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Health Standards: Essential Concepts

Everyone has the right to health. This right is recognised in various international legal instruments and includes timely and appropriate healthcare, as well as the underlying determinants of health. These include water and sanitation, safe food, healthy environmental conditions, gender equality, and health-related information and education, among others.

Health services must be provided without discrimination and must be accessible, i.e. available, acceptable, affordable, and of good quality. The right to health can be assured if:

- the population is protected;
- the professionals responsible for the health system are well-trained and committed to universal ethical principles and professional standards;
- the system in which they work is designed to meet minimum standards of need; and
- the State is willing and able to establish and secure conditions of safety and stability.

In an armed conflict, International Humanitarian Law (IHL) affords specific protections to medical personnel, facilities, and transport (both civilian and military). These protections are derived from the basic obligations to respect and protect the wounded and sick. **Medical personnel, facilities, and transport cannot be attacked or harmed in any way and must be spared during hostilities.** They should also not be prevented from fulfilling their medical functions.

The minimum standards on health reflect the core content of the right to health and help to progressively realise the right. In cases where there are gaps between national standards and the minimum standards on health (i.e. the minimum standards are higher), work towards progressively attaining the minimum standard while – when appropriate – supporting the government to improve their standards.

The right to health is intricately linked to the realisation of other universal human rights, including the right to life, the right to water and sanitation, the right to food, and the right to shelter. Health responses must coordinate with other technical sectors to work progressively towards achieving the right to health.

Health in humanitarian response

Humanitarian emergencies, including armed conflicts or disasters, almost always have a significant impact on the public health and well-being of affected populations. Access to healthcare is a critical determinant for survival in the initial stages of an emergency. The impacts of a disaster on public health can be both direct and indirect:

- **Direct impacts** include death from violence or injury.
- **Indirect impacts** include increased rates of infectious diseases, interrupted treatment, and/or malnutrition. Different factors, such as a breakdown in sanitation, inadequate quantities and quality of water, deterioration of food security, overcrowding, and inadequate shelter, increase public health risks. These increased risks can result in outbreaks or communicable diseases. Disruption or reduced access to healthcare can interrupt, for example, maternal healthcare or on-going treatment of non-communicable diseases (such as

hypertension or diabetes). Climate change also increases vulnerability and risks to public health.

The primary goals of responding to humanitarian emergencies are to prevent and reduce excess mortality and morbidity. Different types of emergencies have differing scales and patterns of mortality and morbidity. As a result, the health needs of an affected population will vary according to the type and extent of a disaster.

Essential health services are priority interventions that effectively address the major causes of excess mortality and morbidity. In a humanitarian response, the health sector provides essential healthcare (preventative interventions and health promotion) in order to reduce health risks. A health systems approach is important to progressively realise the right to health. Humanitarian organisations must carefully consider staffing and how they invest in strengthening local health systems and health-workers. Hiring national and international staff in the immediate post-disaster period risks weakening the existing health-care system, both in the short- and long-term.

The planning, organisation, and delivery of health interventions can enhance or undermine existing health systems, their future recovery, and their development. Analysing the existing health system determines its level of performance and allows the identification of major constraints to the delivery of – and access to – healthcare. In the early stages of an emergency, targeted health and multi-sectoral rapid assessments should be undertaken. Incomplete information and inaccessible areas should not impede timely public health decision-making. Undertake more comprehensive assessments as soon as possible.

Urban crises require a different approach to health responses, given the greater density of people, buildings, policies, and behaviours. Identifying people who are at risk and may not have access to – or may not be able to afford – healthcare poses particular challenges. People seeking refuge in towns and cities often do not have information about the types of existing health services or where to access them, risking disease escalation. Outreach is crucial to help people cope with new urban stress factors (e.g. inadequate access to shelter, food, healthcare, jobs, or social support networks).

In urban crises, technology allows better communication of information related to healthcare and services. However, information can move quickly through high concentrations of people so be aware that rumours – and misinformation (e.g. of an outbreak) – spread quickly and must be addressed immediately. In towns and cities, optimise the potential of secondary and tertiary care providers who are often more present in urban settings: affected populations may go to them first to seek healthcare. It is important to increase the capacity to deliver primary healthcare, which includes participating in early warning systems for communicable diseases. Also increase the capacity to deliver usual specialised services.

Health, Protection Considerations, and the Core Humanitarian Standard

Attacks, threats, and other violent obstructions of the work of health-care personnel, facilities, and medical transport often occur in armed conflict or other emergencies. Measures must be put in place to prevent this violence and/or mitigate its effects. Many different factors need to be considered, including understanding applicable laws and regulations, as well as military doctrine and practice on the subject. Humanitarian organisations should understand and consider the following:

- compliance with the professional and ethical principles of healthcare;
- whether health-care providers have access to facilities and are accepted by – patients and communities;
- the physical safety and mental well-being of health-care workers; and
- the security of health-care facilities and infrastructure (*see Appendix on Recommendations and measures for the protection of healthcare in conflict*).

Health responders implement many of the Core Humanitarian Standard commitments through “patient engagement” (i.e. community engagement, village health committees, or direct contact with patients). Ensuring safe and accessible feedback mechanisms remains a challenge in many cases, particularly in acute emergencies. However, such feedback mechanisms are an essential element of any health response (*see Core Humanitarian Standard chapter and Health systems standard 1*).

When providing critical life-saving medical services to all parties to a conflict, humanitarian organisations must take extra care to present themselves as impartial and neutral actors. The standard of care in a health-care facility and its quality of services can influence perceptions of the facility. These perceptions may have an indirect effect on security. The **delivery of services must remain impartial. Healthcare needs to remain as neutral as possible when managing patients**, including by respecting and maintaining confidentiality and ensuring the safety of patient data.

Health-care facilities typically apply a no weapons policy. Before entering a health-care facility or medical transport, encourage weapons to be left outside to promote a neutral environment. Such a preventative measure avoids tension or the escalation of conflict within the facility. Take security measures to protect the facility and staff from hazards. At the same time, understand how those security measures identified may affect the general public’s perception and acceptance of the health-care facility.

Trust between community members is critical. Engage community leaders in advocacy and information dissemination to help increase response among community members for the services provided. Such engagement can also foster understanding of the impartial nature of healthcare delivery.

The location of a health facility will also influence perceptions (for example, e.g. if it is situated near a military camp). Humanitarian organisations must consider their **choice of profile management strategies**, such as taking a **low-profile management approach** (for example e.g. non-branding of assets or locations) or a **high-profile management approach** (e.g. displaying large logos on assets or locations).

Civil-military coordination or cooperation should be carefully considered for humanitarian organisations involved in health activities. Such considerations are particularly crucial in conflict environments where civilians may be vulnerable to risks. In such situations, perceptions of neutrality and acceptance in the community may also be affected. Humanitarian agencies may – as a last resort – have to utilise some capabilities that militaries can provide, such as infrastructure support (i.e. to re-establish power supplies to health facilities) or indirect assistance (i.e. to transport health items). The impact on humanitarian principles and perceptions of neutrality and impartiality must be carefully considered before turning to the military’s capabilities as a last resort (*see Civil-Military Coordination in “What is Sphere?”*).

The protection and care of health providers and caregivers must be prioritised, given that they are exposed to incredibly challenging and traumatic situations. Ensuring good mental health and providing psychosocial support, when necessary, is critical for caregivers. They must also be given adequate information – for example in a pandemic setting – in order to care for themselves and make free and informed choices when necessary.

An unaccompanied child in need of critical healthcare, but without an adult present to provide consent, poses a particular protection challenge in emergencies. In such cases, the health-care provider must make a decision concerning treatment, knowing that such a decision will need to be carefully managed thereafter. The right to life will likely outweigh the right to consent in such cases, but such a decision must be sensitive to the context, cultural norms, and practices.

With developments in past years, **increasingly, healthcare must be provided at sea, in international waters or once individuals are brought to shore**. Such healthcare provision – often accompanied

with specific protection challenges and political complexities – is becoming a more frequent mode of delivery. Careful planning, preparedness, and mitigation of protection risks are essential in such health responses.

For further reading

1. OHCHR and WHO (2008). *The Right to Health: Fact Sheet No.31*. <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>
2. UN OCHA (2014). *Humanitarian Civil-Military Coordination: A Guide for the Military*. <https://docs.unocha.org/sites/dms/Documents/UN%20OCHA%20Guide%20for%20the%20Military%20v%201.0.pdf>
3. UN OCHA (2015). *UN-CMCoord Field Handbook*. <https://www.unocha.org/legacy/what-we-do/coordination-tools/UN-CMCoord/publications>
4. Global Health Cluster (2011). *Position Paper on Civil Military Coordination during Humanitarian Health Action*. www.who.int/entity/hac/global_health_cluster/about/policy_strategy/ghc_position_paper_civil_military_coord_2_feb2011.pdf?ua=1
5. ICRC (2015). *Ensuring the preparedness and security of health-care facilities in armed conflict and other emergencies*. <http://healthcareindanger.org/what-can-be-done/>
6. ICRC (2012). *The responsibilities of health care personnel working in armed conflicts and other emergencies*. <http://healthcareindanger.org/what-can-be-done/>

1. Health systems

It is very rare that humanitarian actors operate in an emergency where there is no pre-existing health system. Where a system is weak or a vacuum exists, systems will need to be strengthened or developed (for example referral pathways, health information collation and analysis).

A well-functioning health system can ensure that health care delivered in a crisis is responsive to all needs. It contributes to avoiding excess mortality and morbidity from vaccine preventable diseases or easily treatable conditions even during a large-scale health crisis such as an Ebola outbreak.

Any actor that is involved in promoting, restoring or maintaining health contributes to the health system. It encompasses all levels from national, regional, district, and community, as well as carers in the household and the private sector. Core aspects of a health system include the delivery of quality health services; a trained and motivated health workforce; appropriate supply, management and use of medicines, diagnostics material and technology; good health information and analysis; appropriate financing of health care, and leadership and coordination. They are not independent, but affect each other in many ways (e.g. insufficient health workforce will affect service delivery).

In an emergency, health systems are weakened affecting the provision of healthcare. For example, there may be loss of health staff, interruption to medical supplies or damage to infrastructure. It is important contextualise and understand the impact of the crisis on health systems to determine humanitarian response.

Health Systems Standard 1.1: Health service delivery

People have access to safe, effective and quality health care from health promotion to prevention, treatment, rehabilitation and palliative care during an emergency.

Key Action 1: Provide sufficient and appropriate health care at the different levels (such as household, health post, health centre, mobile clinics, hospital) of the health system.

- Identify and address obstacles to accessing services by at-risk groups.
- Engage with community to design health services relevant to their needs and access acceptable to the affected population.

(see PHSS and HSS standard 6 for prioritising health services)

Key action 2: Establish or strengthen referral system and for all agencies.

- Address referrals between levels of care and services, including emergency referral services.
- Establish or strengthen a protocol for triage at health facilities to ensure those with emergency presentations received immediate treatment and stabilisation care during transport when referred.
- Include referrals between sectors (for example, nutrition, psychosocial support and mental health, child protection).

Key action 3: Provide health care that guarantees patients' rights to dignity, privacy, confidentiality, safety and informed consent.

- Address special considerations for those unable to give valid consent such as children, those with psychiatric conditions, marginalised populations

Key action 4: Adapt or utilize standardised protocols for health care, case management and rational drug use

- Use national standards and adapt to the emergency context, or international guidelines if not available (for example, IMCI WHO 2014, Medecins Sans Frontiers Clinical Guidelines Diagnosis and Treatment Manual 2016)

(see below, HSS Standard 2: Health workforce, HSS Standard :4 Medicines)

Key action 5: Provide safe health care and services.

- Use appropriate infection prevention and control measures (see below XXX).
- Employ appropriate use (rational drug use) and safe management of medicines, laboratory and technology (see HSS standard 3 medicines and devices).
- Develop appropriate infrastructure for the level of care.

Key action 6: Manage and bury dead persons in a safe, dignified, culturally appropriate manner, based on good public health practice.

- taking into consideration people's the faith practices.

Key indicators

Availability of health facilities

- one community health unit per 1,000
- one health facility/10,000 population
- one community health unit per 1,000
- one health facility/10,000 population
- five health facilities with BEMOC and newborn care / 500, 000 (see SRH Section)
- one health facility with CEMOC and newborn care / 500,000 population (see SRH section) (see SRH Section)
- ten inpatients beds /10,000

Utilisation rates at health facilities *for discussion*

- 2–4 new consultations/person/year

>1 new consultations/person/ year in rural and dispersed communities

Proportion of health care facilities utilizing referral system

Proportion of population within 5km of health facility

What else do I need to know?

When setting standards and meeting minimum requirements it is important to contextualise the situation. The architecture of the pre-existing health system, type of crisis and its impact on the various aspects of the health system (for example, on health workforce, drug supply system) as well as geographical variations and population spread will determine how, where and when services should be delivered.

Access to health care is dependent on availability of health facilities, in terms of the physical reach, affordability, and acceptability.

Availability

The number and location of health facilities needed, and the different services that should be provided at the different types of health facilities will vary due to context. In rural areas with dispersed populations, where health staff with a diverse skill set may be difficult to attain, outreach with community programmes, mobile clinics and facilities reaching a smaller population (for example, 1/5,000) should be sought instead of the standard 1/10,000. Likewise, in urban areas secondary health care facilities may be the first point of access to health care, with an increased demand to provide primary and specialised secondary health care. It is thus important to consider availability of facilities and services, guided by national standards (if they exist), but adapted to the emergency context, analysing regional variation, assessing public health risks and needs, to determine how to deliver prioritised health services. (See standard 6 leadership and coordination, and Section 2 Prioritising Health Services).

In protracted crisis settings the aim should be to provide an essential package of services which will be more comprehensive.

Scaling up of services during an emergency may require either supporting existing health facilities, through HR, supplies, operational costs, providing specified services, or through the formation of additional facilities, mobile clinics or field hospitals. Providing surge capacity for health care is critical in emergencies however care must be taken not to duplicate service provision in an area thus wasting valuable resources, nor to diminish a community's trust in existing health service points, or weaken them e.g. through the poaching of staff (see health workforce). This is especially important with temporary health care delivery (for example, mobile clinics and field hospitals) as when they close the population will need to return to access care at previous service delivery points. All health care provision should be coordinated with the Ministry of Health (or lead agency) and health partners to avoid duplication or gaps (see standard 6 leadership and coordination).

Acceptability

Health seeking behaviour should be understood by analysing previous data and conducting assessments, household surveys, key informant interview and so on. Consultations should be held with all sections of the community, including at risk groups such as women, children, people living with HIV, people with disabilities, and older people. Having a people-centred approach and including people in the design of the programme, addressing their health needs and socio-cultural expectations, and addressing barriers to healthcare, can increase acceptability and patient engagement. This can improve access to and timeliness of care, particularly for marginalized groups. It also ensures resources are aligned with patient and community priorities.

Affordability: see HSS standard health care financing

Readiness

Health facilities should have the capacity to deliver the services offered and be able to respond to increased or changed needs. This includes having trained staff, guidelines, infrastructure, and medicines. Service availability and readiness helps the delivery of quality care.

Primary health care includes provision of care at household and community level. This may be through community health workers (CHWs) or community health promoters (CHPs). Although not facility based, CHWs and CHPs should have strong links with the nearest primary health care facility to ensure integrated and longitudinal (that is, continuity of) care and for clinical supervision and monitoring of program progress. This is also pertinent if CHWs or CHPs are screening for acute malnutrition where referral to nutrition services (at health facilities or other locations) is needed (see FSN). It should be done in collaboration with village health committees to increase patient and community engagement.

Health promotion

Initiate programmes on community health promotion in consultation with the community, local health authorities, community representatives, and local faith leaders ensuring a balanced representation of women and men of all ages and backgrounds. Identify key factors that can protect health and wellbeing that are influenced by local cultural and religious understandings. The programme should provide information on the major environmental risk zones, health problems, health risks, the availability and location of health services and behaviours that protect and promote good health, and address and discourage harmful practices. Develop and validate the messages and strategies with the participation of women, girls, men and boys (separately when necessary) to ensure their age, gender, diversity and cultural appropriateness. Schools and child-friendly spaces are useful for messaging to children and parents.

Emergency referral systems (including pre-determined transport mechanisms) should be available 24 hours a day, seven days a week. Communication between referrer and receiving health care provider should occur, including a clinical handover explaining the status and medical needs of the patient.

