

# Health and Nutrition Emergency Response Framework

Draft for CoP Webinar (11/21/2016)



In line with the World Humanitarian Summit Health consultation, the purpose of this framework is to outline WV's basic package of Health and Nutrition services in different types of emergencies, the types of interventions and technical approaches to be employed.

## STRATEGY

Addressing the health and nutrition needs of populations affected by disasters has always been a priority focus for World Vision. The Emergency and Nutrition Framework is integral to World Vision's work during an emergency response because it leads to improved health outcomes for children and communities affected by disasters. It also helps to ensure consistent, quality results. World Vision's responses for Health during emergencies are aligned to the universally-agreed Sphere Minimum Standards for Health in Action.

**OBJECTIVE: TO REDUCE MORTALITY AND MORBIDITY IN VULNERABLE POPULATIONS AFFECTED BY HUMANITARIAN EMERGENCIES AND RESTORE ACCESS TO CURATIVE AND PREVENTATIVE HEALTH AND NUTRITION SERVICES.**

OUTCOME 1: Vulnerable groups such as women and children can access essential health and nutrition services in the immediate aftermath of a disaster.

- SERVICES: Provision of lifesaving health, psychosocial and nutrition services in acute phase of emergency or in the event of health system collapse.

*Examples: Establishment of WAYCS incl. IYCF services, Mobile Medical Services, CMAM screening and treatment units*

OUTCOME 2: Health and nutrition systems are strengthened to meet the immediate and longer term needs of the affected populations.

- SERVICES: Strengthen basic package of primary health, psychosocial and nutrition services (incl. RMNCAH) by partnering with and building capacity of the Ministry of Health at national, district and health facility level.

*Examples: staffing support, provision of supplies, resourcing trainings, rehabilitation and equipping health facilities*

OUTCOME 3: Families and communities are supported to understand, monitor and protect themselves from public health risks, ensure each other's wellbeing and access to health and nutrition services.

- SERVICES: Support community and family health by recruiting, equipping, training and strengthening supervision of CHWs (Health posts) to undertake community mobilization, health

education, referral system strengthening, surveillance and where appropriate health-focused conditional cash transfers.

*Examples: provision of job aids, digital platforms, IEC materials, incentive provision, health and hygiene promotion BCC, surveillance of disease and malnutrition.*

**OUTCOME 4:** Early Warning and Surveillance are established to enable rapid detection and response to public health issues of concern.

- **SERVICES:** Strengthen assessment, monitoring and surveillance diseases of outbreak potential at community and Health Facility level (incl. communicable diseases and malnutrition)

*Examples: HeRAMS, EWARN, HIS, training and support to health workers with case definitions and reporting, observational assessments, SMART surveys.*

**OUTCOME 5:** Inter-agency level health and nutrition coordination platforms (area / country / regional levels) are supported, effective and meeting key needs of target groups

- **SERVICES:** Coordination and advocacy with the humanitarian community in order to inform and contribute to cluster and inter-agency initiatives.

*Examples: contribute data and information to the Health and Nutrition Clusters, feed into planning and appeals, advocate for specific needs in areas of operation.*

## TYPE I: RAPID

### Definition / sub-types

- **Geophysical:** Earthquakes, Landslides, Tsunamis, Volcanic activity
- **Hydrological:** Avalanches, Floods
- **Meteorological:** Cyclones, Storms / wave surges
- **Climatological:** Wildfire

### WV H&N Response History (Annex I)

Haiti

Nepal

Philippines

### Response time-frame (after DDG) subject to change as specific timeframes are determined by RM, ND & Partnership stakeholders.

- 0-72 hours 'first steps'
- Up to 30 days 'emergency response'
- 30-90 days 'continuing response'
- Phase out

