CENTRAL FUND FOR INFLUENZA ACTION PROGRAMME[1]
QUARTERLY PROGRESS UPDATE
3rd Quarter Report: 01 July-30 September 2010

Participating UN or Non-UN Organisation:	UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR)	**UNCAPAHI Objective(s) covered:** ***Obj 3: Human Health*** ***Obj 5: Communication: Public Information and Supporting Behavior Change*** ***Obj 6: Continuity under Pandemic Conditions***
Implementing Partner(s):	**UNHCR's implementing partners involved in humanitarian assistance in refugee camps:** DRC: IMC Rwanda: ARC and AHA Burundi: AHA RoC: MDA CAR: ACTED Ethiopia -ARRA, Djibouti – AMDA East Sudan-HAI Tanzania-TWESA, TRCS Kenya – GTZ Uganda - GTZ Nepal: Association of Medical Doctors of Asia (AMDA) Myanmar- Malteser International Pakistan - Frontier Primary Health Care (FPHC), Union Aid for Afghan Refugees (UAAR), Community Development Program (PAK-CDP), Centre of Excellence in Rural Development (CERD) Thailand: Committee for Coordination of Services to Displaced Persons Middle East and North Africa (Egypt -Caritas / Refuge Egypt / Egyptian Family Planning Association/ Catholic Relief Services; Algeria-Triangle Generation Humanitarian- Algerie; Syria-Syrian Red Crescent; Yemen-SHS/ MSF-Spain/ Interaction for Development/ CSSW; and **UNHCR direct implementation in 12countries.**	
Programme Numbers:	CFIA-B15	
Programme Title:	Avian and Human Influenza Preparedness and Response in Refugee Settings	
Total Approved Programme Budget: B15	US$ 990,000	
Location:	B15: Countries hosting refugee communities assisted in camps and in urban situations	

[1] The term "programme" is used for projects, programmes and joint programmes.

MC Approval Date:	B15: 14 December 2009				
Programme Description:	UNHCR is the sole UN Agency with the mandate to protect refugees. UNHCR has the responsibility to: 1. Ensure preparedness and pandemic mitigation; and 2. Create appropriate conditions for the continuity of basic delivery assistance in case of pandemic				
Programme Duration: B15	12 months	**Starting Date:**	23 December 2009	**Completion Date:**	31 December 2010
Funds Committed: B15	US$ 990,000			**Percentage of Approved:**	**100%**
Funds Disbursed: B15	US$ 703,608			**Percentage of Approved:**	**71%**
Expected Programme Duration: B15	12 months	**Forecast Final Date:**	September 29, 2011	**Delay (Months):**	9 months

Outcomes:	**Achievements/Results:**	**Percentage of planned:**
1. Advocacy: Advocate for refugees, internally displaced persons (IDPs), returnees and other persons of concern to UNHCR (PoCs) to be fully integrated as beneficiaries in the national host Government contingency plans.	• Repeated verbal assurance given from MoH in Bangladesh, Malaysia and Nepal though not yet officially done. In Bangladesh, refugees were included in certain activities (e.g. H1N1 vaccination) carried out by the MoH • Central Africa (CA): Rwanda: Refugees are included in National Contingency plans (NCP) for AHI. Verbal approval provided by the MOH to include refugees into (NCP) for A (H1N1) expected to be issued shortly. All camp health workers are included in A (H1N1) vaccination plans. Burundi: Advocacy is going on to have refugee included into the first draft. DRC: MOH and WHO had agreed to highlight covering vulnerable populations without necessarily mentioning refugees. Chad: UNHCR and WFP advocated for	**60%**