The utilisation rate of health services should be guided by national standards (if they exist) adapting it to the emergency setting. If the rate calculated is lower than anticipated, it may indicate inadequate access to health services, poor quality of services, direct or indirect costs, preference to use other services (for example, traditional healers, dispensaries) or overestimation of the population. If the rate is higher, it may suggest over-utilisation due to a public health problem or under-estimation of the target population. (see Appendix XX to calculate utilization rate). It is important to conduct assessments to understand health seeking behaviour, population preferences and barriers to health care.

Patients' rights

Design health facilities and services in a manner that ensures privacy and confidentiality. Seek informed consent from patients (or their guardians if they are not competent to do so), before medical or surgical procedures. Ensure that health staff understands that patients have a right to know what each procedure involves, as well as its expected benefits, potential risks, costs and duration and other available options. Protect patient data (see HIS standard).

Safety

Multiple factors such as understaffing, inadequate structures, overcrowding, insufficient equipment, poor hygiene and sanitation contribute to unsafe care. Most unsafe care is avoidable through basic measures.

Infection prevention and control

Protects both patient and healthcare staff. Priorities are to prevent transmission of healthcare associated infections (HAI) as well as spreading antimicrobial resistance (AMR). Within a healthcare facility the aim is to minimise transmission of infectious diseases and to prepare and prevent outbreaks (see Communicable diseases). Core components of an IPC program are:

- providing technical guidelines on prevention and management of infections;
- training all staff and occupational staff in IPC;
- surveillance of diseases and compliance with IPC practice;
- laboratory support for diagnosis;
- clean and safe environment;
- monitoring programs; and

- linking with other public health services such as WASH. (see Aide-Memoire. Core components of infection prevention and control programmes in health care. Global Alert and Response WHO 2011)

Appropriate infrastructure

Ensure there is appropriate and accessible infrastructure for the level of care provided. For example, private spaces for consultations, adequate patient flow, sterilization room (not open air) for hospitals, sufficient energy supply to support critical equipment, adequate WASH structures. (See Planning and Design of Health Care Facilities. Medecins Sans Frontiers 2013; Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters. EMT WHO 2013).

Facilities should also consider preparedness measures to make health facilities safe and accessible during a disaster (such as flooding or conflict). This is especially relevant in protracted settings, or where multiple hazards are faced over time. (See Hospital Safety Index Guide for Evaluators. WHO 2015; and Ensuring the preparedness and security of health care facilities in armed conflict and other emergencies. ICRC 2015)

Healthcare waste

Contains potentially harmful organisms such as HIV and Hep B, which can infect patients, health staff, the community, as well as contaminate soil and water sources. Segregate waste at the point of generation by the patient, right through to final disposal. As a minimum, segregate waste into three parts:

- general waste, such as paper;
- hazardous sharps (such as needles and knives); and
- hazardous non-sharps (such as used dressings, swabs, gloves).

Train all staff in waste segregation and management. Assign and train designated personnel to collect and dispose of healthcare waste and ensure that they wear protective equipment (gloves and boots are minimum requirements). Dispose of waste according to the type of waste. For example, dispose of hazardous non-sharp and sharp waste by incineration or in protected pits. If organic waste such as placenta, or limbs due to surgery, is produced, burial in adequate cement pits is possible. Incineration may be possible but has large energy and fuel requirements. (see Safe management of wastes from healthcare activities WHO 2014) (see standard 3 for disposal of medicines, and WASH and Health Chapter)

Health facility WASH standards

See Standard x (WASH and Health), and Essential Environmental Health Standards in Health Care (p28) WHO (2008)

Adverse events

Studies show that 10% of hospital patients suffer an adverse event, the most common being due to unsafe surgical procedures (27%), medication errors (18.3%) and health care associated infections (12.2%), poor clinical handovers during referrals, and poor injection safety. Health care providers can improve safety by engaging with patients, checking procedures, learning from errors and communicating effectively within the healthcare team. For further information see Safer Primary Care Series WHO (2016) (looking at Patient engagement, education and training, human actors, administrative errors, diagnostic errors, medication errors, multi-morbidity, transitions of care, electronic tools); WHO Safe Childbirth Checklist (2015); WHO Surgical Safety Checklist (2008). Also see Minimal Information Model for Patient Safety (2014), Patient Safety Incident Reporting and Learning Guidelines WHO (2017), to facilitate learning from adverse events.

Handling the remains of the dead

Promote proper and dignified management of dead bodies, allowing also for their identification especially during large disasters with missing people. Do not dispose of bodies unceremoniously in mass graves. It is false to consider dead bodies represent a health risk if not buried or burned quickly. Only in certain cases (such as Ebola) are specific precautions required. People should have the opportunity to identify their family members and to conduct culturally appropriate funerals. Mass burial may be a barrier to obtaining death certificates necessary for making legal claims. Consider potential legal issues when burying the victims of violence. (see Management of Dead Bodies after Disasters: A field Manual for First Responders Second Edition. ICRC, IFRC, WHO 2016). (see Shelter and settlement standard 2).

Health Systems Standard 1.2: Health workforce

People have access to quality health workers at all levels of health care to meet the health needs of the population

Key Action 1: Review existing staffing levels using national standards and classifications of job functions if available adapting to the emergency setting

- map against findings to determine gaps

Key Action 2: Recruit sufficient staff to match needs ensuring a mix of skills and gender and ethnic ratios where possible.

Key Action 3: Integrate local health workers into emergency response.

Key Action 4: Train staff based on an assessment of their performance and skills.

- Use national standards adapting it to the emergency setting or international guidelines on:
 - clinical protocols and case management
 - standard operating procedures (e.g. IPC, healthcare waste management)
 - codes of conduct (e.g. medical ethics, patients' rights, humanitarian principles)
- Ensure refresher training where turnover is high
- Share details on trainings conducted with MoH at national and sub-national levels

Key Action 5: Ensure health workers operate (including CHWs) in a safe working environment. Provide:

- occupation health training and protection (e.g. Hep B, tetanus immunisation for clinical workers)
- IPC training and provision (see HSS standard 1)
- adequate IPC and protective equipment to carry out duties (see HSS standard X)

Key Action 6: Develop incentive and salary strategies that minimise pay inequities and maldistribution of health workers between MoH, and other health providers.

Key Action 7: Share health workforce data availability and readiness with MoH at national and sub-national levels.

- see Minimum data set for Health workforce registry WHO 2015

Key indicators

Availability of health workers

- 1 -2 community health workers / 1000
- Number of midwives / xxx (check with SRH)
- 23 qualified health workers/10,000population (The 2006 World Health Report states minimum number of health workers i.e. doctors, nurses and midwives, to attain high coverage 80% of skilled birth attendance was 23/10,000).

Number of consultations per clinician per day

- 50 (UNHCR 2014)

Percentage of births assisted by skilled birth attendant

Number of health workers newly recruited at primary health care facilities in the last 12 months (WHO MBHSS 2010)

What else do I need to know:

Availability of healthcare workers

The health workforce includes a broad range of personnel including medical doctors, nurses, midwives, clinical officers, laboratory technicians, pharmacists, CHWs as well as management and support staff (such as cleaners). Variations exist for the classification or competency requirements for many job functions (such as community health worker, clinical officer), so follow national guidelines and classifications especially with the recruitment of local staff. If national guidance is unavailable, follow international guidelines (see template on classifying health workers WHO 2012).

The recruitment and utilisation of international staff should follow national and ministry regulations as required (for example, evidence of qualifications, especially for clinically practice). The number of health care workers and skills mix of staff should match the needs of the population, the level of health care and type of services that health workers will support (see WISN Workload Indicators of Staffing Need, User's Manual WHO 2010 HR planning)

Distribute healthcare workers equitably. This improves care for populations in hard to reach rural and urban areas, for groups of all socio-economic status, ethnicities and where there are critical gaps.

In rural areas where recruitment of higher level clinical staff may be difficult, increase availability to lower level health care through community outreach, mobile teams or health posts but develop strong referral mechanisms.

Acceptability

The sociocultural expectations of the population should be understood and met to increase patient engagement. Recruit staff who represent the diversity of the population being served. Ensuring appropriate gender balance, and mix from different socio ethnic groups can encourage increased attendance from marginalised groups.

Quality

Agencies have an obligation to train and supervise staff to ensure that their knowledge is up-to-date and their practice is safe.

Education

May be from pre-service and in-service education, on the job training, mentoring and supervision and refresher training. The production of safe and competent health staff should be standardised between health care providers to ensure equitable distribution. As such agencies should aim to standardise training programmes in alignment with national guidelines, adapting them to the emergency setting, or agreed international ones if not available. Records of delineating who has been trained, in what, by whom, when and where should be shared with the Ministry of health at national and local levels.

Health systems standard 1.3: Essential medicines and medical devices

People have access to essential medicines and other medical devices that are safe, effective and of assured quality.

Key action 1: Establish and utilise a standardised essential medicine and medical device list.

- Review existing national essential medicines and medical device list early in the response
- Advocate for the inclusion of critical medicines and equipment, such as:
 - NCDs;
 - SRH;
 - appropriate pain relief for palliative care and surgery;
 - anaesthesia; and
 - assistive devices for people with disabilities.

Key action 2: Ensure availability of safe, essential medicines through an effective medicines management system.

Key action 3: Ensure availability of safe, essential medical devices through an effective management system.

Key action 4: Accept donations of medicine and medical equipment only if they follow internationally recognised guidelines.

- Do not use donations that do not follow these guidelines.

Key indicators

Total number of days key medicines were not available in the past 30 days

- Suggest for example paracetamol, amoxicillin for child health, oxytocin (at certain levels of health care) for SRH, ACE inhibitor for NCD

Total number of days basic equipment were not available (or not functional) in the past 30 days

- Suggest for example blood pressure instrument, thermometer, stethoscope, weighing machine, cabinet/box for medicine, basin for water.
- See Global Atlas of Medical Devices (WHO 2017, page 78)

What else do I need to know?

Availability of essential medicines depends on the main elements of the medicines management cycle: selection, forecasting, procurement, storage, distribution.

Selection

The national essential medicines should be used as a basis for selection. Health partners should advocate for adjustments should any gaps exist (see controlled drugs below)

Quantification and forecasting

Should be based on consumption data, morbidity data (estimated in the early response, using health compiled data see HIS standard). National supplies of medicines may also be disrupted in the disaster (e.g. reduced local manufacturing capacity, damaged warehouses, delays to MoH international procurement) health actors will need to determine if or how to support maintaining existing systems and facilities (e.g. transport medicines from district to local health facility) or forecast the resultant increased demand on their facilities.

Procurement

Procurement methods should adhere to national customs regulations and quality assurance mechanisms (for international procurement). If delays are occurring health partners should advocate for improved mechanisms (through MoH, lead agency, NDMA, humanitarian coordinator). If systems do not exist health actors should aim to procure prequalified products, safe, well within expiry date, and in the language of the country and health workforce. IEHK should only be used in early phases of the emergency.

Storage

At every point in the drug supply cycle medicines should be kept in appropriate physical conditions to maintain safety and efficacy. Requirements vary between products. In the store room medicines should not be placed directly on the floor. The area should be separated for expired items (locked up), flammable products (well ventilated with added fire protection), controlled substances (with added security), products requiring cold chain, and products requiring temperature control

Distribution

Safe transport mechanisms from central stocks to health facility level should be established. Partners may use a push or pull system to ensure stock availability at facility level.

Safe disposal of expired medicines

Prevent environmental contamination, or hazards to people. Disposal mechanisms comply with national regulations if they exist (ensuring adaptation to the emergency setting), or international guidance. Ultra-high incineration is costly, pharmaceutical stockpiling useful only in the short-term, engineered landfills, waste immobilization by encapsulation or inertization may be a possibility. (See Guidelines for safe disposal of unwanted pharmaceuticals in and after emergencies, WHO 1999).

Availability of medical devices

Carefully define a list of the necessary devices and equipment (including laboratory reagents etc) to be available at each level of healthcare. This should be guided by national standards if available and adapted to the emergency setting or by international standards if not (see Global Atlas on Medical Devices. WHO 2017) Include provision of assistive devices for people with disabilities (see Priority Assistive Products List, The GATE Initiative. WHO. USAID 2016).

Establish a clear management system for medical devices

Select products as determined above. Procure safe devices and products in line with national regulations, or international guidance. Keep a clear inventory on products. Ensure safe use of devices including providing regular maintenance. Decommission devices in a safe manner. (see Medical Devices Technical Series. WHO 2011)

For assistive devices, distribute or replace lost devices together with easy to use information on its use and maintenance. Refer to rehabilitation services for prescription of appropriate size, fitting, use and maintenance. Avoid once off distribution.

Controlled drugs

Includes medicines providing pain relief for surgery and palliative care, some medicines for mental disorders as well medicines used in post-partum bleeding. Governments aim to balance appropriate usage with abuse but 80% of low income countries do not have access to adequate pain relief. When access to adequate medicines is insufficient, health actors should advocate with MoH and government to determine mechanisms for its availability e.g. through MoH (see Guidance for availability and accessibility of controlled medicines, WHO 2011).

Blood products

All activities should be coordinated with the national blood transfusion service if it exists. Collection should be from volunteers only. All products should be tested for HIV, hepatitis B and C, Syphilis as a minimum with blood grouping and compatibility testing. Products should be stored and distributed safely. Rational use of blood and blood products should be promoted with training clinical staff. (See Guidelines on management of blood and blood components as essential medicines. Annex 3. WHO 2017)

Health Systems Standard 1.4: Health financing

People have access to free healthcare for the duration of the emergency.

Key action 1: Protect people from catastrophic health expenditure.

- Identify and mobilise financial resources that will enable the provision of free health care at the point of delivery to the affected people for the duration of the emergency.

Key action 2: Plan for user fees to be abolished or temporarily suspended where they are charged through the government system.

- Apply this for the duration of the humanitarian response.

Key action 3: Provide support to government health facilities to cover any financial gaps created by the abolition and/or suspension of user fees.

Key indicators

Provision of primary health care to the affected people is free of charge at all government and nongovernmental organisation facilities for the duration of the humanitarian response.

What else do I need to know?

User fees

A fundamental humanitarian principle is that services and goods provided by humanitarian organisations should be free of charge to recipients. User fees (paying for services at point of delivery) impedes access to health care and results in at-risk groups not seeking appropriate healthcare when needed. In an emergency, remove or reduce financial barriers as much as possible to provide financial protection against catastrophic health expenditures (where expenditure is >40% of household income). Health organisations should ensure there are no user fees for service delivery, receiving medication or transportation for an emergency referral (see Position Paper on User Fees, Global Health Cluster 2011).

Suspending user fees at government facilities will cause financial strain. Consider supporting MoH health facilities with staff salaries and incentives, extra medicines, medical devices and assistive devices supply. Carefully monitor the accessibility and quality of services after the removal of user fees. If user fees at government health facilities are temporarily suspended, ensure there is clear communication to the population regarding the timing and reasons.

Funding for health interventions includes public sector for MoH activities, existing development funding (implemented by various actors), as well as humanitarian funding. In an emergency it is critical to determine which essential services to deliver (see Section Prioritising Health Services), by whom, and its cost. The gap in funding to provide surge capacity, scale up programmes and address needs should provide a basis for mobilising funds. Resource mobilization for humanitarian funding may sometimes involve a collaborative appeal, such as through a Flash Appeal (for the first 3 to 6 months of an emergency), a Humanitarian Response Plan, or a refugee response plan.

Cash based incentives (CBIs) and cash transfer programming (CTPs)

At this writing, there is a lack of clear evidence on good practice in using CBIs or CTPs for health interventions in humanitarian contexts with a positive impact on health outcomes. Social sectors such as health are characterised by services, rather than accessing goods, where CBIs may be more effective. There have been some examples of good practice in the development context for reducing financial barriers, and improving use of health services. In the humanitarian context, examples where CBIs have been useful are when:

- an emergency has stabilised;
- there is a predictable service to support (such as antenatal care, chronic diseases)
- there is existing positive health seeking behaviour and high demand, and
- other critical household needs have been met (e.g. food and shelter).

Interventions to cover indirect costs such as transport has been documented as useful.

Health Systems Standard 1.5: Health information management

People have access to health care that is guided by evidence through the collection, analysis interpretation and utilisation of relevant public health data.

Key action 1: Analyse pre-disaster health information where available.

- conduct rapid multi-sectoral and targeted assessments to identify risks and needs to prioritise health response measures (see Prioritising Health Services).
- Map pre-existing health facilities, assess their current status including functionality, service availability and damage

Key action 2: Adapt or develop or a health information system that is suitable and appropriate for the context and the emergency.

Key action 3: Adapt or develop a disease early warning alert and response system to detect epidemic-prone communicable disease outbreaks and response.