### Anticipated Health and Nutrition Specific Needs

1. **Injury and death** (trauma injuries i.e. blunt and penetrating trauma, fractures, wounds, crush; burns, smoke inhalation, suffocation / intoxication; debris injuries; RTI, ↑ disabilities, psychological trauma & grief)
2. **Water and sanitation related diseases** ↑risk
3. **Vector borne diseases** – common after floods, Initial flushing of vectors for first 3-6 weeks, rapid increase from water and rubbish build up
4. **Environmental caused health problems** (humidity i.e. heat distress, fungal diseases), cold & immersion in water (hyperthermia); increased spread of communicable diseases due to overcrowded living conditions; chemical spillages; Increased level of dust ≈ acute respiratory distress (ARI)
5. **Maternal and newborn child health and children's health** – mothers limited in ability to care (stress), children play in unsafe areas, deterioration in nutrition status of children
6. **Infant and young child feeding** (BF disrupted through injury/trauma/stress, BMS uncontrolled distribution, lack of support for BF, conditions not conducive for hygienic BMS feeding.)
7. **Nutrition** – short-term shortage of food, rapid deterioration of children with SAM in areas with high prevalence, micronutrient deficiency (particularly in populations with poor nutritional status, pre-emergency)
8. **Medical services and provision** – damage to HFs or displacement of population, breakdown in routine PHC and SHC services, poor access and availability of medicines, supplies and equipment

*The health and nutrition needs will vary according to location and intensity of the disaster and the socioeconomic situation prior. Refer to pre-disaster situation including deterrents of health and endemic diseases and pre-disaster nutrition situation. Recommended Rapid Assessment Tool to determine needs i.e. WV BRAT)*



or IASC IRA

## **TYPE I RECOMMENDED RESPONSE PACKAGE**

**0-72 HOURS 'FIRST STEPS' → <1 MONTH** (possible H&N components of multi-sector response, situation dependent)

### **ASSESS**

- Observational needs assessment within 72 hours including mapping of functioning HFs or health services in temporary structures, and functioning first aid posts. Include observations on IYCF (unaccompanied infants, PLW, feeding method of affected populations e.g. BF or BMS dependent)
- Within 1 week contribute to BRAT and undertake additional needs assessments as appropriate i.e. HF assessments.
- Start HeRAMS or cluster assessment tool for health centres as soon as available.

### **PLAN / COORDINATE**

- Interact and participate with established H&N coordination mechanisms, clarify WV's role and ensure regular participation and submission of data and information i.e. sitreps, 4Ws, area reports, health facility data. Meet with other NGOs as appropriate to collaborate and avoid duplication.
- Meet with the MoH to confirm and begin implementation of the response plan and work with them collaboratively.
- Donor liaison and initial resource acquisition (emergency grant mechanisms i.e. ECHO primary decision).

### **RAPID INITIAL ACTIVITIES**

- GRRT Health and Nutrition response staff bring and/or mobilise transport of stock piled first-aid & medical supplies (including basic PPE) and organize distribution to designated HFs / teams of national clinician first responders and first aid posts.
- Raise awareness at the community level of available health services and facilitate transport (informed by assessments).
- Advocacy on initial health and nutrition issues i.e. disposal of dead bodies in a manner that is dignified and based on good public health practice.
- Establishing MMS in coordination with MoH and Health Cluster (if supporting communities have poor access to health services) - dependent on MoH staff availability.
- Establish WAYCS rapidly and support PLW to resume / continue optimal IYCF practices (support with breastfeeding and complimentary feeding) and prioritise psychosocial support component. Also provide suitable and culturally appropriate complimentary foods for infants where possible. Protect, promote and support optimal IYCF, including minimizing risks for infants that require artificial feeding. Ensure HHs with children U2 and PLW are prioritized for registration and access. Ensure skilled breastfeeding support is available within maternity services for all new deliveries. Uphold the provisions of the Operational Guidance on infant feeding in emergencies (IFE) and the International Code of Marketing of Breastmilk

Substitutes – ensure code violations are monitored and reported.

- Provide District Hospital, CHC, PHC with Interagency Emergency Health Kits and/or Italian Trauma kits.
- Provide psychological first aid training to HWs and provision of care.
- Initiate health and hygiene promotion activities through HFs & CHWs for prevention of communicable diseases and provide supplies i.e. LLIN, aquatabs as appropriate.
- Surveillance of the health situation (availability and utilization of services, morbidities by type, incidence of diseases with outbreak potential).
- Surveillance of the nutrition situation including IYCF practices and management of acute malnutrition particularly if SAM burden was high prior to emergency, in this case support HFs to resume CMAM / IMAM services through provision of therapeutic foods.
- Design continuing phase through donor liaison, coordination with MoH, health and nutrition clusters and other agencies, proposal submission.

