POC and limited facilities
- Demotivation of staff due to late payment
- Delay in referrals by UNHCR
- Despite of recruiting more staff, still the staff were not adequate Lack of guidelines
- Inadequate documentation and filling of record for patients
- Inadequate medical equipment

Lessons learned

- Enhance advocacy and humanitarian diplomacy on all levels
- Adequate funds for example for the expansion of the operation theatre, laboratory and maternity ward
- Technology:
    - Move towards collecting in soft copy – excel
    - Mtuha – further advance on the roll out.
- More education and awareness raising amongst refugees, for example on drugs and colour coating (for example white pills can be a lot more than paracetamol). HIT should have a flexible agenda to add new topics to their agenda
- Ensure regular feedback to the community
- Strengthen the cooperation with the Ministry of health.

Water, Sanitation and Hygiene Promotion

Water, sanitation and hygiene promotion

Outcome 2: Immediate risk of waterborne and water related diseases to the of the target population is reduced in the Mtendeli and Nyarugusu camps, for a period of 15 months

Output 2.1: Continuous assessment of water, sanitation, and hygiene situation is carried out in targeted communities

Activities:

- Conduct continuous assessment to understand the needs of the refugee population; and response gaps
- Continuously monitor the water, sanitation and hygiene situation in targeted communities
- Coordinate with other WatSan actors on target group needs and appropriate response.

Output 2.2: Daily access to safe water which meets Sphere and WHO standards in terms of quantity and quality is provided to target communities (Target: 6,000 people)

- Monitor use of water through distribution points (tap stands) water quality tests (via the Mass Sanitation Module)
- Distribute 1,000 household water treatment products [chlorine tablets], sufficient for two months, to 6,000 people (via the Mass Sanitation Module)
- Train population of targeted communities on safe use of water treatment products (via the Mass Sanitation Module)
- Monitor treatment and storage of water through household (sampled) water quality tests. (via the Mass Sanitation Module)
- Installation of water supply infrastructure to support for living compound

Output 3.3: Adequate sanitation which meets Sphere standards in terms of quantity and quality is provided (Target: 20,000 people)

- Deployment of the Mass Sanitation Module (MSM 20) to support additional latrine/bathing facility infrastructure, vector control, household water treatment, hygiene promotion, solid waste management options
- Construct 400 latrines in reception centres, households, schools, for 20,000 people (via the Mass Sanitation Module)
- Ensure latrines are clean and maintained through management of cleaners and community mobilization (via the Mass Sanitation Module)
- Equip latrines with hand washing facilities, water and ensure they remain functional (via the Mass Sanitation Module)
- Carry out drainage, vector control, and solid waste management activities in targeted communities (via the Mass Sanitation Module)
- Installation of appropriate sanitation infrastructure to support provision of Basic Health Care services in the Mtendeli and Nyarugusu camp (including improved drainage/piping, incinerators, latrines, placenta pit, and showers).

Output 3.4: Hygiene promotion activities which meet Sphere standards in terms of the identification and use of hygiene items provided to target communities (Target: 250,000 people)

- Select target groups, key messages, and methods of communicating with beneficiaries (mass media and interpersonal communication). (via the Mass Sanitation Module)
- Develop a hygiene communication plan (via the Mass Sanitation Module)

- Train hygiene promoters to implement activities from communication plan. (via the Mass Sanitation Module)
- Design/Print IEC materials (via the Mass Sanitation Module)
- Assess progress and evaluate results. (via the Mass Sanitation Module)
- Engage community on design and acceptability of water and sanitation facilities. (via the Mass Sanitation Module)
- Procurement and installation of communal hand washing facilities 60-100Litre capacity containers fitted with taps and installed on stand. (via the Mass Sanitation Module)
- Conduct awareness campaigns on good hygiene, cholera and Malaria prevention practices using mobile cinema. (Film aid will provide equipment and technical staff and TRCS volunteers will support in hygiene/health) (Target: 20 sessions)

Output 3.5: Hygiene-related goods (NFIs) which meet Sphere standards and training on how to use those goods is provided to the target communities (Target: 6,000 households)

- Procure/distribute basic hygiene items (razor blades, towels, toothbrush/toothpaste, laundry soap (200gr/p/month), bathing soap (250gr/p/month)) (Target: 6,000 households)
- Procure/distribute 6,000 rigid 20L jerry cans with lids and 6,000 buckets with lid for water collection, treatment and storage (Target: 6,000 households)
- Procure/distribute of Menstrual Hygiene Management (MHM) kits to mothers after she's given birth (Target: 6,000 women)

Achievements

- NFI distribution thorough hygiene kits has been completed
- WASH activities were completed as planned, however WASH has not been a large and specific focus of the Operation through 2016 & 2017.
- Handwashing stations are at every toilet, OPD, entry/exit point and ward. Latrines are either housed away from the OPD/waiting area, or, are in a dedicated block.