- Base this on epidemiological risk and context of the emergency (see Communicable Diseases).
- Use standard case definitions, and incorporate both indicator and event-based components in the early warning.
- Ensure all emergency-affected population is represented in the system.

Key action 4: Agree common operating data definitions for all agencies and sectors to use.

- Consider denominator figures, such as population, family size, age disaggregation, etc.
- Consider administrative areas, P codes

(see Common Operating Datasets in Disaster Preparedness and Response, IASC 2010)

Key action 7: Monitor health situation through surveillance and other health information.

- Agree on:
 - standard indicators of what to monitor;
 - reporting units (such as mobile clinics, field hospitals, health posts);
 - reporting pathways; and
 - frequencies of submission, analysis and report generation and dissemination.

Key action 7: The lead agency analyses, interprets and disseminates health surveillance information to partners in a timely and regular manner to all stakeholders.

Key action 8: Use surveillance information supplementary data, such as surveys, health facility assessments in a timely manner to guide decision making for health programmes.

Key Action 9: Take adequate precautions and clearly stipulate actions for the protection of data to guarantee the rights and safety of individuals, reporting units, and/or populations.

Key indicators

Early warning surveillance reports received from health facilities each week (see communicable diseases)

- 90%

A regular overall health information report is produced by the lead health actor, including analysis and interpretation of epidemiological data as well as a report on the coverage and utilisation of the health services.

What else do I need to know

Health information system

Collects data and generates information to identify problems and needs at all levels of the health care system. This is used to make evidence-based decisions on health response. The HIS should be flexible enough to incorporate and reflect unexpected challenges, such as outbreaks, total collapse

of the health system or services. Collect data from various sources, using a valid methodology. It may be qualitative or quantitative.

Health surveillance

This is one method of collecting data. It is the continuous, systematic collection, analysis and interpretation of health-related data. It is also used for the planning, implementation, and evaluation of health care. During the emergency response, health data should include:

- under 5 mortality rate (also see SMART survey see FSM);
- crude mortality rate;
- proportional mortality;
- cause-specific mortality;
- incidence rates for key morbidities;
- incidence rates for outbreak diseases (see Communicable diseases section);
- proportional morbidity of key morbidities (such as ARI, malaria, and AWD);
- measles coverage rate (or DTP3 coverage as a marker of childhood routine immunisation);
- number of functional health facilities;
- service availability of priority health services (such as EMOC, BEMOC, mental health)
- health centre utilisation rate; and
- number of consultations/clinician/day.

Other important health data can be by performing all hazard risk analysis, population based surveys, health facility assessments, service availability and readiness assessments, quality of service measurements, data from other sectors such as, nutrition, WASH, protection etc

Disaggregation of data

As a minimum, disaggregate mortality and morbidity data for children under and over five years old. But after the early stage of the emergency aim to disaggregate data by sex, age, disability, affected and host populations, context (such as camp/non-camp situation), and administrative level (for example, region, district). Such detail helps to detect potential inequity for at-risk groups.

Data management, security and confidentiality

Take adequate precautions to protect the safety of the individual, as well as the data itself. Staff members should never share patient information with anyone not directly involved in the patient's care without the patient's permission. Give special consideration to persons with intellectual, mental or sensory impairment that compromises their ability to give informed consent. Be aware that many people living with conditions such as HIV may not have disclosed their status to their close family members. Treat data that relates to injury caused by torture or other human rights violations, including sexual assault, with care. Consider passing such information to appropriate actors or institutions if the individual gives their informed consent. See Protection Principles X and CHS Commitment X.

Health Systems Standard 1.6: Leadership and coordination

People have access to health services that are coordinated across levels, agencies and sectors to achieve maximum impact.

Key action 1: Ensure that representatives of the Ministry of Health lead coordination of the health sector at all levels of health care, or at least are closely involved in it.

- If the MoH lacks the necessary capacity or willingness to lead the coordination identify another agency with the capacity to do so.
- The lead agency should work in line with principles of aid effectiveness and humanitarian principles.

Key action 2: Identify priority health needs and determine mechanisms to address them.

- Employ sector-wide approach.
- See Prioritising Health Services section.

Key action 3: Participate in health sector coordination to minimise duplication, address gaps and ensure a standardised response.

- Coordinate at and between all levels of health care (national, sub national, district and local).
- Conduct coordination meetings at certain levels depending on context.
- Coordination should occur between humanitarian response and usual development programming

Key action 4: Coordinate health activities with other relevant sectors (such as nutrition or WASH), or with cross-sectoral working groups (such as MHPSS or HIV) at all levels

Key action 5: Provide regular and timely information on who is doing what where and when, with realistic reflection of capacities and readiness

Key action 6: The lead agency should regularly produce and disseminate updates and health sector bulletins to inform health partners on current status and impact in a timely manner.

Key indicator

The lead health actor and health sector partners have developed a steering document defining health needs and an agreed response strategy.

What else do I need to know:

Lead health agency

The Ministry of Health should be the lead health agency responsible for leading and coordinating the health sector response. In some situations, the MoH may lack capacity or willingness to assume the role in an efficient and impartial manner. In such situations, another agency should take the responsibility. In refugee situations UNHCR is designated to coordinate health activities. In other situations, or emergencies where a cluster is activated, it is often WHO (as Global Health Cluster Lead). However, when both the MOH and WHO lack capacity, health partners should identify another agency to coordinate activities. If a cluster response is activated Co-leadership with NGOs is advocated.

Coordination occurs at many levels and in many ways. Meetings are just one mechanism and should occur at the national and sub-national level. Sharing information on 4Ws with the sector, and with the lead agency performing analysis and disseminating results in a timely manner is also critical in understanding where needs and gaps are.

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2. Essential health services

Essential Health Services Standard 2.1: Prioritising health services

People have access to health care that is appropriate and prioritised to address the leading causes of excess mortality and morbidity.

Key action 1: Coordinate with the Ministry of Health or lead agency and other health partners to collectively agree and prioritise health services.

Key action 2: Determine pre-disaster health needs and service availability.

- Determine the impact of the disaster on immediate health needs of population and service availability
- Assess risks such as overcrowding, displacement, malnutrition, lack of access to water or continuing conflict and its potential impact on health needs
- Identify population groups vulnerable people who may be at increased risk such as women, children, older people, people persons with disabilities, from marginalised communities, hard to reach areas
- Identify health risks most likely to occur and cause greatest morbidity and mortality.

Key action 3: Analyse which interventions will have maximum impact to reduce morbidity and mortality.

- Review which are:
 - most effective; and
 - most feasible to implement (this includes logistics as well as mobilisation of resources).

Key action 4: Prioritise and implement interventions.

- Target:
 - the most likely and largest causes of excess morbidity and mortality;
 - the population groups most affected;
 - most effective in reducing morbidity and mortality; and
 - most feasible.

Key action 5: Identify barriers that impede access to prioritised health services and establish practical solutions to address them.

Key action 6: Coordinate the implementation of priority health services with the Ministry of Health, or lead agency, and with other health partners.

Key action 7: Repeat the prioritisation exercise as the response evolves to assess and address any changes in health needs.

- The frequency of this should be decided together with MoH, or lead agency, and with all health partners.

Key indicators

Under-five mortality rate (U5MR)

- Number of deaths/10,000/day
 - fewer than twice the baseline rate recorded for the population before the disaster; or
 - fewer than 2/10,000/day if the baseline is unknown

Crude mortality rate (CMR)

- Number of deaths/10,000/day
 - fewer than twice the baseline rate recorded for the population before the disaster; or
 - fewer than 1/10,000/day if the baseline is unknown

Interagency prioritisation exercise conducted in early stages of the emergency

What else do I need to know?

Priority health services are those that are most effective in addressing the primary causes of excess mortality and morbidity. This can vary according to context, type of disaster and its impact. As far as possible, base priority health services on the principle of evidence-based practice. A public health risk assessment tool using risk matrices (or similar) may be used (see WHO Rapid Risk Assessment of Acute Public Health Events 2012).

Use pre-disaster morbidity data and surveillance and health information such as population surveys to collect and analyse data. Conduct health specific and multi-sectoral assessments. Disaggregate data by age, sex and disability.

It is important to understand health seeking behaviour and barriers to accessing health care among different population groups with a focus on the most at-risk. Review any pre-disaster information on this, or conduct assessments. Barriers may be physical, financial, behavioural, cultural, and related to gender, age, disability, ethnicity and language. Design interventions to incorporate mechanisms to overcome them.

Examining pre-disaster morbidity, mortality and availability of services will give an understanding of health needs and population expectations, such as, for complex cases of non-communicable diseases (see section NCD).

Crude mortality rate and under-5 mortality rates are the most useful health indicators to monitor and evaluate the severity of an emergency. The U5MR is the more sensitive indicator. A doubling or more of the baseline CMR or U5CMR indicates a significant public health emergency, requiring an immediate response. When the baseline rate is unknown or of doubtful validity, agencies should aim to maintain the U5CMR below 2.0/10,000/day or CMR below 1.0/10,000/day.

Analysing how the health system and delivery of care has been affected by the disaster will help determine what and how much support is needed to implement interventions. Consider, for example, health workers affected, and medicine supply. (see health systems section).

Base access to health services on the principles of equity and impartiality, ensuring equal access according to need without any discrimination. In practice, organise the location and staffing of health services to ensure optimal access and coverage (see health systems section).

Together with the Ministry of Health, or lead agency, and all health partners produce a strategic document to reflect what health services have been prioritized to be implemented to respond to the disaster.

Once mortality rates have declined, more comprehensive health services should be established if resources allow. In protracted settings an essential package of health services should be implemented. (see XXXX)

Decide on thresholds at country level with MoH or lead agency, and health actors. For example, in countries where the baseline U5CMR already exceeds emergency thresholds, waiting for the doubling of baseline U5CMR to trigger an emergency response would result in a larger number of deaths and is not ethical. In such scenarios the MoH or lead agency, and health actors should agree on the target thresholds.

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2.2 Essential Health Services – Communicable diseases

A humanitarian crisis, whether it is a natural crisis, a conflict, or a famine, brings increased morbidity and mortality from communicable diseases. Population movement into crowded camps or shelters means that diseases such as diarrhoea and measles spread easily. Damage to sanitation infrastructure or lack of availability of clean water means that water and vector borne disease are transmitted rapidly. Breakdown of healthcare structures means that treatment, even for simple respiratory infections and vaccinations, may not be possible.

In conflict-affected settings, between 60 per cent and 90 per cent of deaths are attributable to these four major infectious diseases:

- acute respiratory infections;
- diarrhoea;
- measles; and
- malaria where it is endemic.

Acute malnutrition exacerbates these diseases, especially in children under five years of age and in older people.

The huge numbers of people across the world receiving tuberculosis treatment and/or HIV treatment need to be assured of the availability of basic diagnostic equipment and medications during crises. Systems need to be prepared to provide treatment even in unstable contexts.

Strategies should address communicable disease through prevention, surveillance and reporting, diagnosis and case management, and outbreak response.

More detailed actions related to HIV in emergencies are discussed in Standard XXX.

Essential Health Services - Communicable Diseases Standard 2.2.1: Communicable disease prevention

People have access to information and services that are designed to prevent communicable diseases.

Key action 1: Determine disease risks of affected population

- Review pre-existing data including surveillance data, conduct environmental (on site) assessments, key informant interviews and sector specific and multisectoral assessments.
- Review relevant cross-sectoral information including nutritional status, access to safe water and sanitation.
- Conduct risk assessments for affected population.

Key action 2: Implement cross sectoral communicable disease prevention measures for at risk populations.

- Prevent diarrhoea to the extent possible. Encourage improved hygiene, and handwashing with soap, safe disposal of solid human waste, provision of sufficient and safe drinking water. Ref Wash Standard.
- Provide adequate health facility and shelter space, spacing, and ventilation. Ref Shelter Standard.
- Implement food security and nutrition interventions to reduce vulnerability to communicable diseases. Reference Nutrition Food Security.

Key action 3: Develop and roll out integrated health promotion programs to support effective outreach, referral and implementation of all prevention activities.

- Engage communities including Community Health Workers, community leaders, traditional medicine practitioners, pharmacies, teachers, the private sector and at-risk groups.
- Provide accessible information in formats and languages that consider the needs of older people, people with disabilities, women, children
- Provide information and design programmes that address specific fears, rumours, and common beliefs, and promote healthy behaviour
- Include appropriate feedback mechanisms for all efforts. (see WHO vaccination in Humanitarian Emergencies Implementation Guide 2017; CHS chapter)

Key action4: Implement a coordinated vaccination strategy for affected people.

- Determine the need for mass vaccination for (for example, measles, cholera, and meningitis, influenza, Ebola) based on the following: risk of disease; availability and accessibility of vaccine; and operational feasibility.
- Resume the delivery of vaccination via the routine immunisation programme as soon as is feasible against tetanus, diphtheria, polio and tuberculosis.

(see WHO vaccination in Humanitarian Emergencies Implementation Guide 2017)

Key Action5: Implement integrated vector management (See WASH).

- Determine the need using epidemiological or entomological surveys in the context of population, season, shelter, or type of emergency.
- Promote the use of long lasting insecticide treated nets, indoor residual spraying, environmental spraying, and sanitation interventions that comply with local protocols, and with regard to risks.

Key indicators

Percentage of children aged 6 months to 15 years who have received measles vaccination (see child health section).

- 95% of children aged twelve months have had 3 doses of DPT (diphtheria, pertussis and tetanus)

What else do I need to know?

Vaccination

The decision to vaccinate before an outbreak during a crisis should be based on

- disease-specific risk factors;
- disease burden;
- population risk factors;
- access to vaccine, including considerations relating to the global stockpile; and
- contextual constraints including security and competing priorities.

The use of the WHO Framework for Vaccination in Acute Emergencies 2017 outlines the framework that the government or health lead humanitarian organisation would use to decide which antigens to vaccinate against. The framework currently considers 23 antigens (including

cholera, hepatitis E, PCV, rota virus) as well as being a general guide for the use of new vaccines such as for Ebola, Zika.

Where data on the specific criteria is not known due to the difficulties in diagnosis, lack of surveillance, then decision to vaccinate should be made using the Framework for Vaccination in Acute Emergencies based on proxy indicators or best estimates such as child mortality rate.

Special circumstances

Complex situations require extensive consultative processes when designing certain health education programs. Examples are viral haemorrhagic fevers such as Ebola, Marburg, Lassa fever, Crimean-Congo haemorrhagic fever, and Rift Valley Fever. (see WASH and Health section). Approach the use of experimental vaccines and therapeutics carefully and collaboratively with populations. Some situations require detailed community consultations.

Malaria

Implement specific methods according to the risk of infection, the phase of the emergency, mobility of the population, type of shelters, and vector behaviour.

If use of Indoor Residual Spraying (IRS) is appropriate, then coverage of 80% is required to ensure effectiveness.

Prioritise Long Lasting Insecticide Treated Nets (LLITNs) according to the phase of the crisis. In the early phase, where there is high to moderate malaria transmission, giving high priority to hospital patients, severely malnourished people and households, pregnant women, children under two years and unaccompanied children, and people living with HIV (ensuring their confidentiality is maintained in distributions). In the next phase address people in supplementary feeding programmes, children under five years, and the households of pregnant women and children under two years. Use the LLITNs in clinical settings during the early phase of a crisis in low transmission areas. In some settings, the use of netting or door covers may also be useful. Usage surveys should track the population (percentage and number) that is sleeping under the net. Analyse the data to ensure that men and boys do not receive preference over women and girls. According to national protocols and resistance patterns, pregnant women should have access to malaria prophylaxis (see SRH Section)

Aedes-transmitted diseases prevention for Dengue fever, chikungunya, Zika, and yellow fever (see WASH)

Vector control is the main control method. Target the most productive breeding sites. Base the targets on surveillance data that show the distribution of human cases and vector density.

Provide affected people with water storage containers with lids. Treatment of containers with approved larvicide is also effective.

Always promote the use of personal protection measures.

Initiate environmental clean-up campaigns to eliminate standing water.

Measles vaccination

In crises, malnutrition, vitamin A deficiency, disruption in routine vaccination, and overcrowding increase the risk of infection in young children. These factors can also increase the severity of the disease in all age groups. Therefore, the target age group can also be extended and all children aged between six months and 12-15 years should be immunised during the emergency phase. The aim would be a minimum of 95% coverage. In non-camps where, displaced persons are living within a host population, the host population should be included in the campaign.

Essential health services - Communicable Diseases Standard 2.2.2: Communicable disease surveillance and reporting

Surveillance and reporting systems provide early outbreak detection.

Key action 1: Determine the risk of communicable disease in affected population.