#### INTER-SECTOR LINKAGES

- WASH: ensuring vulnerable groups are accessing clean water and sanitation, collaboration on health and hygiene promotion campaigns and prevention of waterborne disease outbreaks. Joint focus on removing water and preventing accumulation of standing water to prevent communicable diseases such as Malaria and Dengue, AWD and ARI.
- Child protection: identifying children with health needs for referral and ensuring psychosocial support. Ensure that carers are supported to stay with children when transported for treatment, and start family tracing if needed.
- Ensure attendance of any relevant sub-clusters or technical working groups i.e. MPHSS, GBV etc.

#### 3-4 MONTHS 'CONTINUING RESPONSE' (possible H&N components of multi-sector response, situation dependent)

##### COORDINATION

- Active participation in the Health Cluster, sharing information in regular meetings and 4W reports, active participation in any sub-cluster working groups i.e. on RH or HIS, HeRAMS etc.
- Active participation in the Nutrition Cluster where it is a standalone sector or a subsector under Health.
- Regular meetings with MoH at national and district level for progress updates and requests on both sides.
- Regular meetings with health and nutrition donor technical representatives for sharing information, planning, intelligence and advocacy.
- Regular meetings with INGOs to establish opportunities for collaboration i.e. Handicap International for support with inclusion criteria.
- Regular meetings with national and CBOs to assess opportunities for partnership and capacity building.

##### CONTINUING RESPONSE ACTIVITIES

- **Continued assessment of availability and quality of health services in areas of operation:**
  - Trauma and injury
  - maternal health: ANC, delivery care including EmONC, postpartum care, care of the newborn
  - Child Health and immunization: EPI, IMCI
  - Reproductive health
  - Nutrition: prevention, assessment and treatment (CMAM / IMAM) and IYCF support; prevention and treatment of micronutrient deficiency
  - Communicable disease treatment and control: prevention, diagnosis, treatment, vaccinations, surveillance and reporting
  - Non-communicable disease prevention and management (includes chronic disease, mental health & disability services).  
Use assessment for advocacy of needs with MoH, clusters, donors and other NGOs and to determine direct support WV will provide within PHC remit.
- **Provision of medicines, medical supplies and equipment** from WV commodity list to District Hospitals, CHC, PHC, Health posts according to need including kits such as IEHK, Italian Trauma Kits, UNFPA RH kits, Midwifery kits, clean delivery kits, diarrheal disease kits (where appropriate). Provision of PHC standard medicines. Provision of hygiene materials for Infection Prevention and Control.
- **Support referral** through provision of vehicles and communication equipment at all health facility levels, strengthening promotion of referral networks through training / mobilization of CHWs. Advocacy with the Health Cluster to identify referral pathways for specialized services.
- **Structural rehabilitation of HFs damaged by disaster** i.e. water and sanitation, electricity supply (solar panels) for cold chain, repair of infrastructural damage, furnishing, use of tents for temporary expansion or isolation units etc.  
Provision of Mobile Medical Services (where appropriate according to WV guidelines).
- **Capacity building** of MoH staff and CHWs through resourcing and/or leading trainings in all Primary Healthcare and Nutrition topics according to knowledge gaps and health needs identified. Address issues of no pay, reduction in pay and overwork by working with the cluster and the MoH on incentives and also prioritization where additional tasks are being pushed by other stakeholders i.e. pressure on CHWs for distributions can lead to neglect of health and hygiene promotion.
- **Preventative public health measures** – conduct a mapping of CHWs through liaison with HFs, CHW supervisors and the DHO. Equip PHC, CHC and health post / CHWs to provide health and hygiene promotion through trainings and provision of supplies including IEC, job aids and essential health and hygiene supplies such as LLIN, aquatabs, female hygiene products and condom for distribution to target vulnerable groups. Work with community, faith leaders, volunteer committees, schools and groups by facilitating trainings on key messaging and events. Ensure MMS (where functioning) are providing health and hygiene promotion.
- **Strengthen Reproductive and Maternal, Newborn and Child Health (RMNCH)** –in line with WV reproductive health policy and MNCH in Emergencies guidelines:
  - Provide Reproductive Health Kits: (blocks 1-5) to CHC and PHC
  - Support essential maternal and newborn care: where possible and feasible locate and mobilise SBAs and establishing referral links. Support referrals for appropriate services i.e. EmONC which vehicles and resourcing where appropriate. Support SBAs to undertake home visits



within critical 24 to 48 hours after birth and to provide community education on essential newborn and maternal care (thermal care, benefits of colostrum and early initiation of breast-feeding). Where SBAs are not accessible provide clean delivery kits to visibly pregnant women.