	including refugees in the AHI and A (H1N1) national contingency plans. They also urged UN agencies and IPs to develop specific contingency plans for the East of Chad where most of the refugees are located so far away from the Capital. CAR: the National Plan included refugees living in the Batalimo Camp where 2,595 out of the 7,200 refugees were vaccinated against A (H1N1) influenza	
2. Human Pandemic Preparedness: Prepare affected communities for the detection, prevention and mitigation of epidemics including AHI. ***2.1. Systems for surveillance of influenza-like illness through strengthening health services for refugees to include surveillance and detection, hygiene education and other forms of infection control, and contribution to containment.***	• All refugee camps in recipient countries in Asia have functioning surveillance system. No outbreak reported during the reported period. • Health Information System (HIS) training was conducted in Ethiopia and Uganda where 33 and 15 participants attended respectively. 30 participants were also trained in East Sudan in August. The training was to provide feedback and ensure quality data are collected, analysed and timely reported to ensure disease outbreaks are early detected and responded to. Routine surveillance is ongoing in all the camps. • Reporting systems, coordination and surveillance mechanisms at camp level in CA were reviewed and assessed during the missions of the Regional EPR Coordinator and other team members in the different refugee camps in Rwanda, Burundi and RoC and the IDP Camps in N. Kivu. In addition to North Kivu, DRC, training on HIS and epidemiological surveillance extended to cover the Betou and Impfondo Districts of RoC	**98%**
2.2. Strengthen outbreak control and response task force in the camps.	• Asia: Bangladesh-series of discussions were held with implementing partners and Ministry of Health to review and update operational action plans for epidemic preparedness. In Iran, a workshop has been jointly organised by UNHCR and MoH on refugee health, participated by key MoH personnel. The workshop included, among	**97%**

2.3. Stockpile of drugs and medical equipment in place.	other refugee health related topics, disease surveillance, outbreak investigation and response • All the camps in EHA have outbreak control teams in place. Composition and functioning of the camp outbreak control teams were reviewed in East Sudan and Djibouti to ensure inclusion of all relevant stakeholders and adopt a proactive approach to managing disease outbreaks. UNHCR and partners are members of the Kassala state Outbreak Control Team. Outbreak control teams in Uganda (Kyangwali and Kiryandongo camps) were reviewed in the process of reviewing their EPR plans. Most health facilities have some form of isolation ward but not to an acceptable standard. Construction of isolation ward in Shagarab camp in East Sudan is ongoing using the 40,000 USD EPR funds allocated for this purpose. In Kenya (Dadaab), construction of MDR TB ward is also ongoing. • In Central Africa, Task Force Committees were established in the Gihembe, Nyabiheke and Kiziba Camps of Rwanda and the Gasorwe and Musasa Camps of Burundi. • The IPs in Rwanda, Burundi, DRC, RoC continued working with refugees and IDPs to improve camp and district-specific contingency plans. Key staffers of UNHCR, IPs, and MOH in DRC, Rwanda, Burundi, and Chad who were trained on reporting and surveillance were involved in the process and provided camp teams with technical support in this respect. A task force committee for Katanga was enforced and trained • In Nepal, the stockpile medicine and supplies procured under EPR in 2008 moved to IP's store and mainstreamed in the regular drug management system. AHI stock pile replenished in Bangladesh and stationed in the camps. • In EHA, good supply of drugs and medical equipments are available in most country operations. Improved mainstreaming of drug procurement using regular program budget will	**95%**

	minimise drug shortages in 2011. Drug management standard operating procedure was developed and finalised in Uganda to be used by all settlements in the country. EPR funds supported Djibouti in urgently filling gap in drug shortage. Drug management training conducted in September in Ethiopia where 33 participants attended. • Medical equipment and supplies were completely distributed among camp health facilities in Rwanda, Burundi and Chad in addition to provincial health offices of North and South Kivu, DRC. Additional stocks of essential biomedical supplies were delivered to the Likoula Province of RoC this quarter to meet the urgent needs of Congolese 114,000 refugees.	

2.4.Strategic communication plan for entire refugee communities in order to reduce risks and mitigate the impact of any outbreak or pandemic	• In Bangladesh, pregnant women, patients with chronic disease and service providers received H1N1 vaccines from GoB in both camps. Hygiene promotion activities are conducted by 41 volunteers in the camps and 37 community health workers (CHW) conduct regular health awareness talks and plays in both camps, reaching out to 14,020 refugees by home visits. In Malaysia 30 community health workers (CHW) who have been trained in conducting health awareness talks and plays continued with their daily activities. These health workers have adapted and developed many IEC materials including health brochures and video clips into Burmese and other relevant languages (Rohingya, Tamil) which they disseminate and distribute during health awareness talks in the clinics, communities, other provinces, TB centres etc. A telephone hotline will be established soon in order for better communication. In Myanmar, Malteser conducted three-day Water Management Training for 16 water management committee from 8 villages in Sittwe and Rathedaung Townships. • In Nepal, 380 community volunteers both from the camps and immediate host communities trained on Hygiene promotion through AMDA and LWF to undertake regular HP activities in the camps and its surroundings. The reprinting of IEC materials through this project completed and dispatched to the camps by AMDA. Two days long avian and pandemic influenza preparedness training conducted for the health care providers both from the refugee camps and surrounding government health facilities in different groups with a particular focus on non-pharmaceutical interventions. The training was based on the national training manual developed by the MoHP and facilitated by a team of master trainers from the District Public Health Office (DPHO). The use of personal protective equipments and simple hand washing procedure were demonstrated to the participants during the training sessions. A total of 169 participants attended the training	**85%**