- Know the risks posed by the context and those associated with population such a population with low vaccination rates or risks originating in peoples' country of origin.
- Assess crowded camps and urban areas present a greater risk for spread of communicable diseases.

Key action 2: Establish and implement a context-specific disease early warning system and response network.

- Strengthen the national surveillance system to include an Early Warning Alert and Response Network (EWARN) component, or establish a separate EWARN system.
- Integrate health facilities into the surveillance system and ensure it as sufficient coverage appropriate for the risk.
- Train health care workers at all levels, and community volunteers about diseases of concern and mechanisms to notify health authorities (i.e. either immediately for alert diseases, or for priority diseases through the weekly reporting system).

Key action 4: Train and implement Outbreak Response Teams.

- Ensure that outbreak investigations are triggered rapidly by the surveillance systems.
- Ensure that teams have access all affected people. They may need remote investigation with in areas that are hard to reach.
- Secure the ability to confirm the existence of an outbreak with epidemiological and laboratory investigation.

Key indicators

Proportion of surveillance reports received from health facilities each week

- 90%

Percentage of alerts being reported in 24 hours

- 90%

Percentage of alerts being verified in 48 hours

- 90%

What else do I need to know?

Components of Surveillance or EWARN System

In the immediate phase, target the system on the most significant risks. Refine it in the continuation phase. Include:

- a network of implementing partners;
- implementation, where possible, at all health centres and at the community level, including the use of sentinel sites if appropriate;

- comprehensive assessment of all potential epidemic prone diseases;
- a small number of priority conditions for weekly surveillance and a small number of diseases for immediate alert;
- clear case definitions for each disease or condition;
- clearly defined alert thresholds for each disease that would initiate investigation;
- communication structures for rapid notification of formal or informal alerts to relevant authorities (electronic or mobile phone-based systems function well in settings where there is widespread network availability);
- a system for recording and responding to immediate alerts;
- weekly data reporting, data entry into a standard database, and data analysis;
- feedback from health partners from weekly surveillance and immediate alerts;
- regular case investigation (including contact tracing if needed;) and
- standard forms and protocols for initiation of a response.

Outbreak investigation

The nature of the outbreak investigation will depend on context. Adapt the investigation for settings where access is poor. These settings include areas with conflict or where there is a threat to investigating teams. However, the essential components should remain the same. They should:

- confirm the diagnosis: collect blood, stool or cerebrospinal fluid samples as relevant, in appropriate media to perform rapid tests or laboratory tests where indicated;
- define a case;
- count the cases;
- confirm the existence of an outbreak according to established thresholds, differentiating between seasonal peaks and real outbreaks;
- perform descriptive epidemiology of the time, person, and place, and develop an epidemic curve;
- determine who is at risk;
- establish population denominators and attack rates in view of the exposed population;
- determine environmental hazards that increase risk;
- develop hypotheses that explain exposure and disease;
- evaluate hypotheses;
- communicate findings; and
- implement population based control measures as soon as possible.

Disease thresholds for an outbreak

Diseases for which a single case may indicate an outbreak are:

- cholera;
- measles;
- yellow fever;

- Shigella; and
- viral haemorrhagic fevers (such as Ebola, Marburg, Lassa Fever, Crimean-Congo haemorrhagic fever, and Rift Valley Fever).

Diseases for which the number of cases or deaths is above the predefined threshold are:

- Malaria

Outbreak should be country-specific and considered in the context of what is expected at the time of year and whether mass displaced populations have moved from non-malaria endemic areas to endemic areas. In cases with limited data, warning signs include a considerable increase in a two-week period or an increase in case fatality rates. Rely on the country threshold and the WHO definition.

- Meningococcal meningitis.

In a population >30,000 the epidemic threshold is 10 cases per 100,000 persons per week. In populations of less than 30,000, five cases in 1 week or the doubling of cases over a three-week period confirms an outbreak. In a camp, or mass gatherings institutions or schools two confirmed cases in one week confirm an outbreak. (see Meningitis outbreak response in Sub Saharan Africa. WHO 2014)

Essential health services- Communicable Diseases Standard 2.1.3: Communicable disease diagnosis and case management

People have access to effective diagnosis and treatment for those infectious diseases that contribute most significantly to morbidity and mortality.

Key action 1: Develop and disseminate clear health education messages that encourage people to seek care for frequently occurring diseases.

- Involve community health volunteers or outreach networks.
- Develop written materials, radio broadcasts, or mobile phone messages.
- Organise community leaders, religious leaders, red cross / red crescent and related networks.
- Formulate targeted messages with relevant authorities, humanitarian organisations, and sectors in the case of specific outbreaks.

Key action 2: Provide healthcare to patients using approved standard case management protocols.

- Establish clear case definitions and protocols for syndromic diagnosis.
- Ensure drugs and medical supplies are reliably available according to national or essential drugs lists. (see Health systems standard 3).
- Ensure that there are sufficient numbers of trained health care workers at all levels including the community to serve affected people.
- Provide training on, and ensure the availability of protocols at the community, primary care, and hospital levels.

<ul style="list-style-type: none"> • Implement community-based management and referral networks for certain diseases. Examples include antibiotics for acute respiratory infections, or use of oral rehydration points in communities. • Establish referral networks to higher levels of care for severe cases or for isolation.
<p>Key action 3: Provide adequate laboratory and diagnostic capacity, supplies, and quality assurance.</p> <ul style="list-style-type: none"> • Follow international or national guidance (adapted to the emergency setting to determine use of rapid diagnostic tests (RDTs), definitive testing, or sensitivity testing for pathogens, and at which level of health care it should be provided (for example, RDT in the community). • Train health care workers on diagnostic methods, quality assurance, specimen collection, and transport. • Establish a coherent referral network of national, regional and international laboratory facilities where specimens can be tested
<p>Key action 4: Implement Infection Prevention and Control (IPC) measures at levels of health care (see Health system standard 1, and WASH and Health).</p> <ul style="list-style-type: none"> • Ensure that health facilities have clean water, ventilation, and sufficient hand washing stations. • Train staff on IPC procedures and provide them with adequate protective equipment. • Establish isolation areas with adequate personal protective equipment (PPE), according to national or international specifications and for specific diseases such as viral haemorrhagic fevers and cholera. • Manage medical waste and dead bodies management according to national, international, or expert guidance.
<p>Key Action 5: Implement Tuberculosis (TB) treatment programs.</p> <ul style="list-style-type: none"> • Continue treatment for individuals taking treatment pre-crisis need to through strong cooperation between emergency health providers and existing national programs. • Implement a comprehensive TB programme for new cases only when there is assured stability and funding for at least 12-15 months. • Design programmes so that they avoid treatment interruption in unstable contexts. • Develop programmes in close coordination with HIV caregivers and that are adapted to a diagnosis of HIV -TB coinfection. (see SRH section standard on HIV)
<p>Key Indicators</p>
<p><i>Reduction in the disease specific case fatality rate</i></p>
<p><i>Percentage of health centres supporting an emergency-affected population that are using standardised treatment protocols for a specified illness, based on monthly record reviews</i></p> <ul style="list-style-type: none"> • Treatment protocols = Implementation of IMCI national treatment protocols where applicable. • 80% based on limitations of availability of guidance and trained staff.

Percentage of health centres with capacity for isolation of diarrhoea patients and associated water, sanitation, and PPE needs.

- 80%

Percentage of reported cases confirmed by a recommended diagnostic method based on national or international guidance.

- 80%

Percentage of health care workers that wash their hands after every patient contact

- 100%

What else do I need to know?

Treatment protocols

Guide treatment management by agreed-upon national protocols. Protocols should include a package composed of diagnosis, treatment, and referral. If no such package is available in an emergency, consider Integrated management of childhood illness (IMCI) or integrated community case management (ICCM) depending on the context. Similarly, use of the Interagency Emergency Health Kit or WHO Diarrhoea Kits could be used for immediate needs.

Malaria

Access to prompt and effective treatment is important. In endemic regions, the choice of drugs, use of rapid diagnostic tests and treatment protocol (e.g. syndromic management) is determined in consultation with the lead health agency and national malaria control programme.

Tuberculosis

TB control is a complex issue because of increasing cases of drug resistance. Multi-Drug Resistant TB (MDR TB, resistant to two core anti TB drugs isoniazid and rifampicin) and Extensively Drug Resistant (EDR TB, resistant to four core anti TB drugs) have been identified. Both these types require longer, more expensive, and more complex treatments. In emergencies, it is often difficult to access the diagnostic and sensitivity testing that is necessary to ensure correct selection and use of TB medications.

Acute respiratory infections

These cover a spectrum of infections from upper respiratory tract infections and ear infections to pneumonia. Refugees and affected people are vulnerable due to over-crowding, indoor smoke and poor ventilation as well suffering from co-existing malnutrition or vitamin A deficiency.

The key to reducing case fatality rate from pneumonia is timely case identification, administration of oral antibiotics, and referral of severe cases.

Diarrhoea

Diarrhoea, including cholera and dysentery (bloody diarrhoea), are common in emergencies. Poor sanitation, lack of access to safe water, malnutrition, and overcrowding are contributing factors. Globally, the highest mortality is in the under five-year-old population. 40% of the mortality is in the under two-year old population. Early rehydration through the use of Oral Rehydration Therapy, done at household, community or primary healthcare level and increased access is key to controlling mortality. Depending on the context, this could be undertaken in dedicated centres, tents, or small shelters.

Clinically high-risk groups

Older people will suffer from communicable diseases due to co-morbidities and decreased physiological resilience. Consider this when designing treatment protocols and delivering training

to healthcare providers, for example, for cholera management. Initiate similar considerations for pregnant women, malnourished children and people living with HIV.

Healthcare acquired infection

In health facilities there is increased risk for transmission of diseases between infected patients, health care workers and susceptible patients. Health care workers may come into contact with infectious materials (e.g. urine, vomit, sputum, faeces) through direct contact from infected patients or through the use of unclean equipment. They risk exposure to needles and clinical waste such as placentas. If health workers maintain poor hygiene, disease transmission to other patients or workers may occur. Inadequate personal protective equipment, or infrastructure (such as medical waste zones or isolation areas) may also increase risk. Appropriate IPC, medical waste systems and infrastructure should be in place including post exposure prophylaxis (PEP) for HIV exposure. (see WASH and Health, Health Systems Standard 1)

Community-based management

Patients with malaria, pneumonia, diarrhoea, and diarrhoea cholera patients can receive treatment at the community level through the utilization of Community Health Workers, volunteers or similar networks. In the case of acute watery diarrhoea or mild cholera, treatment is through the use of oral rehydration points supervised by community members. Give careful consideration to making sure that women, men, boys, and girls all have access to care when using this method. Use both male and female health workers. Establish referral pathways among the community, health facilities and hospitals, based on triage and assessment.

Neglected tropical diseases

Neglected tropical disease control and treatment are not part of the initial phases of the emergency response. If populations move into a disease endemic area, in line with the risk analysis, they should access to outbreak preparedness and control programmes.

Essential health services- Communicable diseases. Standard 2.1.4: Outbreak preparedness and response

Outbreaks are controlled in a timely and effective manner.

Key action 1: Create and disseminate a multisector outbreak response plan.

- Include locally appropriate, disease specific outbreak thresholds, outbreak control teams, treatment protocols, contingency stocks of medicines, vaccines, and essential medical equipment.
- Build capacity on communicable disease control in emergencies through training workshops and education in epidemic high-risk areas.
- Act on gaps such as medical staff and supplies, that have been identified in the plan.

Key action 2: Execute a coordinated disease-specific outbreak response.

- Follow guidance for national outbreak protocols ensuring its relevance for the context, or using international guidance if not available.

<ul style="list-style-type: none"> • Coordinate vector control campaigns using environmental spraying, waste water clean-up, and NFI distributions in cases such as Dengue and Chikungunya. (see WASH and Shelter) • Implement targeted vaccination campaigns if needed for example for Measles, Yellow Fever, and Meningitis. • Implement isolation programmes and treatment as needed for example for Cholera and hepatitis E outbreaks.
<p>Key action 3: Create and coordinate outbreak specific logistic and response capacity.</p> <ul style="list-style-type: none"> • Ensure cold chain capacity for vaccines. • Ensure transport and storage capacity for medicines, NFIs, and supplies. • Implement additional medical facility capacity such as cholera or meningitis tents. • Ensure access and transport to laboratories at local, national, and international levels to test samples.
<p>Key action 4: Implement multisectoral, coordinated action between sectors.</p> <ul style="list-style-type: none"> • Coordinate provision of sanitation and clean water infrastructure. (see WASH) • Implement Infection Prevention and Control measures specific to outbreaks at health facilities. • Interact with nutrition programs for vulnerable groups such as children, pregnant and lactating women, older people, and the severely ill.
<p>Key indicators</p>
<p><i>Percentage of reported outbreaks investigated within 48 hours of alert.</i></p> <ul style="list-style-type: none"> • 90% of outbreaks investigated within 48 hours of alert. A higher rate is required during an active outbreak.
<p><i>Percentage of target populations successfully vaccinated against specific diseases.</i></p> <ul style="list-style-type: none"> • The percentage is determined by using WHO guidance and a decision framework during specified time periods that is responsive to outbreak dynamics. • Aim for minimum herd immunity (measles 94-95%).
<p>What else do I need to know?</p> <p>Outbreaks can spread rapidly in emergency situations and may lead to high rates of morbidity and mortality. Outbreaks may be a result of overcrowding in urban settings or in camps. Outbreaks may also be a result of an influx of un-immune populations. There is often a critical strain on the health system during a crisis. Health facilities may become isolation centres for specific outbreaks such as Ebola or cholera, leading to the collapse of other health services. Staff may be redirected to respond to the outbreak (see Health Systems section). Outbreaks expand beyond the health sector are multisectoral. Early coordination among sectors is crucial to a comprehensive and effective response. SEE WASH AND HEALTH</p> <p><i>Outbreak preparedness</i></p> <ul style="list-style-type: none"> • Brief all those who require knowledge of risk assessment and disease threats. • Disseminate an integrated outbreak response plan in partnership with all of the following sectors: WASH; nutrition; shelter; education; the host government; and military present in the area.

- Coordinate stockpiles of medicines, especially in areas with seasonal outbreaks or with other factors contributing to increased risks of outbreaks.
- Consider pre-positioning pre-packaged cholera or diarrhoeal disease kits in epidemic prone areas, including displaced person settlements, areas that have decreased access due to seasonal variation or security issues. Also consider emergency kits based on the list of potential outbreaks.
- Determine prompt procurement, shipping, and storage methods for supplies that are not suitable for prepositioning. An example of this type of supply is vaccine that requires continuous cold chain capabilities.
- Ensure the availability of protective devices for health workers.

Ensure the availability of laboratory supplies and guidelines for rapid testing for malaria, cholera, Dengue, and haemoglobin. Develop a protocol for definitive testing on a national or regional level. Definitive testing should include the following: serological, antigen or RNA diagnosis of measles, yellow fever, and viral haemorrhagic fevers; and culture for cholera. Develop protocols to transport media for bacterial pathogens such as meningitis, and plague. Develop plans for a means of transport such as trucks, and transport schedules.

Logistic support

Managed outbreak response requires instituting reliable medicine and medical device supply chains. This requires extensive cooperation with humanitarian organisations that move supplies, governments, ministries of health, the military, and the private sector. Where seasonal access problems exist or are likely, due to instability, incorporate the effort into preparedness activities.

Meningitis

Serogroups A, C, W and Y are known to cause outbreaks in emergency settings. Vaccines are available for use in epidemics for A and C. Routine vaccination in refugee settings is not generally recommended. If there is significant concern about an outbreak, based on knowledge of population movement, mass vaccination could be carried out. The spread may be rapid. Vaccination should be targeted at specific age groups, based on known attack rates, or at those aged six months to 30 years.

Given the need for lumbar puncture for a definitive diagnosis, a clear case definition should be established and disseminated during an emergency.

Viral haemorrhagic fever

The management and diagnosis of viral haemorrhagic fevers such as Ebola or Lassa fever are based on stringent national and international guidance. This includes protocols on the use of new vaccines and innovative treatment methods. The role of community engagement during these outbreaks is complex and may require an extensive consultative process.

Yellow Fever

Mass vaccination is recommended once one single case is confirmed in a displaced settlement for displaced and host populations. This should be combined with Aedes vector control measures, and strict isolation of cases.

Polio

While polio is included in EPI, it should be restarted following the initial stages of an emergency. Mass vaccination should be initiated if a case of paralytic polio is detected.