- Support family planning services: provision of condoms for STI prevention to HFs and CHWs for appropriate distribution; provision of post-rape kits including (PEP) – RHK 3. Support family planning education at health facilities and through health posts through training and job aids.
- STI / HIV prevention and management: community-based approach to prevent and control STIs/HIV through safer sex and condom programming and public awareness raising of STIs and available clinical services. At the health-service level, ensure comprehensive STI case management through provision of medicines and supplies.
- Support to victims of Sexual and Gender-based violence: staff can provide immediate PFA. Training of MoH staff on PFA for victims of SGBV. Use communication channels to raise awareness among communities on prevention, incident reporting and confidential support services available through provision of education and IEC to community networks, faith leaders and CHWs. Provide referrals to clinical management and counselling for rape survivors / those exposed to SGBV. Provide protection mechanisms i.e. safe areas.
- **Strengthen Mental Health and Psychosocial Support (MHPSS)** – At the PHC level: train MoH HWs in Psychological First Aid (PFA) to respond appropriately to distress and refer as required. Improve basic mental healthcare at PHC by also training MoH HWs on improving case management (i.e. mhGAP) and supporting the scale up of group counselling (IPT-G). At the community level: provision of community support MHPSS programs through training and support for CHWs in general mental health first aid, good listening skills, Cognitive Behavioural Therapy and inter-personal therapy. Establish caregiver groups such as Go Baby Go / or playgroups to serve as social support and focus on maternal mental well-being practices.
- **Communicable disease preparedness** (see type 4 for treatment)
  - Communicable disease preparedness planning with national and district level MoH.
  - Implement health and hygiene promotion activities by educating and supporting community networks, faith leaders and CHWs to raise awareness at the community level of disease risk transmission and preventative behaviours / methods. Organise and resource community events and campaigns.
  - Enhance control methods i.e. by distributing PPE to health facilities and supporting medical waste disposal and enhancing vector control measures (esp. after a flood). Preposition reserve stocks of materials and supplies that support personal and household protection i.e.: LLINs, water-treatment tablets, insect repellent, condoms, soap, disinfectant and hand sanitizer.
  - Support the country disease surveillance system by engaging health providers in case definitions, reporting and referral mechanisms and protocols. Identify closest laboratory and ensure all stakeholders are aware. Provide HFs with test kits. Ensure WV-run health facilities are contributing to the HIS and EWARN - monitor weekly or monthly morbidity/mortality rates.
  - Support emergency vaccination campaigns with provision of vehicles, fuel, incentives and sustenance for vaccination teams.
- **Strengthening health monitoring and surveillance** – Implement HeRAMS where this is initiated by the health cluster. Ensure supported health facilities contribute to existing HIS and EWARN where such mechanisms are in place. If no MoH HIS, second support to the MoH or

develop a patient database. Ensure HF use standardized case definitions for all morbidities reported in conjunction with the cluster and other agencies. Submit HIS data to the Health Cluster on a regular basis as required. Provide support to HF with accurate data collection avoiding double counting beneficiaries where information is manually tallied (cross check data entry with paper records at HF). Linkage of program to LMMS beneficiary tracking system.