	including 50 participants from the government health facilities located in the environs of the refugee camps. • In EHA, treatment guidelines for cholera, meningitis, measles and Ebola obtained from MOH in Uganda as well as IEC materials for Ebola, H1N1 and measles to be printed and shared with all settlements. East Sudan also acquired some IEC materials from state MOH in Kassala and distributed to all camps • In Central Africa, translation of public awareness documents into Swahili and Kenny Rwanda done in all camps and IDP sites in DRC, Rwanda and Burundi. A TOT workshop on pandemic influenza and cholera was conducted in Katanga; DRC .The purpose of the workshop was to initiate a series of cascaded training on the subjects so that training activities can continue targeting health professionals, community promoters and community leaders at various levels. The workshop targeted professionals from MOH, WHO, UNICEF and a number of implementing and operational partners in the Province. Radio spots with key messages on pandemic influenza, cholera and hygiene continued to be regularly aired through 14 local channels in N. Kivu, DRC. Community health promoters trained in Burundi, DRC and Rwanda. UNHCR and IP teams continued BCC activities targeting refugee living in refuge camps of Abeche.	
2.5. Coordination: A strong coordination mechanism for supporting and monitoring all related operations in the field and to play an active role within the different bodies/platforms established under the leadership of UNSIC	• UNHCR regularly attends the UNSIC, WHO, and PIC-OCHA, and other related meetings and teleconferences	**100%**

3. Continuity of humanitarian services: ***3.1. Organise and put in place adequate planning with Implementing and Operational Partners (IPs/Ops) for ensuring basic delivery assistance under pandemic conditions.*** ***3.2. Improvement and enhancement of water delivery capacity and sanitation conditions in view of creating optimal conditions for the response to an outbreak***.	• Provisions to ensure continuity of essential health, food and WASH services are in place in almost all country operations. Business continuity plans are updated in countries with camps (e.g. Nepal, Bangladesh) in cooperation with WFP and IPs/CPs. • Bangladesh took significant measures to improve existing WatSan facilities in the two refugee camps of Kutupalong (KTP) and Nayapara (NYP) and to address the gaps in epidemic preparedness plan. 3 tube wells were constructed in KTP, and 7 additional tube wells were replaced due to irreparable damage. This brings to a total of 89 functioning tube wells out of 107 units in KTP (18 pending repair by GoB), delivering about 28litres/person/day which is more than the international minimum standard of 20litres/person/day. 20 garbage pits constructed in NYP has lead to an improved waste management situation in the camps, providing refuse pits for 395 persons per pit (meeting the minimum standard of maximum 500 persons per refuse pit). In Myanmar, Malteser has collected the essential materials for 4 opened wells in Sittwe Township which will be started in November (able to start only after the raining season) and will be completed in December 2010. • In EHA, most health facilities have running water supply for hand washing and other hygiene needs. Improvement of water supply in health facilities in East Sudan and training of WATSAN committees in Tanzania are being implemented • In Central Africa, in Burundi, water provision and sewage disposal improved in health posts in 3 refugee camps. In Rwanda, physical rehabilitation of camp health posts in Gihembe and Nyabiheke was completed with activities including cementing of floor and providing piped water to all inpatient and outpatient sections. A patient isolation room was constructed in Kiziba camp. Construction of additional latrines is in	**>95%** **90%**