Cholera

According to WHO, a cholera outbreak should be suspected in the following situations: when a patient older than 5 years develops severe dehydration, or dies from acute watery diarrhoea; when there is a sudden increase in the daily number of patients with acute watery diarrhoea, especially patients who pass the rice water stools typical of cholera. In refugee or displaced settlements, any adult death by dehydration is thus highly suspect. An outbreak is declared as soon as there is a single bacteriologically confirmed case. Clear treatment and outbreak protocols should be available. The response should be coordinated across sectors. Oral cholera vaccines should only be used in stable setting, early on in an outbreak. It has little effect after cholera has spread widely. The use of these vaccines must be complementary to existing strategies for cholera control.

Hepatitis A and E

These present a significant risk particularly in refugee camps. Preventive measure should be put in place to improve sanitation, hygiene and safe water availability to prevent and control outbreaks

Measles (see standard 1)

Special situations: care of children

In epidemic contexts, consider children a specific group when designing and implementing programs. Encourage coordination among health workers, psychologists, and social workers to ensure referrals between the health and child protection sectors. Address the risks of separating children from their parents. The risks may be caused by morbidity and mortality of the parents or may resulting from the design of programs. Coordination should focus on preventing family separation. Ensure parental or child consent for treatment where appropriate. Take measures to keep education facilities open. Initiate referral systems between the child protection and health sectors.

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2.3 Essential health services – Child Health

During crises, children are especially vulnerable to infections, diseases, and increased rates of morbidity and mortality. Addressing their specific health needs requires child focused interventions. Child health interventions must alleviate suffering and address survival, growth, and development. These goals can be reached by alleviating the major causes of morbidity and mortality, such as acute respiratory infections; diarrhoea; measles; malaria; malnutrition; and neonatal causes.

Essential health services, child health. Standard 2.3.1: Prevention of vaccine-preventable diseases.
In stabilised situations, children aged six months to fifteen years have immunity against measles and access to routine Expanded Programme on Immunization (EPI) services.
Key action 1: Support and set up a health information system.
Key action 2: Estimate measles vaccination coverage of children aged nine months to fifteen years at the outset of the humanitarian response to determine the risk of outbreaks.
Key action 3: When measles vaccination coverage is <90% or unknown, conduct a mass measles vaccination campaign for children aged six months to fifteen years. Include the administration of Vitamin A to children aged 6–59 months.
Key action 4: Ensure that all infants vaccinated between 6–9 months of age receive another dose of measles vaccine upon reaching 9 months.
Key action 5: Establish a system for mobile or displaced people to ensure that at least 95% of newcomers to a camp or community, aged between six months and fifteen years, are vaccinated against measles.
Key action 6: Re-establish the EPI as soon as conditions permit. Routinely immunise children against measles and other vaccine-preventable diseases included in the national schedule.
Key action 7: Consider reactive or pre-emptive vaccination for certain communicable diseases against imminent or ongoing outbreaks. These communicable diseases are cholera, measles, meningitis, yellow fever, and polio. (see also Communicable Diseases)
Key action 8: Screen children attending health services for vaccination status. Administer any needed vaccinations.
Key indicators
<i>Upon completion of measles vaccination campaign, percentage of children aged six months to fifteen years who have received measles vaccination.</i> <ul style="list-style-type: none"> ● 95% ● Link this with essential health services. See control of communicable disease standard 3: Outbreak and detection response
<i>Upon completion of measles vaccination campaign, percentage of children aged 6–59 months who have received an appropriate dose of Vitamin A.</i> <ul style="list-style-type: none"> ● 95%

Case fatality rate of measles:

- Aim for <5% in conflict settings;
- Refer to confirmation of the existence of outbreak;
- 100 % enrolment of infants in national immunisation programmes, including a dose of the standard measles vaccine at 6 months.

Percentage of children aged 12 months who have had three doses of DPT.

- 90 %

Percentage of primary health care facilities that offer the basic EPI services at least 20 days/month.

- 90%

What else do I need to know?**Measles vaccination coverage**

Measles immunisation is a priority health intervention in crises. Determine measles vaccination coverage in the affected population through a review of immunisation coverage data. Based on this review, determine if routine measles immunisation coverage has been $\geq 90\%$ for the preceding five years. As an alternative, determine if a measles vaccination campaign conducted in the preceding twelve months has reached ≥ 90 per cent of children aged nine months to five years. Carry out the campaign on the assumption that the coverage is inadequate if measles vaccination coverage is < 90 per cent, unknown, or if doubts remain regarding the coverage estimates. Administer vitamin A supplementation at the same time to reduce complications of measles.

Age ranges for measles vaccination

Some older children may have escaped both previous measles vaccination campaigns and the measles disease. These children remain at risk of measles infection and can serve as a source of infection for infants and young children who are at higher risk of dying from the disease. This is the reason for the recommendation to vaccinate up to the age of fifteen years. In resource-poor settings, it may not be possible to vaccinate all children aged six months to fifteen years. In these settings, give priority to children aged 6–59 months. Immunise all children in the target age group against measles, regardless of their previous immunisation status.

Repeat measles vaccination for children aged 6–9 months

All children aged 6–9 months who received the measles vaccine should receive an additional dose of measles vaccine upon reaching nine months of age. Separate doses by at least one month.

Re-establishment of the national EPI programme

At the same time as the preparation of a mass vaccination campaign against measles, make plans to re-establish the EPI programme in coordination with national authorities. The prompt re-establishment of EPI vaccination not only directly protects children against diseases such as measles, diphtheria and pertussis, it also reduces the risk of respiratory infections.

Nutrition

Nutrition services are instrumental to reduce Under 5 Mortality Rate (U5MR).

Camps

Consider population-based surveillance that measures mortality rates in camps.

Referrals

Train health staff to recognise the signs and symptoms of child abuse, child sexual abuse and GBV against girls. Provide care and referral for the GBV survivors, as occasion demands.

Pre-emptive and reactive vaccination

For cholera, measles, meningitis, and yellow fever, consider pre-emptive vaccination campaigns in areas where the disease is endemic. Organise mass vaccination campaigns on a reactive basis, in response to an outbreak. The goal is to reduce mortality and limit the spread of the disease. Tackling fast spreading diseases and outbreaks should be a priority action. Vaccination should minimise disruptions to other high-priority health interventions controlling and preventing disease.

Vaccine safety

Ensure the safety of vaccines at all times. Follow the manufacturer's instructions for storage and refrigeration.

Informed consent

Obtain informed consent from parents or guardians. Informed consent must include information regarding the risks of any potential side effects.

EPI

When coverage reaches 90%, initiate case-based surveillance:

- Collect and report information on age, immunisation status, date of onset, geographical locations, and outcome (life or death).
- Report every pertussis outbreak immediately to the ministry of health and the WHO regional office for follow-up investigations.
- A single case of measles may indicate an outbreak. Measles virus is one of the most transmissible infectious diseases.

For polio, in the Horn of Africa, during drought and famine, recommend Oral Polio Vaccine (OPV) to all children <5 years of age with measles vaccine and vitamin A supplementation. At the outset of an outbreak, all children should receive at least one dose, with a second round of mass vaccination after thirty days.¹

Child health. Standard 2.3.2: Management of newborn and childhood illness

Children have access to priority health services that are designed to address the major causes of newborn and childhood morbidity and mortality.

Key action 1: Design health education messages to encourage the affected population to seek early care for any illness such as fever, cough, or diarrhoea among children and newborns.

- Consider children who do not have an adult or parent caring for them (see Health systems standard 1).
- Proactively engage the community.

Key action 2: Design health education messages to encourage families to engage in appropriate promotional and preventive practices

¹ WHO, 2012: <http://www.who.int/immunization/sage/meetings/2012/april/en/>

<ul style="list-style-type: none"> Consider: <ul style="list-style-type: none"> exclusive breastfeeding; infant and young children feeding; keeping young infants warm; and hand washing.
Key action 3: Provide essential newborn care to all newborns according to the Integrated Management of Pregnancy and Childbirth (IMPAC) guidelines.
Key action 4: Provide preventative and curative health services according to the context through clinic based and outreach services, mobile clinics, community health worker programmes. <ul style="list-style-type: none"> Facilitate integrated community case management (iCCM) using the national protocol or the Integrated Management of Childhood Illness (IMCI) guidelines. Provide treatment for severe acute malnutrition, and hospital care for severely ill children. (see also FSN)
Key action 5: Establish a standardised system of assessment and triage at all health facilities that provide care to sick children. <ul style="list-style-type: none"> Ensure that children with danger signs (unable to drink or breastfeed, vomits everything, convulsions, and lethargic or unconscious) receive immediate treatment.
Key action 6: Screen children attending health services for their growth and nutritional status. <ul style="list-style-type: none"> Refer or encourage all malnourished children to avail nutritional services. (See Management of acute malnutrition and micronutrient deficiencies standards 1–3)
Key action 7: Identify children with a disability or developmental delay. Provide advice on care or rehabilitation services.
Key action 8: Establish an appropriate case management protocol for the treatment of diphtheria and pertussis in situations where the risk of outbreak is high.
Key action 9: Make essential medicines available in the appropriate dosages and formulations for treatment of common childhood illnesses.
Key action 10: Assess signs of poisoning and offer immediate remedial measures. Call for independent investigations to verify poisoning from chemical warfare when necessary.
Key indicators
Under 5 mortality rate <ul style="list-style-type: none"> Number of deaths per 10,000 per day <ul style="list-style-type: none"> Fewer than 2 per 10,000
Percentage of children under five years old presenting with malaria that received effective anti-malarial treatment within 24 hours of the onset of their symptoms. <ul style="list-style-type: none"> 100%
Percentage of children under five years old presenting with diarrhoea that received both oral rehydration salts (ORS) and zinc supplementation within 24 hours of the onset of their symptoms.

<ul style="list-style-type: none"> • 100%. • An exception is children under five years old experiencing severe acute malnutrition.
<p>Percentage of children under five years old presenting with pneumonia that received appropriate antibiotics within 24 hours of the onset of their symptoms.</p> <ul style="list-style-type: none"> • 100%
<p>Percentage of all children under five years of age screened for malnutrition.</p> <ul style="list-style-type: none"> • 100%
<p>Percentage of all children under 6 months of age that are exclusively breastfed.</p> <ul style="list-style-type: none"> • 100%
<p>Percentage of all children identified with a disability or developmental delay who are referred to service providers who are able to support their specific needs.</p> <ul style="list-style-type: none"> • 100%
<p>All caregivers recognise danger signs and know when to seek care for sick newborns and children.</p> <ul style="list-style-type: none"> • 100%
<p>What else do I need to know?</p> <p>Care of the newborn</p> <p>Provide all newborns with skilled care at birth, preferably in a health facility. Keep them warm and encourage early and exclusive breastfeeding. Assess all newborns for any problems, particularly feeding difficulties. Assess all sick newborns for possible sepsis and local infections.</p> <p>Integrated Management of Childhood Illness (IMCI)</p> <p>IMCI is an integrated approach to child health that focuses on the care of children under five years old at a primary healthcare level. After establishing IMCI, incorporate clinical guidelines into standard protocols and train health professionals properly.</p> <p>Integrated Community Case Management (iCCM)</p> <p>iCCM is a strategy that extends the reach of public health services by providing timely and effective treatment of malaria, pneumonia and diarrhoea to populations with limited access to facility based health care providers, and especially to children under 5.</p> <p>Complementary Feeding</p> <p>Encourage appropriate complementary feeding at six months of age in addition to continued breastfeeding. (also see FSN IYCF)</p> <p>Management of diarrhoea</p> <p>Treat children with diarrhoea with low osmolality ORS and zinc supplementation. Low osmolality ORS shortens the duration of the diarrhoeal episode and reduces the need for intravenous fluid. Have caregivers continue feeding or increase breastfeeding during the episode. Increase all feeding after the episode.</p> <p>Management of pneumonia</p> <p>Assess children with a cough for fast or difficult breathing and chest indrawing. Treat those with fast or difficult breathing with an appropriate oral antibiotic. Refer those with chest indrawing for priority care. Consider provision of alternative cooking stoves to reduce smoke and fumes and the respiratory illness they cause. (Refer to Shelter chapter, Habitable Living Space and household items).</p>

HIV

In areas where the prevalence of HIV is greater than 1%, all children who present with severe acute malnutrition (SAM) should be tested for HIV (see also FSN)

Pertussis or diphtheria outbreaks

Pertussis outbreaks are common in settings of population displacement. Due to concerns about risks among older recipients of whole-cell DPT vaccine, consider avoiding a pertussis outbreak-related vaccination campaign. However, use an outbreak to address routine immunisation gaps. Case management includes antibiotic treatment of cases and early prophylactic treatment of contacts in households where there is an infant or a pregnant woman. Diphtheria outbreaks are less common, but are always a threat in populations with low diphtheria immunity in crowded settings. In camps, mass diphtheria vaccination campaigns with 3 separate doses of vaccine are not unknown. Case management includes the administration of both antitoxin and antibiotics.

Feeding separated children

In contexts where children have lost or are separated from their mothers, make arrangements for feeding them under supervision. Establish protocols and referral systems for the treatment of children and newborns.

Newborns

Establish protocols and referral systems for the treatment of children and newborns.

Household air pollution

Cooking stoves and fuels should not amplify household air pollution.

Poisoning

Poisoning can occur when children are exposed to toxic chemicals through mouth, nose, skin, eyes, ears or bites. The child should be assessed for physical emergency and priority signs. Collect exposure evidence from caregivers and through observation of the children's recent living environments. When a poisoning agent is suspected, immediate management should be offered accordingly. An independent medical investigation is necessary to confirm the probability of poisoning and its treatment.

Table. Symptoms of exposure to toxic chemicals (modified from WHO, Environmental health in Emergency)

Class of toxic chemical	Common features of exposure
Nerve agents such as Sarin, tabun, or VX.	Pinpoint pupils; blurred vision; headache; copious secretions; tight chest and breathing difficulty; nausea; vomiting; diarrhoea; muscle twitching; seizures; loss of consciousness.
Blister agents such as mustard gas.	Tearing; eye irritation; conjunctivitis; corneal damage; redness and blisters of the skin with pain; respiratory distress.

Cyanide	Gasping for air; asphyxiation; seizures; confusion; nausea.
Incapacitating agents such as BZ.	Dry mouth and skin; tachycardia; altered consciousness; delusions; hallucinations; hyperthermia; incoordination; dilated pupils.
Tear gas and riot control agents.	Stinging and burning of mucous membranes; lacrimation; salivation; runny nose; tight chest; headache; nausea.
Chlorine	Eye redness and lacrimation; nose and throat irritation; cough; suffocation or choking sensation; shortness of breath; wheezing; hoarse voice; pulmonary oedema.
Thallium (rat poison)	Abdominal pain; nausea; vomiting; diarrhoea; constipation; seizures; delirium; depression; scalp and body hair loss; painful peripheral neuropathy and distal motor weakness; ataxia; neurocognitive deficits.
Lead	Anorexia; vomiting; constipation; abdominal pain; pallor; inattentiveness; weakness; peripheral palsies.
Organophosphates	Salivation; lacrimation; urination; defecation; gastric cramps; vomiting.

Furthermore

Children differ from adults in the following aspects: physiology; developing organ systems; behaviour; emotional and developmental understanding of and response to traumatic events; and dependence on others for basic needs.

Children's rapid ventilation, large surface area relative to body mass, more permeable skin, and proximity to the ground increase their risk of adverse outcomes from exposure to environmental hazards.

Children are in a critical period of development where toxic exposures can have profound negative effects. The² effects of crises on children's health include growth retardation³ as well as increased child mortality and morbidity, and impaired nutrition.

A delay in treating *Plasmodium falciparum* malaria in infants and young children can have fatal consequences, particularly for more severe infections.

² Disaster Preparedness Advisory Council. Pediatrics. 2015 Nov; 136(5): e1407-17. doi: 10.1542 /peds.2015-3112

³ Hodinott J, Kinsey B. Child growth in the time of drought. Oxford Bulletin of Economics and Statistics. 2001; 63(4):409–436.

A fever that persists after 2 days or returns within fourteen days of receiving anti-malarial treatment suggests that the malaria parasite is resistant to first line of therapy (refer to IMCI). A confirmed significant increase in malaria fever cases in the past two weeks is a clear warning signal that calls for action.

ORS packets should be given to patients for five days. Patients should return to the clinic after five days for review.

Diarrhoea is defined as stopped if there are fewer than three stools per day.

Since bacterial pathogens are the leading cause of severe pneumonia among children, initiate prompt treatment of pneumonia with a full course of appropriate antibiotics is life-saving.

Treat children with fast breathing pneumonia and no chest indrawing or general danger sign with oral amoxicillin. The dosage is at least 40 mg/kg/dose twice daily (80mg/kg/day) for five days. In areas with low HIV prevalence, give amoxicillin for three days⁴.