Challenges

For water, sanitation and hygiene promotion challenges were limited as a lot of the activities went well and had been completed and handed over. Generally, in the feedback received from beneficiaries during the mid-term review, 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.

Shelter and Settlements

Shelter and settlements

Outcome 4: Immediate shelter and household items needs are provided to refugees at entry points and reception centres

Output 4.1: Some 15,000 people have access to temporary waiting shelters at the entry points

- Procure and transport 1,000 tarpaulins
- Distribute 1,000 tarpaulins into entry points
- Locally procure remaining construction materials for the shelters (poles, nails)
- Construct the temporary waiting shelters

Output 4.2: 6,000 vulnerable households receive basic NFIs

- Engage the community in the selection and registration of beneficiaries.
- Procure and transport NFIs (blankets, mosquito nets, jerry cans, water treatment kits and hygiene kits)
- Distribution of NFIs

Output 4.3 At least 250 people from the most vulnerable groups are accommodated in tents for privacy and protection

- Procure 50 family tents for most vulnerable families
- Install 50 family tents

Achievements

- Support to Lumasi Transit centre for supplies, NFIs and shelter was completed as planned
- Tarpaulins and temporary shelters were distributed and constructed as planned

Challenges

Challenges were limited as a lot of the activities went well and had been completed and handed over. Generally, in the feedback received from beneficiaries during the mid-term review, it was felt that people should have received more food and items for cooking upon arrival.

Restoring family links

Outcome 5: A self-reliant national society that can respond to humanitarian crisis
Output 5.1: The TRCS has adequate resources to respond to the Burundi Refugee influx

Activities:

- Recruit support services personnel: finance officers (NHQ and field), logistics and PMER
- Recruit operations personnel; operations manager, for the implementation of the response at NHQ and branch levels (including an operations, health, logistics and drivers etc.)
- Review internal systems and protocols for response
- System upgrade of the Navision finance software at NHQ level; and installation of accounting systems at branch level
- Provide refresher training of NHQ and field staff on the Navision finance software
- Recruit a driver
- Procure laptops/software, printer, and a heavy-duty printer

Output 5.2: Positioning of RCRC response operations is enhanced through evidence based communications and advocacy

Activities:

- Produce bi weekly movement facts and figures and share with relevant stakeholders
- Develop a communication strategy with movement partners in coordination with external actors
- Produce regular regional infographic
- Produce Videos, and photographs to media and key stakeholders
- Deploy IFRC communications to Tanzania on at least one mission to gather materials
- Maintain a social media presence throughout the operation utilizing IFRC sites such as website and Twitter
- Support the launch of this appeal and other major milestones throughout the operation using people-centered, community level diverse content for use on various communications channels including the IFRC Africa web page, www.ifrc.org/africa
- Provide the NS communication team with communication training and appropriate equipment, if required (photo and video camera, spoke persons)

Achievements

- IFRC Delegates who have been deployed include Operations Managers, Finance Delegates, Logistics Delegates, Health Delegates, Clinical Health Delegates
- Case study and public relations material created for Operation
- Computers, printers and photocopiers were procured for NHQ, Regional office and field teams

Challenges

- BPRM and ARC vehicles taken out of the operation thus hindered the implementation of activities such as in supervisory meeting
- Communication breakdown due to lack of communication devices and reliance on mobile phones without airtime
- Budget constraints leading to cancelation on some of the items to be purchased
- Inadequate capacity in logistic management thus IFRC had to offer technical support
- Shifting from IFRC to UNHCR made life tough for the volunteers.
- Delay of funds transfer from NRB to the field/UNHCR
- There were a lot of delays when suppliers were and had to be paid through Nairobi.
- The accounting system is still in excel.
- Communication on staff payments.

Lessons learned

- TRCS DSM HQ should have a separate account for IFRC funds and submit account statements on a bi-weekly basis
- There is a need to move towards Navision
- There is a need for more training.
- Vehicle allocation
- Communication tools to be in place, put a radio network back in place
- Increase the amount of logistics and fleet training. For logistics this includes, stock keeping, warehousing, drivers. Stronger resource mobilisation plan and funds for tools, spare parts, tires.

D. THE BUDGET

Budget will be attached in the final report to be published on 31 December 2017.

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Click here

1. Revised Emergency Appeal budget *(if needed)* below
2. Click here to return to the title page

How we work

All IFRC assistance seeks to adhere to the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and the Humanitarian Charter and Minimum Standards in Disaster Response (Sphere) in delivering assistance to the most vulnerable.

The IFRC's vision is to inspire, encourage, facilitate and promote at all times all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

www.ifrc.org
Saving lives, changing minds.

The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:

1. Save lives, protect livelihoods, and strengthen recovery from disaster and crises.
2. Enable healthy and safe living.
3. Promote social inclusion and a culture of non-violence and peace.