	process for the Kiziba Refugee camp. In Chad, an isolation room was established in the Hagar-Haded camp and infection control measures improved. In RoC, UNHCR is currently establishing a water purification and distribution point to meet needs of 3,600 refugees living in the Zemio Camp is in process	
2.5. Contingency Plans at camp level.	• Asia: Contingency plans already existing in the camps in Bangladesh and Nepal and being updated. • EHA: Review and update of EPR plans for common outbreaks undertaken in Kyangwali and Kiryandongo camps in Uganda. These will be reviewed periodically and their implementation followed closely by the outbreak control teams • CA: Contingency plans developed in all refugee camps of Rwanda and Burundi and in the Provinces of N. Kivu and S. Kivu of DRC. Trainers from East Chad who had been previously trained on the principles of contingency planning continued working on their camp-specific plan. A provincial contingency plan was developed for the Katanga Province of DRC with detailed plans for each of Kalemie and Moba Districts reported to be endemic of cholera.	**88%**
2.6. Logistics and food pipe line contingency planning with WFP	• In Asia, done in Bangladesh and Nepal • In EHA, food pipeline is healthy in all country operations in the region at least up to the end of the year. Adequate storage and food transport capacity is available • In Central Africa, in Rwanda and DRC, UNHCR is liaising with WFP counterparts for food pipe line contingency planning. A mission was carried out jointly with WFP to Chad to assess the situation and conduct hazard –risk analysis. In the East of Chad, UNHCR and WFP held a meeting in July to overcome food distribution problems and improve effectiveness of the post distribution activities	**88%**
AHI Coordination in Geneva	• AHI Coordination is operational in HIV and PH Section in UNHCR HQ.	**100% (CA)**

Qualitative achievements against outcomes and results:

During this quarter, the UNHCR EPR Coordinators undertook various missions to support and enforce coordination on AHI.
A guideline is underway being finalised by the EPRCs which will include outbreak control in detail and will be used by public health coordinators in the UNHCR country operations.

Asia:

1/ Refugees included in National Plans.

- No country in Asia region has formally included refugees in national plans, though substantial verbal commitment made in Bangladesh and Nepal. Some MoH responses included refugee population like H1N1 vaccination in Bangladesh.
- While no explicit mention of refugees in national plans, there are clear examples of where refugees are included in some programming. In East Sudan, UNHCR and its partners are fully involved in the Kassala state planning and response to epidemics / pandemic and refugee camps and health staff have benefited from vaccination and training. In Kenya, refugee camps were part of the national vaccination planning for H1N1.
- A total of 2,595 Congolese refugees currently living in the Batalimo Camp in the Republic of Congo (RoC) received vaccinations against A (H1N1) influenza within the context of the National Contingency Plan. Refugees were also targeted for the BCC campaigns that preceded the vaccination and targeted all inhabitants of the area.
- In the Katanga Province of DRC, UNHCR lead the efforts to develop the first contingency plan on potential outbreak and pandemics including pandemic influenza and emphasizing cholera as an endemic disease in the area. UNHCR targeted 24 and 20 professionals from the Kalemie and Moba Districts respectively for TOT workshops in contingency planning. The participants that included staffers of the MOH, WHO, UNICEF, MDMF, AHA, AIDES, the "Commission National Pour les Refugees (CNR), MONUSCO, Radio Okabi developed a comprehensive contingency plan and submitted it to the MOH for approval and adoption.

2/ Medical supply and protection equipment.

- Medical supply and protection equipments are gradually being integrated with regular supply management mechanism in order to obtain sustainability.
- Drug stocks are good in all country operations in the region except Uganda and Djibouti where they experienced stockouts in particular of antimalarials, RDTs and medical equipments. In Uganda, this is a result of more than 50% of nationals using refugee services with little input from the govt. In Djibouti, delay in the procurement process and poor drug estimation contributed to the shortage. This has now been resolved by making an early comprehensive order for 2011.
- In CAR, UNHCR procured 1,000 kits of Paracheck to replenish supplies at the health posts

that serve 3,600 and 7,200 refugees living in the Camps of Zemio and Batalimo respectively.

- A USD 13,000 worth of hygienic supplies and tools including antiseptic lotions, detergents, water reserving containers and cleaning tools were distributed among the same camp facilities to improve infection control at the health posts and enhance hygienic conditions in a select of refugee households.
- In DRC, North Kivu, the procurement of additional stocks of hygiene kits is in process. The supplies include tools and materials that will help improve the hygienic conditions in IDP and returnee households and consequently help prevention of pandemic influenza and other potential epidemics.