Approximately 4% of patients receive a diagnosis of malnourishment despite prevalence rates reported between 24% and 50% worldwide. Identification and treatment of malnutrition are important to achieve optimal final height and development.

⁴ WHO, Revised WHO classification and treatment of childhood pneumonia at health facilities • EVIDENCE SUMMARIES, available at: http://apps.who.int/iris/bitstream/10665/137319/1/9789241507813_eng.pdf

2.4 Essential health services – Sexual and Reproductive Health

All individuals, including those living in humanitarian settings, have the right to sexual and reproductive health (SRH). To exercise this right, affected populations must have access to the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations, and transition to comprehensive SRH information and services as soon as feasible. SRH services must respect the cultural backgrounds of the community and religious beliefs while conforming to universally recognised international human rights standards. SRH services should be coordinated with the health and protection actors, and have a dedicated SRH coordinating body that optimises the delivery of the MISP.

Essential health services - sexual and reproductive health Standard

2.4.1: Coordination of services.

Service providers work in collaboration and complement each other to ensure that people have access to the Minimum Initial Service Package (MISP) at the onset of a crisis, and comprehensive SRH as soon as the situation stabilises.

Key action 1: Identify a lead SRH agency within the health sector to facilitate the coordination and implementation of the MISP.

- Ensure that an SRH officer (nominated by lead SRH agency) is in place and functioning within the health sector or cluster.

Key action 2: Organise regular stakeholder meetings to support the implementation of MISP

- Report back to the health cluster/coordination mechanisms on challenges and solutions related to implementation of MISP
- Share information that is accessible to all, including older people and people with disabilities about the availability of SRH resources and supplies.

Key action 3: Identify, assess gaps and capacities (existing services) and support in-service clinical skills development.

Key action 4: Procure and make available SRH medical supplies, equipment and devices.

Key action 5: Ensure that community members are aware of available MISP services and take specific measures to reach adolescent girls and boys, persons with disabilities, and other people to whom such information is traditionally denied or not easily accessible.

Key action 6: Work with other relevant actors to support referral mechanisms and implement measures to reduce the risk of sexual and gender-based violence (GBV).

Key action 7: Ensure services for clinical management of sexual violence, including access to medical care, psychosocial support and legal assistance.

Key action 8: Establish the minimum set of HIV prevention, treatment, and support services to reduce the transmission of HIV and provide care to people living with HIV.

Key action 9: Plan for comprehensive SRH using the health system framework of the six building blocks (see health system standards).

- Ensure availability of key services such as antenatal care (ANC) for visibly pregnant women postnatal care (PNC), more comprehensive family planning programs and, treatment for reproductive tract infections.

Key indicators
<p><i>SRH officer is in place and is leading coordination within the umbrella of the health coordination body.</i></p> <ul style="list-style-type: none"> • One SRH officer at national level • One SRH officer at each sub-national level
<p><i>Regular SRH meetings held and minutes documented.</i></p> <ul style="list-style-type: none"> • Weekly; then biweekly; and then monthly as the situation stabilises
<p><i>Relevant stakeholders (MoH, UN agencies, NGOs, civil society organisations) actively participate in SRH working group meetings.</i></p>
<p><i>Percentage of the affected areas covered within the first 48 hours of an event, with existing and new MISP availability.</i></p> <ul style="list-style-type: none"> • 100%
<p><i>Percentage of health facilities that have reproductive health kits within a month after event.</i></p> <ul style="list-style-type: none"> • 100%
<p><i>Percentage of primary health centre/clinics report availability of at least four methods of contraception (pills, injectable, IUD, implant) within three and up to six months from the onset of the disaster/crisis.</i></p> <ul style="list-style-type: none"> • 100%
<p>What else do I need to know?</p> <p><i>Minimum Initial Service Package (MISP)</i></p> <p>The MISP is a list of priority activities and services that must be implemented within days after a crisis, to prevent sexual and reproductive health (SRH) related morbidity and mortality among women, men and adolescents. It comprises a coordinated set of priority SRH services.</p> <p>The MISP includes six objectives: ensure the health sector actors identify an organization to lead implementation of the MISP; prevent sexual violence and respond to the needs of survivors, prevent the transmission of, and reduce morbidity and mortality due to HIV, prevent excess maternal and newborn morbidity and mortality, prevent unintended pregnancies, and plan for comprehensive SRH services as soon as the situation stabilises. Planning for the integration of good-quality comprehensive SRH activities into primary healthcare at the onset of an emergency is essential to ensuring a continuum of care. Comprehensive SRH care involves upgrading existing services, adding missing services and enhancing service quality.</p> <p><i>SRH supplies</i></p> <p>Procure and distribute supplies for the MISP immediately. Pre-position (including virtually) to avoid delay in getting these essential products to the population. The Interagency Emergency Health Kit includes a limited quantity of medicines for patient post-exposure prophylaxis for HIV/AIDS, magnesium sulphate and instruments and medicines for midwife care, but not all supplies are required for the MISP. The Interagency Reproductive Health Kits, developed by the Interagency Working Group on SRH in crises, contain medicines and supplies for a three-month period. In addition, newborn kits designated for rapid response can be procured immediately directly from UNFPA Supply Division or from wholesale suppliers.</p>

Ensure that modern contraceptive methods (short acting and long acting) are accessible and available.

Ensure basic and comprehensive (blood transfusion/surgery) emergency obstetric and newborn care (EmONC) is established and coordinated with other actors through referral systems.

Sexual violence

All actors in humanitarian response must be aware of the risk of sexual violence including sexual exploitation and abuse, and must work to prevent and respond to it. Aggregate information on reported incidents must be safely and ethically compiled and shared to inform prevention and response efforts on a strictly need to know basis in accordance with established referral pathways and information sharing protocols. Measures for assisting survivors must be in place in all primary-level health facilities and include skilled staff to provide to children, adults and elderly in a child-friendly, accessible and survivor-centred manner, including clinical management that encompasses emergency contraception, post-exposure prophylaxis to prevent HIV, presumptive treatment of sexually transmitted infections (STIs), wound care, and tetanus and hepatitis B prevention. Emergency contraception must be offered to girls and women with proper counselling so that they can make an informed decision. Psychosocial support to survivors of sexual violence needs to be part of the package. GBV prevention and care, must include care for boys and men that have survived sexual violence.

Inclusion

Take steps to ensure sensitivity to the needs of adolescents, people with disabilities, LGBTI (lesbians, gays, bisexuals, transgender, intersex) people, and other marginalised populations in service delivery

Essential health services, sexual and reproductive health Standard 2.4.2: Maternal and newborn health services.

People have access to life-saving maternal and newborn health care at the onset of an emergency and comprehensive SRH as the situation stabilises.

Key action 1: Provide basic emergency obstetric and newborn care (BEmONC) services at health centre level. Provide skilled birth attendants and supplies for normal births and basic management of emergency obstetric and newborn complications.

Key action 2: Provide comprehensive emergency obstetric and newborn care (CEmONC) at all referral hospitals. Provide skilled medical staff and supplies for comprehensive management of obstetric and newborn complications.

Key action 3: Ensure supplies, instruments and facility for blood screening and safe blood transfusion and in circumstances where blood banks are not functioning.

Key action 4: Establish a functioning communication and transportation system (covering the community, health centre and referral hospital) to manage obstetric and newborn emergencies.

- Ensure it is functioning 24 hours a day, seven days a week.

Key action 5: Provide clean delivery kits and essential newborn kits to visibly pregnant women and birth attendants to promote clean home deliveries and essential newborn care when access to a health facility is not possible.

Key indicators

Number of health facilities with BEmOC and newborn care/500,000 population are in place and operational 24 hours per day, seven days per week.

- 5/ 500,000 population

Number of health facilities with CEmOC and newborn care/500,000 population 24 hours per day and seven days per week.

- 1/500,000 population

Number of qualified health workers on duty per 50 outpatient consultations per day.

- 1 per 50 outpatient consultations/day

Number of qualified service providers on duty per 20-30 inpatient beds for the obstetric wards.

- One

Number of teams of doctor/nurse/midwife/anaesthetist on duty 24/7.

- One team of doctor, nurse, midwife, and anaesthetist

Adequate drugs and supplies to support BEmOC.

Adequate drugs and supplies to support CEmOC.

Referral system that includes obstetric and newborn emergencies available 24/7.

Percentage of deliveries in health facility that has skilled provider and is well equipped.

- 80%

Percentage of all deliveries that are safe caesarean sections.

- 5 – 15%

What else do I need to know?

Emergency obstetric and newborn care

Approximately 4 per cent of the affected people will be pregnant women. Approximately 15 per cent of all pregnant women will experience an unpredictable obstetric complication during pregnancy or at the time of delivery that will require emergency obstetric care and 5–15 per cent of all deliveries will require surgery, such as caesarean section. To prevent maternal and newborn mortality and morbidity resulting from complications, skilled birth attendance at all births, BEmOC

and neonatal resuscitation should be available at all primary health centres. BEmOC functions include parenteral antibiotics, uterotonic drugs (parenteral oxytocin), parenteral anticonvulsant drugs (magnesium sulfate), removal of retained products of conception using appropriate technology, manual removal of placenta, assisted vaginal delivery (vacuum extraction) and maternal and newborn resuscitation. CEmOC functions include all of the interventions in BEmOC as well as surgery under general anaesthesia (caesarean delivery, laparotomy) and rational and safe blood transfusion. Ensure that the referral system refers all women or newborns. Ensure that they have the means to travel to and from a primary health centre with BEmOC and newborn care, and to a hospital with CEmOC and newborn care services.

Approximately two-thirds of infant deaths occur within the first 28 days and most of those in the first seven days of life. The majority of these deaths are preventable by initiating essential actions that can be taken by health-care workers, mothers or other community members. Approximately 5% to 10% of newborns do not breathe spontaneously at birth and require stimulation. About half of those who have difficulty initiating breathing, require resuscitation. The major reasons for failure to breathe include preterm birth and acute intrapartum events resulting in severe asphyxia.

Contraceptive services

Provide access to contraceptive services (short and long acting methods) to meet demand. Undertake outreach to raise awareness on family planning, and use of contraceptives, targeting specific messages for men and women of different age groups, particularly adolescents and youth.

Micronutrients

Micronutrient supplementation should be provided to women during antenatal care. Coordination should occur with the nutrition sector to ensure that pregnant and lactating women are referred to receive nutritional services if available e.g. targeted supplementary feeding (see FSN malnutrition).

Essential health services - sexual and reproductive health Standard

2.4.3: HIV

Key action 1: Ensure anti-retroviral treatment (ART) continuation.

- Provide ART to all people who were previously on ART.
- Provide information to community about where to access ART drugs at key points.
- Actively trace people living with HIV to ensure treatment continuation.
- Provide people living with HIV appropriate healthcare, including Cotrimoxazole prophylaxis for HIV-related infections.

Key action 2: Ensure prevention of mother to child transmission of HIV (PMTCT) service continuation.

- Provide HIV testing services for pregnant women.
- Provide early infant HIV testing.
- Provide ART to women who test HIV positive or are already known to be HIV positive.

- Provide ART prophylaxis and cotrimoxazole for infants (cross ref with Infant and young child feeding standard and see Guidance for Cotrimoxazole under PEP Provision).
- Provide infant feeding guidance and retention and adherence support.

Key action 3: Put in place minimum activities to prevent HIV both in health care settings, and amongst the general population.

- Establish access good-quality, free, lubricated male condoms and, where applicable (already used by the population), female condoms, good-quality free male and female condoms, including information on proper condom use.
- Provide post-exposure prophylaxis (PEP) services to persons with HIV negative or unknown status as early as possible and within 72 hours of the potential exposure, either by accidental blood exposure or sexual exposure to HIV (see Guidance below).
- Establish and implement referral pathways for preventing and treating both HIV and sexual and gender-based violence SGBV at facility and community levels.
- Establish standard precautions and safe procedures for waste disposal within all healthcare settings. Ensure availability of supply for implementation of standard precautions at all healthcare levels (see section Health Systems).
- Establish and follow safe blood supply and rational use of blood transfusion (see section Health Systems).
- Provide syndromic management to all patients presenting with symptoms of a sexually transmitted infection.
- Provide information and education in accessible formats and education on prevention of HIV and other STIs to both the public and key populations at higher risk of HIV infection.
- Provide people at higher risk of exposure to HIV with harm reduction services including provision of sterile injecting equipment and opioid substitution therapy for people who inject drugs where these services already existed.

Key action 4: Provide services for HIV/TB Coinfection.

- Provide TB screening and referral for people living with HIV.
- Provide TB treatment to people previously enrolled on it (see Communicable Disease Standard.)
- Establish linked testing services for TB and HIV in high prevalence settings.
- Establish TB infection control in healthcare settings.

Key action 5: Establish a coordinated response.

- Initiate plans to broaden the range of HIV services in the as soon as possible.
- Establish contingency measures for HIV treatment and PMTCT continuation and commodity security, including buffer stocks of ART and condoms for prevention, in emergency settings.
- Disseminate key messages to partners and communities about where to access HIV services.

Key indicators
<p><i>People previously on ART continuing to receive ARV drugs.</i></p> <ul style="list-style-type: none"> • 90%
<p><i>Pregnant women accessing health services are tested for HIV where HIV prevalence is greater than 1%.</i></p> <ul style="list-style-type: none"> • 90%
<p><i>Pregnant women known to be HIV positive receive ARV drugs for PMTCT.</i></p> <ul style="list-style-type: none"> • 100%
<p><i>Number condoms distributed per person in total population per month.</i></p> <ul style="list-style-type: none"> • 0.5
<p><i>Percentage individuals potentially exposed to HIV (occupational exposure in healthcare settings and non-occupational exposure) receive PEP within 72 hours of an incident.</i></p> <ul style="list-style-type: none"> • 100%
<p><i>Proportion of transfused blood screened for transfusion-transmissible infections including HIV.</i></p> <ul style="list-style-type: none"> • 100%
<p><i>HIV-exposed infants who receive Cotrimoxazole at 4-6 weeks of age.</i></p> <ul style="list-style-type: none"> • 95%
<p><i>Primary healthcare facilities that have antimicrobials to provide syndromic management to individuals presenting with symptoms of a STI.</i></p> <ul style="list-style-type: none"> • 100%
<p><i>Proportion of people living with HIV who are screened for TB in HIV care or treatment settings.</i></p> <ul style="list-style-type: none"> • 100%
<p>What else do I need to know?</p> <p>Actively pursue the involvement of the affected community and key populations (leaders, women, women groups, and health workers) in HIV service delivery. In most contexts, there will be an association of people living with HIV who should be consulted and involved in programme design and delivery.</p> <p>Triple combination PEP to prevent HIV infection includes counselling, HIV exposure risk assessment, informed consent, assessment of the source and provision of ARV medicines. PEP should not be provided to a person who is known to be HIV positive. HIV counselling and testing is recommended before starting PEP; however, if this is not feasible it should not delay the initiation of PEP</p>

References

1. [WHO Consolidated Guidelines on the Use of ART Drugs for Treating and Preventing HIV Infection](#)
2. [PMTCT in Humanitarian Settings Inter-Agency Task Team to Address HIV in Humanitarian Emergencies Part II: Implementation Guide](#) (Interagency Task Team HIV in Humanitarian Emergencies)
3. [WHO Guidelines on post-exposure prophylaxis for HIV and the use of Cotrimoxazole prophylaxis for HIV-related infections among adults, adolescents and children](#)
4. [WHO policy on collaborative TB/HIV activities Guidelines for national programmes and other stakeholders](#)

5. Guidelines for the delivery of antiretroviral therapy to migrant and crisis-affected populations in Sub Saharan Africa (UNHCR et al, 2014)

Essential health services, sexual and reproductive health Standard

2.4.4: Clinical management of sexual violence and rape

Reduce the risk of sexual violence and ensure that people have access to services for clinical management of sexual violence, including access to mental health and psychosocial support and legal assistance.

Key action 1: Implement measures to reduce the risk of sexual violence, in coordination with other relevant sectors or clusters.

Key action 2: Ensure services for appropriate clinical management of sexual violence that includes prophylaxis for HIV/AIDS, and access to mental health and psychosocial support and legal assistance (see Protection Principles 3 and mental health standards section).

Key action 3: Raise awareness about sexual and gender based violence.

Key action 4: Inform populations about the benefits and availability of clinical services for survivors of sexual violence and the emergency referral system for complications of pregnancy and childbirth.

Key action 5: Inform, educate and communicate the importance of seeking health care within 72 hours after a sexual violence.

Key action 6: Implement a correct data collection system to record and monitor the situation.