- **Nutrition surveillance** through observation, supporting active case finding mechanisms, SMART or Rapid SMART surveys, mass screening campaigns, HF and CHW records and reports.
- **Strengthen access to nutrition curative services** - Establishment / improvement of IMAM / CMAM where malnutrition has previously been a health problem or if anticipated food aid shortages through training of MoH staff / CHWs, provision of RUTF (via UNICEF) and RUSF and supplementary food for TSFP and BSFP (via WFP). Provision of medicines, medical supplies and equipment (Inc. deworming and vitamin A) in accordance with WHO / CMAM protocols. Provision of micronutrient supplements for target groups where required i.e. PLW and children <5 years in accordance with WV MNCH in emergencies guide. Strengthening referral networks through education and mobilisation. Strengthening CHW coverage and activities through support to MoH with recruitment, training and on-the-job support. Ensure accurate monitoring and reporting at all levels of HF (SC, OTP, SFP). Provide education in food-distribution points and in CMAM on importance of EBF, continued breastfeeding (BF), complementary foods. Ensure all nutrition and food aid supplies meet with WV policies including the WVI milk policy, operational guidance on infant feeding in emergencies, the Code. Ensure inclusion of PLW
- **Strengthen IYCFe initial WAYCS interventions** - Where temporary structures have been used for WAYCS, construct more permanent spaces offering the full range of services or, if appropriate, integrate and strengthen services already provided at HF and in the community such as breastfeeding corners, counseling and education for PLW, and re-lactation support. Support to artificially fed children in transit or separated from their mothers i.e. through provision of safe feeding kits. Provide age-appropriate nutritionally adequate complementary foods and demonstrate hygienic food preparation, storage and serving. Support existing services by providing refresher training, and resources such as infant feeding models and IEC materials and job aids to HWs and volunteers. Main components of the WAYCS:
  - Promotion of adequate nutrition for women, children and adolescents
  - Support for pregnant women
  - Promotion of good health and hygiene
  - Support for young mothers and families
  - Family planning, emergency contraception and support to survivors of gender based violence (GBV)
  - Provision of a safe recreational space that benefits women and infants
  - Encouraging men to support women's and infant's health and nutrition
  - Psychosocial Support to families
  - Information and support around protection issues
  - Support to adolescents (girls and boys with priority to girls)
- Monitor and report violations of the BMS code of conduct.

#### LINKAGES WITH OTHER SECTORS

- Food Security and Livelihoods: collaboration with nutrition to assess needs to the next harvest where mass damage of agricultural/food storage. Predict impact on future planting and harvest season and food availability.
- WASH: coordination on HF rehabilitation, health and hygiene campaigns, joint strategy in the event of a waterborne disease outbreak
- Protection: identifying vulnerable groups, collaboration on meeting the needs of victims of SGBV, CFS incorporate space and support for IYCFs
- Child Protection: continue identification and support to separated children and maintain vigilance of trafficking
- Livelihoods: cash / voucher program collaboration

#### PHASE OUT / RECOVERY

If recovery stage is anticipated to last longer than 4 months, recommend to expand and continue above interventions. Phase out should be done in coordination with the MoH to ensure ownership and MoUs should detail the handover at the close of the project.

## TYPE 2: SLOW

### Definition / sub-types

- Climatological: Drought, extreme temperatures
- Displaced populations

### WV H&N Response History (Annex I)

### Response time-frame (after DDG) subject to change as specific timeframes are determined by RM, ND & Partnership stakeholders.

- Days → weeks from early warning until deterioration to the point of humanitarian action being required
- 0-5 days 'first steps'
- 30 days 'emergency response'
- 30-90 days 'continuing response'
- Phase out

### Anticipated Health and Nutrition Specific Needs

1. Health - Heat exhaustion, stroke, dehydration, renal failure, malnutrition, frost bite, and hyperthermia.
2. Water borne diseases – limited or contaminated water supply, ground water polluted or saline, ↑ risk of water/sanitation /hygiene related diseases, (e.g. dermatitis, conjunctivitis, ear nose and throat infections, giardia etc). ↑ Overcrowding in displaced camps. Hygiene related diseases due to limited water, so scabies, fungal disease, lice and fleas.
3. Vector borne diseases ↑ incidence vector disease, poor HH hygiene practices.
4. Environmental caused health problems - ↑ spread of communicable diseases exacerbated by malnutrition, especially if people in camps. Animal and crop diseases due to lack of water. Water contamination from dead animals.
5. Maternal and newborn child health and children's health - infant and children's health needs, mothers are stressed & limited in ability to care; deterioration in nutritional status due to disease / lack of food.
6. Infant and young child feeding - lack of support available for breastfeeding women, lack of suitable complementary foods for children > 6months. BF undermined by efforts of find food and water, by mother. Lack of food for lactating women.
7. Nutrition - food shortage and lack of diversity in food leading to micronutrient deficiencies, rapid deterioration of children with GAM. Nutrition issues exacerbate chronic illness where either or both medication and food access are problematic. Malnutrition among PLWs.
8. Medical services and provision - loss of assets result in people unable to afford medical treatment, especially those with chronic diseases and



ongoing conditions, PLHIV do not have access to ARVs.