3/ Outbreak control

- A joint UNHCR-MoH workshop conducted in Iran involving key MoH personnel.
- All camps in EHA the region have Outbreak Control Teams involving at least the main stakeholders in the camps. However, some of these teams are not very active and functions ad hocly when an issue arise. Continuous effort is needed to ensure regular meetings to review preparedness including surveillance activities and capacity building needs.
- In DRC: Surveillance and reporting under the "influenza-like" category continued using the UNHCR-HIS system.
- In Katanga, DRC, as a result of the training workshop, surveillance tools and data collection forms developed by the WHO were improved and allowed data collection with breakdown by water source, age group and geographical location. This was useful in analysing the data on cholera cases and identifying the source of infection, risk factors and recommending action points.
- In RoC: the IP; MDA and the Provincial Health Authorities continued disseminating the biweekly statistical report with influenza-like illnesses category included.

4/ Public Information and awareness campaigns.

- An IEC data bank has been created in Bangladesh, Myanmar and Nepal listing all the materials available with possibility of rapid mobilisation/reproduction and sharing with regional countries hosting refugees of common origin.
- In DRC: The North Kivu Radio Association resumed airing key radio BCC messages on AHI, cholera and hygiene. The broadcast covers the whole Province of North Kivu reaching all refugee, IDP, returnee and resident populations.
- A health festival took place at the Mogonga III IDP Camp located in N. Kivu, DRC. About 2,000 of the most vulnerable IDPs participated in the events of the festival. Music, quiz games, with awards for best answers, banners and leaflet were employed to enhance public awareness on AHI and other epidemics.
- In Burundi, the IP, AHA continued outreach activities to improve household hygiene and increase refugee awareness on preparedness for epidemics in the Camps of Gasorwe, Musasa and Gihinge.
- In Rwanda, ARC and AHA continued BCC activities targeting refugees living the camps of

Gihembe, Nyabiheke and Kiziba for outreach visits using mobile video strategy to increase awareness in AHI, epidemics and common diseases.

5/ Business Continuity.

a) Food

- In CAR, UNHCR distributed a USD 10,000 worth of the therapeutic Food, Plumpy Nut, among severely malnourished refugee children living in the camps of Batalimo and Zemio. Preliminary results of a survey that has been recently conducted by MERLIN shows that almost 10% of refugee population under 5 years of age living in Batalimo suffer from some form of sever acute malnutrition.
- In the East of Chad, UNHCR and WFP held a coordination meeting in July to: address difficulties encountered while transposing food stocks from the WFP warehouse to the distribution points; identify ways for improving the effectiveness of the monthly post-distribution monitoring activities; and prepare for the upcoming nutritional survey. Key recommendations were to: 1) move the distribution points closer to the WFP warehouse so that food can be transported by manual labour rather than trucks. This was piloted in the Guéreda Camp and will possibly be applied to all camps; 2) establish a committee to study the possibility of using old distribution points that has been abandoned; and establishing a joint committee to enhance collaboration on food provision protocols and funding and ensure inclusion of IDPs.

b) Water and Sanitation

- In RoC, the needs of a total of 3,600 Congolese refugees living in the Zemio Camp were assessed and thoroughly discussed with MSF/H, ACTED and UNICEF. In response to the acute shortage of water supply UNHCR mobilized its medical and WASH team from HQ, Kinshasa and RoC to the area. UNHCR, its IP; ACTED and the refugee community are in the process of installing a water bladder of 15 CM that was provided by the UNICEF along with a water purification system. UNHCR has so far procured an electric generator, a water pump and other necessary accessories for this purpose.
- In Rwanda: interventions to improve access to clean water and latrine to 28.000 refugees
- living in the Gihembe and Nyabiheke are in process.
- Business continuity plans being updated in countries with camps (Nepal, Bangladesh) in cooperation with WFP and IPs/CPs.
- Provisions to ensure continuity of essential health, food and WASH services are in place in most country operations. Public health including disease outbreaks planning featured prominently in country contingency planning in Kenya, Ethiopia and Uganda for the anticipated influx from Somalia, South Sudan and DRC

6.Regional Coordination

- EPR issues were actively discussed in the Asia Public Health regional retreat held in Kuala Lumpur in July.