Key indicators

All health centres have trained staff, sufficient supplies and equipment for clinical management of rape survivor services based on national or WHO protocols.

- A trained (local) health care professional on call 24 hours/day.
- National or WHO protocols are available, distributed and used at 100% of health facilities.

Number of reported cases of sexual violence reported to health services per month.

- 2% of women of reproductive age

Timing of emergency contraception (percentage of eligible rape survivors that received EC pills within 120 hours).

- 100% of women and girls seeking health care within 120 hours of rape receive EC.

Timing of PEP (percentage of eligible rape survivors that received PEP within 72 hours).

- 100% of eligible survivors of sexual violence receive PEP within 72 hours.

What else do I need to know?

Sexual violence

All actors in humanitarian response must be aware of the risk of sexual violence including sexual exploitation and abuse by humanitarian workers, and must work to prevent and respond to it, regardless of whether or not data on the prevalence of sexual violence is available. Aggregate information on reported incidents must be safely and ethically compiled and shared to inform prevention and response efforts.

Measures for assisting all (male, female, children) survivors must be in place in all primary-level health centres and include skilled staff to provide clinical management that encompasses emergency contraception, post-exposure prophylaxis to prevent HIV, presumptive treatment of sexually transmitted infections (STIs), wound care, tetanus prevention and hepatitis B prevention. The use of emergency contraception is a personal choice. Women make the decision whether to use it or not. Provide women with unbiased counselling so they can make an informed decision. Refer and encourage survivors of sexual violence to seek clinical care and ensure that they have access to mental health and psychosocial support. Confidentiality is essential at all stages.

Whole of facility training should be provided on issues of gender, GBV, women's/human rights, social exclusion, sexuality and psychological first aid as well as sensitivity training to address the needs of survivors in a confidential and non-judgemental way.

Same-sex providers should be available for survivors, recognizing that for most female survivors, a female health caregiver speaking the same language is optimal, while for male survivors it may not be the case that a male provider is optimal. If the provider of choice is not available, a female health worker or companion should be in the room during the examination of female survivors.

The healthcare centres must include skilled clinical staff to provide survivor-centred clinical management of sexual violence, including child-friendly services that encompasses the following: emergency contraception; post-exposure prophylaxis to prevent HIV; treatment of STIs; wound care; tetanus prevention; and hepatitis B prevention. The use of emergency contraception is a personal choice. Women make the decision whether to use it. Offer women unbiased counselling so that they can make an informed decision. Only perform examination and treatment with the informed consent of the survivor. Confidentiality is essential at all stages.

At the survivor's request, protection staff should provide protection and legal support.

Assessment and programming should take into consideration the needs of boys and men that have survived or are at risk of sexual violence and exploitation.

Ensure that referral pathways for sexual violence survivors who may disclose to health staff are in place and that health personnel have had training on how to provide safe, ethical and confidential referrals for additional mental health and psychosocial support and legal and security services, according to survivors' wishes. Providing information to survivors about their rights and options in health care and other GBV services is a critical responsibility.

Furthermore

Acknowledge that SRH concerns tend to affect adolescents and youth disproportionately.

Adolescents have unique needs and face specific challenges in acquiring services.

Sensitisation and capacity building to address these needs in a confidential and non-judgmental way is key.

For a female survivor, a female health caregiver speaking the same language is optimal. If this is not possible, a female health worker (or companion) should be in the room during the examination.

Male survivors can also face severe physical and psychological consequences of sexual violence. They too should have access to confidential, respectful, and non-discriminatory services to address the consequences.

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14. Including children with disabilities in humanitarian action. Health booklet. <http://training.unicef.org/disability/emergencies/index.html>

2.5. Essential health services – Injury care

Injury and trauma can be a cause of high mortality and morbidity in many emergencies. In a sudden onset emergency, such as an earthquake, there may be a high number of injuries resulting in a mass casualty incident. This means more people will require emergency care than locally available resources can manage. Complex emergencies and armed conflict may also cause trauma that is specific to weapons and warfare. It is important therefore that health actors are able to understand mass casualty management, triage, and basic emergency care.

Essential health services – Injury care Standard 2.5.1

People have access to effective injury care during disasters to prevent avoidable suffering, morbidity, mortality and disability.

Key action 1: Ensure that health workers have adequate skills and knowledge to address injury care including:

- Mass casualty management (including for those coordinating health sector response)
- Basic first aid and resuscitation
- Early recognition, resuscitation, and treatment including wound management and pain control (for frontline healthcare providers likely to receive injured patients)
- Use of recognized protocols for triage and appropriate referral of the injured for advanced care/

Key action 2: Establish or strengthen an appropriate standardised triage system that includes guidance on:

- Assessment, prioritisation, basic resuscitation and criteria for emergency referral
- Routine and surge situations (see, for example WHO / ICRC interagency integrated triage tools)

Key action 3: Establish or strengthen standardized protocols for

- the referral of injured patients for emergency and advanced care, including surgery, post-operative care & rehabilitation.
- child protection, referral and reporting mechanisms of suspected child abuse cases.

Key action 4: Provide a tetanus vaccine that contains toxoid for workers at risk of injury such as those involved in rescue or clean-up operations and those with open wounds

Key action 5: Establish and follow safe and rational use of blood supply and blood products (see Health Systems).

Key action 6: Ensure standard assistive devices and mobility aids (for example, wheelchairs, crutches) are available for injured patients and persons with disabilities.

<ul style="list-style-type: none"> • Ensure that these aids can be repairable locally (see Health Systems).
<p>Key action 7: Establish or strengthen health information systems for trauma to inform decision making.</p> <ul style="list-style-type: none"> • Maintain mandatory individual patient records • Adapt health surveillance systems to adequately monitor trauma and injuries using definitions for example in EMT Minimum data set, GACI Trauma registry (also see Health Systems)
<p>Key action 8: Initiate health promotion using (preferably existing) materials that are culturally and context appropriate, at the community and health centre levels.</p> <ul style="list-style-type: none"> • Include material on prevention (according to identified risks & needs from key action 12), Household & community level first aid (e.g. IFRC eCBHFA tools) and information on when and where to seek medical help.
<p>Key indicators</p>
<p><i>All health facilities have a disaster plan including management of mass casualty which is reviewed and rehearsed on a regular basis. All staff should be familiar with this plan and their specific roles.</i></p>
<p><i>Explicit protocols exist to ensure systematic approach to the acutely injured, including the use of formal triage instruments.</i></p>
<p><i>All frontline providers have at least basic training in approach to the acutely injured.</i></p>
<p><i>All health facilities utilize the WHO trauma care checklist and the safe procedure checklist.</i></p>
<p><i>All health facilities demonstrate effective data collecting systems, analysis, monitoring and evaluation.</i></p>
<p><i>Evidence of implementing quality improvement measures to improve baseline morbidity & mortality according to data available.</i></p>
<p>What else do I need to know?</p> <p>Triage</p> <p>Triage is the process of categorizing patients according to the severity of their injuries, in order to identify those who would most benefit from immediate medical intervention. There is no standardized system of triage and several are in use throughout the world. The WHO/ICRC interagency initiative * uses the five-colour code system: red signals high priority, yellow for medium priority, green for ambulatory patients, blue for patients beyond the technical capacity of the facility or patients who require palliative care and grey for deceased.</p> <p>First aid, resuscitation and basic medical care</p> <p>Evidence proves timely and appropriate first aid, resuscitation and basic medical care saves lives and improves patient's chances of survival, if conducted in a comprehensive manner. All first aiders & healthcare workers should be familiar with the essential principles of first aid, resuscitation and medical care for all injured and or unconscious patients (see ABCDE Initial Assessment, ICRC). Non-operative procedures are equally vital, such as cleaning and dressing wounds and administering antibiotics and tetanus prophylaxis.</p>

Trauma and surgical services with post-trauma and post-surgical rehabilitation, should be undertaken only by organizations with appropriate expertise, resources and sustainability.

Wound management

In most disasters, many patients will present for care more than six hours after injury. Delayed presentation greatly increases the risk of wound infection mortality. It is critical that local healthcare workers are familiarized with relevant principles and protocols to manage wounds (including burns) and prevent and treat infection. These principles and protocols include provision of appropriate antibiotic, debridement (surgical removal of foreign material and dead tissue), and dressing.

Tetanus

In sudden-onset natural disasters the risk of tetanus can be relatively high. Administer tetanus toxoid-containing vaccine (DT or Td – diphtheria and tetanus vaccines – or DPT, depending on age and vaccination history) to those with open wounds. Individuals with dirty/ highly contaminated wounds should also receive a dose of tetanus immune globulin (TIG), if available, if they have not previously been vaccinated against tetanus.

Anaesthesia, trauma and surgical care

Trauma surgical care and war surgery saves lives and prevents long-term disability and requires specific training and resources. Trauma and surgical services with post-trauma and post-surgical rehabilitation, should be undertaken only by organizations with appropriate expertise, resources and sustainability. Inappropriate or inadequate surgery may do more harm than doing nothing. Moreover, surgery provided without any immediate appropriate pre- & post op care, and ongoing rehabilitation can result in a complete failure to restore functional capacities of the patient.

Rehabilitation and social reintegration

Rehabilitation services in many low and middle-income settings are under-resourced and will be quickly overwhelmed during the response phase of an emergency. Early (acute) rehabilitation can greatly increase survival, maximise the impact of medical and surgical interventions, and enhance the quality of life for injured survivors.

- Responding medical teams with inpatient capacity must be able to provide early rehabilitation, patient and caregiver education, and essential assistive devices (such as crutches and wheelchairs) for patient safety.
- Teams must consider the ongoing needs of patients with injury and with pre-existing disability prior to their discharge, including medical and rehabilitation follow up, Psycho-social support, and access to other essential services
- Patients requiring assistive devices (such as prostheses and mobility devices) will also need physical rehabilitation. Where available, a partnership with community-based rehabilitation programmes will optimize the post-operative care and rehabilitation for injured survivors.
- The coordination of responses must include mapping of existing rehabilitation capacities and the communication or establishment of referral pathways. Establish linkages between social welfare systems already in place and multi-sectoral disaster response services. That includes Shelter, cash and so on, to provide assistance in obtaining assistive devices and additional support e.g. if the injured individual is the family financial provider,

cash/vouchers should be provided to assist the family as well as the injured. Teams should establish links with local providers (such as rehabilitation centres or community based rehabilitation organisations) or responding specialist INGOs for the provision of ongoing care. Where these are absent, teams should consider the provision of medium term outpatient or “outreach” follow up services (including rehabilitation).

- Psychosocial support for those with life-changing injuries should begin as an inpatient, with team members trained to support people with new injuries, and locally appropriate support should be integrated into the team where possible. Links to ongoing support services are essential (see Mental Health standard).
- Physical rehabilitation specialists should be paired with Psychosocial Workers/Counsellors or Psychologists to develop multidisciplinary care plans and teams for individuals who are seriously injured. In particular where the level of serious injury and newly acquired disabilities is high, specialized support is required to recover from life changing impairments.

Pain Control

Good pain management after injury is vital for the prevention of both physical and psychological morbidity and for a return to good function after injury. Good pain relief aids mobilisation after injury allowing compliance with physiotherapy and reductions in the incidence of pneumonia and deep vein thrombosis; it reduces the physiological stress response leading to a reduction in cardiovascular morbidity and reduces psychological stress with a reduced incidence of anxiety, depression and post-traumatic stress disorder. Acute pain from trauma should be treated using a multimodal approach as detailed in the reverse WHO pain ladder, neuropathic pain resulting from nerve injury may be present from day 1 and should be treated appropriately (also see Health Systems Standard 3).

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2.6. Essential Health Services - Mental Health

Mental health and psychosocial problems occur in all humanitarian settings. The horrors, losses, uncertainties, and other stressors associated with conflict, displacement, and crisis place people at increased risk of social, behavioural, psychological, and psychiatric problems. Mental health and psychosocial support (MHPSS) involves multisectoral supports. These supports require coordinated implementation through a multi-sector working group. This mental health standard focuses on actions by health actors. Readers should also consult the Core Humanitarian Standard and Protection Principles for more discussion of psychosocial interventions as well.

Essential health services. Standard 2.6: Mental Health

People have access to health services that address mental health problems and associated impaired functioning.

Key action 1: Develop programmes based on identified needs and resources. Take sociocultural context into account.

- Explore a range of needs and resources, especially staff competencies. Be pragmatic by integrating mental health assessments in other assessments, and using rapid participatory approaches. Do not limit to one clinical issue. Mental health problems may be emergency-induced, pre-existing or both.
- Rates of mental health problems are substantial in any emergency. Prevalence studies of mental health problems are not essential to initiate services.

Key action 2: Enable community members, including marginalised people, to strengthen community self-help and social support.

- Preserve or support re-initiation of pre-existing support mechanisms (for example, women and youth groups, group for people living with HIV, etc)

Key action 3: Orient/train staff and volunteers how to offer psychological first aid.

- Manage acute stress after exposure to extreme stressors, such as potentially traumatic events, following the principles of psychological first aid.

Key action 4: Ensure the availability of basic clinical mental health care for priority conditions at every health facility.

Key action 5: Provide psychological interventions for people with prolonged distress-disabling emotional problems.

Key action 6: Protect the rights of people with severe mental health problems in the community, hospitals, and institutions.

- Visit mental hospitals and residential homes for people with severe mental health problems from early in the crisis and on a regular basis. Address neglect and abuse in institutions, and organise care.

Key action 7: Minimise harm related to alcohol and drugs.

<ul style="list-style-type: none"> Consider training and supervision of health and community staff in detection and brief interventions; facilitation of harm reduction interventions; and management of withdrawal and intoxication.
Key action 8: Take steps to develop a sustainable mental health system during early recovery planning.
Key indicators
<i>Percentage of secondary health care services (such as general hospitals) with trained and supervised staff and systems for the management of mental health problems</i>
<i>Percentage of primary health care services with trained and supervised staff and systems for the management of mental health problems</i>
<i>Percentage of the population participating in community self-help and social support activities.</i>
<i>Percentage of people who receive clinical management of mental disorders through health services.</i> <ul style="list-style-type: none"> Disaggregate by age, sex, and mental health conditions.
<i>Percentage of people with mental health problems who report improved functioning and reduced symptoms.</i> <ul style="list-style-type: none"> Disaggregate by age, sex, mental health conditions and outcomes.
100% of secondary healthcare services, such as general hospitals, have trained and supervised staff and systems for the management of mental health problems.
What else do I need to know <p>Psychological first aid</p> <p>Psychological first aid is a basic, humane, and supportive response to those who are suffering and need support. This form of support intervention includes listening carefully; assessing and ensuring basic needs; encouraging social support; and protecting from further harm. It is a nonintrusive technique, which does not press people to talk about their distress.</p> <p>Psychological first aid is not a clinical intervention. First responders across sectors can deliver it after a brief orientation. These first responders can be volunteers, and staff delivering humanitarian assistance, including health staff.</p> <p>Single session psychological debriefing is at best ineffective and should not be applied. Single session psychological debriefing is the promotion of ventilation by encouraging the person to briefly but systematically recount perceptions, thoughts, and emotional reactions experienced during a recent, stressful event.</p> <p>Community self-help and support</p> <p>Health agencies, like humanitarian organisations in other sectors, can engage community workers, leaders, and volunteers. The people who are engaged can enable community members, including marginalised people, to increase self-help and social support. Examples of such activities include the creation of safe spaces and community centres, and conducting recreational community activities.</p>

Clinical Mental Health for priority concerns

The conditions most frequently presented to mental health services in emergencies are psychosis, depression, and a neurological condition, epilepsy. Maternal mental health is of specific concern.

Providing basic clinical mental healthcare usually involves:

- Either of the following: organising brief training and supervision of general health staff in assessment and management according to evidence-based protocols such as the mhGAP Humanitarian Intervention Guide; or adding a mental health professional, such as a psychiatric nurse, to general health facilities.
- Arranging a private space for consultations.
- Orienting all health staff and volunteers about available mental healthcare.
- Integrating mental health categories into the health information system.
- Organising an uninterrupted supply of essential psychotropics. (See Interagency Emergency Health Kit (2017 – forthcoming).
- Organising a bi-directional referral mechanism between mental health specialists, general healthcare providers, community-based supports and other services.

Psychological care and support

Non-specialised staff and volunteers can deliver empirically supported psychological interventions for depression, anxiety, stress, and PTSD when they are well trained, supervised and supported. Examples of empirically supported psychological interventions include interventions based on cognitive behaviour therapy or interpersonal therapy.

Protect the rights of people with mental health problems

During humanitarian crises, people with severe mental health problems are extremely vulnerable to human rights violations such as abuse, neglect, abandonment, lack of shelter, food, or medical care.

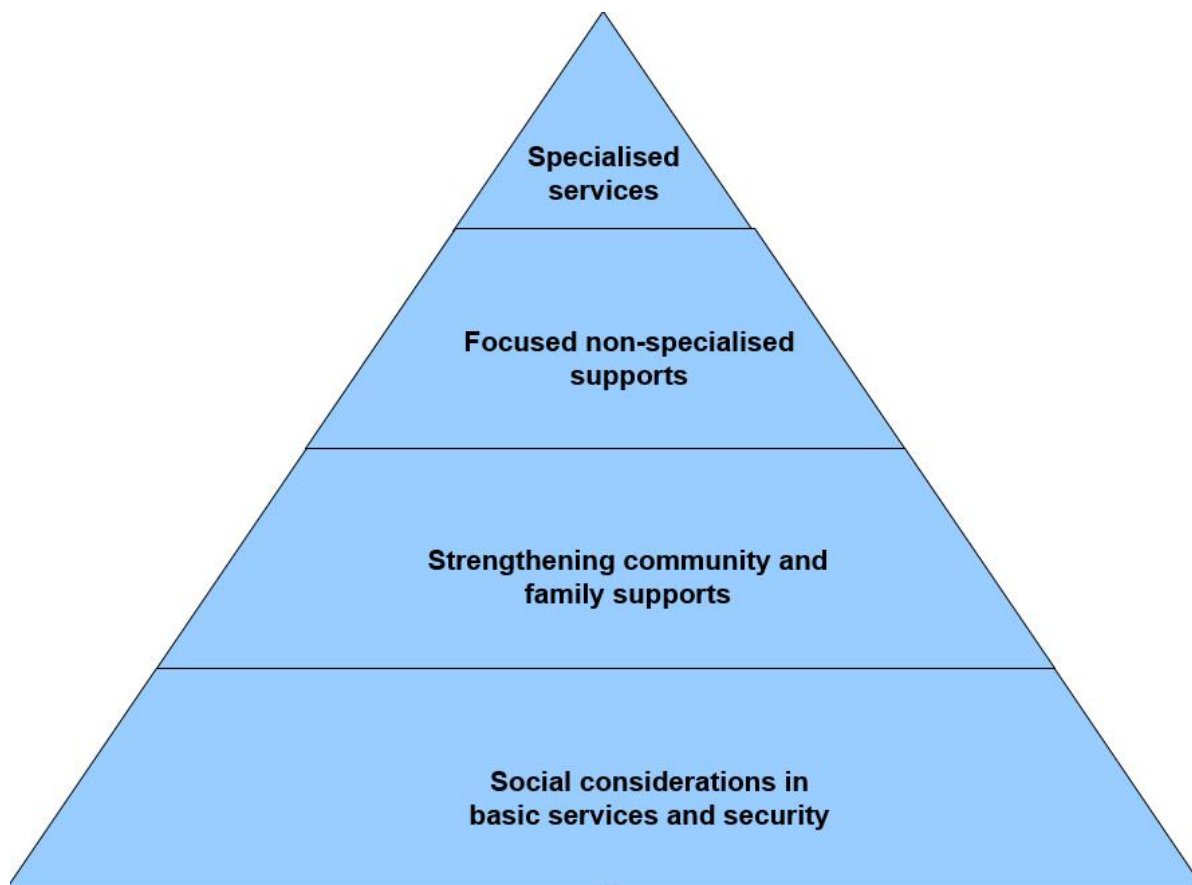
Coordinate across sectors

In large emergencies, it often works best to have a cross-sector technical working group for mental health and psychosocial (MHPSS) issues. The working group can be co-chaired by both a health agency and a protection agency humanitarian organisation. (See Health Systems Standard 6).

Transition to post-crisis

As part of early recovery and during protracted crises, steps can be taken to develop a sustainable mental health system. Humanitarian crises increase the long-term rates of a broad range of mental health problems. Initiate plans to develop the mental health system to scale up sustained mental health treatment coverage across the affected area.

Figure 1: Pyramid of multi-layered services and supports.



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2.7. Essential health services - Non-Communicable Diseases

Protracted crises, coupled with aging populations, have led to increased focus on non-communicable diseases (NCDs) in humanitarian settings. While populations vary greatly, globally in any adult population of 10,000 people, there are likely to be 1,500-3,000 people with hypertension, 500-2,000 people with diabetes, and 3-8 acute heart attacks over a normal 90-day period.

While the priority diseases will vary by context, key considerations are diabetes, cardiovascular disease (including hypertension, heart failure, strokes, chronic kidney disease), chronic lung disease (e.g. asthma, chronic obstructive pulmonary disease), and cancer. Initial response should aim to manage acute complications and avoid treatment interruption. Health actors can then aim to implement more comprehensive programs. Pre-emergency availability of services should be reviewed to determine appropriate level of response for those requiring specialized and more complex care.

Mental health and end of life care are specifically addressed in Sections 2.6 and 2.8.

Essential health services Standard 2.7.1: Non-communicable diseases

People have access to preventive programs, diagnostics and essential therapies for acute complications and long-term management of non-communicable diseases (NCDs).

Key action 1: Identify the NCD health needs of the disaster affected population with regard to NCDs and determine availability of NCD services pre-disaster.

- Use pre-emergency data, multi-sectoral and targeted assessments according to phase of emergency.
- Groups with priority needs should be identified, such as those at risk of life threatening complication (for example. insulin dependent diabetes or severe asthma).
- Determine the types of service availability and readiness prior to the disaster, especially for complex cases (such as for cancer or chronic renal disease). This will help determine services that need supporting in the medium to long term

Key action 2: Implement NCD programs using a phased approach based on life saving priorities and relief of suffering.

- Devise or improve programmes according to the needs identified and principles.
- Ensure patients diagnosed with life threatening complications have access to care at the appropriate level (e.g. severe asthma attack, diabetic ketoacidosis). If not available palliative care and supportive services should be offered. (see End of Life section 2.8).
- Patients diagnosed prior to the emergency should not have sudden disruption of treatment if resources allow.
- In the medium to long term aim to support pre-disaster services for complex cases if resources allow.

Key action 3: Ensure integration of NCD care into health system at all levels to help continuity of care.

- Provide health promotion and education, using contextually and culturally appropriate communication where needed.
- Facilitate and promote self-care, NCD risk factor modification and adherence to treatment.

<ul style="list-style-type: none"> • Provide Ensure access to basic care treatment for NCDs at primary health care level in line with national standards for NCDs. Where standards exist adapt them to the emergency setting, or use essential medicines list and international emergency guidance where there are no existing standards. • Ensure access to first line medicines and medical devices (diagnostic and monitoring tools) at primary health care level including community programmes and mobile teams. (see Package of Essential Non-Communicable Disease Interventions. WHO 2010; and Health Systems Standard 3) • Adapt the existing or develop a HIS for the emergency setting to include monitoring of main NCD diseases of focus: hypertension, diabetes, asthma, chronic obstructive pulmonary disease, IHD, epilepsy (see Health Systems Standard 4 and Annex HIS). • Establish a clear and standardised referral system for the management of acute complications and complex cases in secondary or tertiary care if available or to palliative and supportive care. • Coordinate and refer to nutrition sector as patients may require inclusion in nutrition or food security interventions.
<p>Key action 4: Establish prevention and preparedness programs for non- communicable diseases.</p> <ul style="list-style-type: none"> • Include essential drugs and supplies for people with chronic diseases as part of standardised emergency medical supplies. • Health centres in unstable or disaster-prone contexts should have preparedness for NCD service-delivery readiness. • Facilitate and promote individual patient preparedness.
<p>Key indicators</p>
<p><i>Percentage of primary health care facilities providing services for specified NCDs</i></p> <ul style="list-style-type: none"> • 80% by disease (NCDs in Emergencies – UN Interagency Task Force on NCDs)
<p><i>Total number of days key medicines for NCDs were not available in the past 30 days</i></p> <ul style="list-style-type: none"> • These may include aspirin, a statin, an ACE inhibitor, thiazide diuretic, a long-acting calcium channel blocker, metformin, insulin, a bronchodilator and a steroid inhalant - from WHO Global Reference List of 100 core indicators WHO NCD GMF indicator 2025, and PEN 2010) • 80% (WHO Global NCD GMF indicator 2025)
<p><i>Total number of days basic equipment for NCDs were not available (or not functional) in the past 30 days</i></p> <ul style="list-style-type: none"> • These may include blood pressure measurement device, weighing machine, blood sugar reagents or measuring device, urine strips for albumin - from WHO Global NCD GMF indicator 2025, and PEN 2010) • 80% (WHO Global NCD GMF indicator 2025)
<p><i>Percentage of primary health care facilities centres that use standard operating procedures for referral of patients with NCDs to secondary and tertiary care facilities</i></p> <ul style="list-style-type: none"> • 80% (WHO Global NCD GMF indicator 2025)

<i>Percentage of NCD cases managed according to agreed national/international standards</i>
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<i>Percentage of health workers who successfully completed a training on non-communicable diseases in the past 12 months. Disaggregated by type of health worker</i>

What else do I need to know
Needs and risk assessment

Needs assessments and risk assessments should be designed according to context and phase of emergency. This could be review of records, use of existing government or NGO surveillance data, household survey or, epidemiological assessment with a cross-sectional survey. Data regarding specific NCD prevalence and incidence should be sought and identification of life-threatening needs or severely symptomatic conditions.

Pre-disaster service availability and readiness to manage NCDs should be assessed, examining various aspects of health systems e.g. HR availability and capacity. Data on service utilization should be gathered. Understanding pre-disaster care of complex cases will help understand the socio-cultural expectation and health system capacity. The medium to long term aim would be to support and reinstate such services if resources allow.

Treatment not available

The ethics of diagnosis of complex disease without potential for treatment should be considered carefully.

Complex treatment needs

For patients with complex needs such as renal dialysis, radiotherapy and chemotherapy for cancer referral pathways, clear and accessible communication should be provided and continuity of care should be provided if possible. Referral to palliative care support should be made if available.

Integration of NCD care into the health system

Community engagement should be sought to allow for early detection and referrals from camps and communities. Community Health Workers should be engaged in programs along with community leaders, traditional healers and the private sector. Outreach services can assist with access NCD health services for those that are homebound.

Health promotion and education

Disseminate information on healthy behaviours and risk factor modification, engaging women, girls, boys and men (separately when necessary) in the development of messages and in strategies for their dissemination so that they are age, gender and culturally appropriate. Due to limitations on food supply and crowding, adapt these prevention and control strategies to context. Examples could be regular physical activity, healthy diet, health visits and reducing consumption of alcohol and tobacco. Provide information about NCD services and where to access care. Provide information that is accessible to all people including older people and people with disabilities.

Medicines and medical devices

(see Health Systems standard 3). Review existing national list of essential medicines, technologies and core laboratory tests available to manage NCDs with a focus on primary health care. Ensure and advocate if needed the inclusion key essential medicines and devices in line international and emergency guidance on NCDs ((see PEN WHO 2010, IAWG XX placeholder XX NCD in Emergencies). Provide access to them at the appropriate levels of care.

Training

Train clinical staff in all levels of health care on case management NCD conditions, and train all staff of priority NCD management issues including SOPs on referral. (also see Health systems standard 2)

Prevention and preparedness plans

Include NCD management into national disaster and emergency plans ensuring:

- it is specific to the different types of facilities e.g. major hospitals, those with dialysis units;
- formation of a registry of patients with complex conditions with critical needs e.g. ventilator, dialysis;
- the creation of standardized operating protocols for referral of patients with specific needs; and
- development of individual patient preparedness strategies including planning a backup supply of medications and instructions on where to access emergency care.

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2.8 Essential health services – Relief of suffering and end of life care

End of life care can be key to alleviating human suffering after disaster or conflict. Prevention and relief of acute pain, including intra-operative and post-operative pain, for example, can help reduce distress as well morbidity and mortality. However, there is a need to adequately and appropriately care for people expected to die. The health care system often uses the term “expectant” patients. End of life or palliative care should be integrated with life-saving or disease-modifying care.

Essential health services – Relief of suffering and end of life care Standard 2.8.1: Palliative Care

People have access to integrated health care that relieves pain and suffering, maximises the comfort, dignity and quality of life of patients, including those who are dying, and provides support for family members

Key action 1: Establish guidelines and policies on end of life care.

- Ensure that all humanitarian health actors responses organisations and teams have a policy recognizing that relief of suffering is important and dying patients should receive comfort-oriented care.
- Ensure availability and use of national or international pain and symptom control guidelines and essential drug list at health care facilities.
- Clarify triage guidelines to support consistent and fair care to patients in need of palliative care. A triage decision that a patient cannot be saved should be based on the patient’s medical condition and on the availability life-saving resources.

Key action 2: Allow for patients determined to be “expectant” (dying) to receive palliative care. This involves:

- controlling symptoms, including with pain relief;
- exploring the patient’s or family’s understanding of the situation;
- correcting any misconceptions, and exploring and addressing the patient’s or family’s values if culturally appropriate; and
- agreeing with the patient or family on a care plan.

Key action 3: Integrate palliative care into all levels of the healthcare system.

- Prioritise community-based management involving home-based care.
- Establish strong referral networks to provide continuity of support and care.

Key action 4: Train local clinical personnel to provide palliative care.

- Ensure that health workers are trained in basic pain and symptom control, as well as psychosocial support, according to national or international standards (if national standards do not exist).

Key action 5: Provide essential medical supplies and equipment.

- Ensure that regulations on emergency importation of controlled medicines essential for treating victims of health crises do not impede the timely availability of these medicines in adequate quantities (see health systems standard 3).
- Ensure availability of essential palliative medicines and appropriate medical devices (such as. diapers, catheters and so on) at health care facilities.

Key action 6: Support services and networks for patients, caregivers and families in the community and at home.

- Raise awareness in the target community, and train community health workers, community leaders, family and caregivers in basic community and home-based care.
- Provide appropriate tools and devices for community and home-based care (see also WASH standard XXX).

Key Indicators

*Proportion of health centres, hospitals, mobile clinics and field hospitals with the following *essential palliative medicines in stock at the time of review*

Percentage of staff trained in basic pain and symptom control/palliative care in each health centre, hospital, mobile clinic and field hospital

Percentage of expectant patients that receive end of life care

*Percentage of health centres, hospitals, mobile clinics and field hospitals with the following *essential palliative medicines in stock at the time of review (Essential Package of Palliative Care in the Report of the Lancet Commission on Global Access to palliative Care & Pain Control)*

What else do I need to know?

Humanitarian health actors should endeavour to learn about and respect local modes of medical decision-making and local values related to illness, suffering, dying, and death.

Developing a care plan

Carefully identify expectant patients. Patients should be regarded as individuals. Respect their preferences and right to make informed decisions about their health and social care (if they can). Provide the unbiased information they require. Take account of their needs, expectations and

preferences. The care plan should be agreed upon by the different actors involved in end of life care and based on patient preferences.

Training health care workers

Should be kept up to date and meet national or international standards (if national standards do not exist). Health workers should develop skills and knowledge on the:

- assessment and management of symptoms; and
- assessment and management of broader needs (including psychosocial, spiritual, social) and palliative care.

Availability of medicines

Some palliative care medicines, such as pain relief, are available in IEHK supplementary modules. IEHK are useful for early phases of an emergency, but should not be used in protracted situations as more sustainable systems should be strengthened.

Mental health and psychosocial support

Increase the capacity at health facilities to identify and manage significant mental health conditions in patients and caregivers and provide psychosocial care that meets the needs of patients, their caregivers and health care providers.

Family, community and social support

- Provide medical supplies for home care needs (such as diapers, urinary catheters and dressing packs).
- Coordinate with relevant sectors to ensure that basic daily needs are met (such as food, sleeping mat, and hygiene products) for destitute patients and family members (see WASH section xx).
- Coordinate with relevant sectors to determine referral pathway for patients with needs to access national social and welfare systems, or organisations who could offer assistance in areas such as shelter, cash programmes, and legal assistance.

Spiritual and religious support

- Identify relevant local faith leaders by using contacts within faith groups, and by establishing protocols for identifying faith traditions of patients and matching with local actors. These spiritual care providers can act as a resource for patients, carers and humanitarian actors.
- Orient local faith leaders to key principles of psychosocial support for patients facing major health issues by providing training on key psychosocial principles
- Establish reliable mechanisms for referral in both directions between health care system and relevant faith actors/spiritual leaders for any patient, caregiver or family member who requests it.
- Ensure support for safe and dignified burial practices in collaboration with the local community, according to national or international guidance (see Health Systems standard 1)

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