## **TYPE 2 RECOMMENDED RESPONSE PACKAGE**

### **DAYS → WEEKS FROM EARLY WARNING**

#### **ASSESSMENT**

- Continue monitoring: reduced rainfall, loss of livestock, deficit food production, food shortages, infestation of food crops, significantly increased grain prices, market demand for food, epidemics, population displacement and indicators of household food insecurity.
- Assess CMAM admissions and exits by type at HFs. Analyse trends over time (proportion of CMAM admissions from the total number screened).
- Work with food security staff on primary data collection i.e. HH surveys, FDGs, KIIs or support national surveys with resourcing, staff, logistics etc. Ensure multi-sector or food security surveys include data collection on IYCF and if possible MUAC screening.
- Conduct area level SMART or Rapid SMART survey to assess GAM and SAM in areas of operation and aggravating factors against benchmarks.
- Nutrition Causal Analysis – recommended for populations with poor nutritional status pre-emergency. Use WV triggers for action.
- Utilise data from surveys to advocate for funding and resources as appropriate and to contribute to overall country level surveillance efforts.

#### **PLANNING**

- Program design, resource acquisition and liaison with technical donor reps sharing data and information.
- Continue liaison with sector clusters and MoH and preparedness planning and mapping, ensure WV's role is determined and MoUs are in place.
- Continue focus on stockpiling of supplies medicines, medical supplies and equipment.
- Work in partnership with UNICEF and WFP to arrange supply chain of therapeutic and supplementary food.
- Continue inter-sector coordination.
- Assess and implement any small adaptations to existing programming i.e. changes in health and hygiene promotion messaging, change in the type of support provided to health and nutrition services in the event of population movement
- Begin implementation of the emergency response plan which should include scale up of existing CMAM / IMAM, Health and WASH interventions where possible and appropriate.

### **EMERGENCY → CONTINUING RESPONSE**

#### **RESPONSE ACTIVITIES**

- **Improve access to nutrition curative services** - establishment / scale up of CMAM / IMAM through:

- Identification and mapping of SC / OTP / SFP sites to support in conjunction with MoH and full needs assessment of site capacity (staff, supplies, equipment etc.)
- Mapping and mobilization of CHWs through HFs and DHO. Support with active recruitment of health posts / CHWs where required.
- Support the scale up of staffing where required i.e. incentivizing MoH staff to increase working hours and manage SC in addition to existing wards.
- Resource and organize trainings with MoH in CMAM for HWs at all levels (including clinical training for SC staff in Hospitals with existing units).
- Resource and organize trainings with MoH / DHO in CMAM for Health posts / CHWs.
- Collaborate with UNICEF and WFP to ensure regular supply chains of RUTF, RUSF and supplementary food.
- Provision of CMAM routine medicines, medical supplies and equipment (including anthropometric and Hospital equipment for SCs).
- Support HFs at all levels with monitoring and reporting and ensure services are of sufficient quality (IQA tool).
- Provide BSFP in addition to TSFP during nutrition emergency or if food distribution is not in place at the onset or if there are problems.
- Ensure all nutrition and food aid supplies meet with WV policies including the WVI milk policy.
- Link with food aid to ensure packages are appropriate for context and nutrition needs.
- Where populations are displaced as a result of food insecurity and access to nutrition curative services is difficult, implement nutrition services through MMS in coordination with MoH and the Nutrition Cluster.
- **Strengthen IYCFe**
  - Mapping of existing support services at clinic and community levels such as breastfeeding corners, mother to mother support groups, counseling and education for PLW, and re-lactation support.
  - If appropriate establish WAYCS or strengthen existing services to provide all aspects of the WAYCS model through training HWs, SBAs and CHWs. Provision of resources according to WV commodity list such as infant feeding models and IEC materials to HFs and community volunteers engaged in these activities. Ensure support to artificially fed children in transit or separated from their mothers i.e. through provision of safe feeding kits.
  - Uphold the provisions of the Operational Guidance on infant feeding in emergencies (IFE) and the International Code of Marketing of Breastmilk Substitutes – ensure code violations are monitored and reported.
- **Prevention of micronutrient deficiency** through the provision of micronutrients to food aid dependent populations.
- **Nutrition surveillance** through observation, supporting active case finding mechanisms, SMART or Rapid SMART surveys, mass screening campaigns, HF and CHW records and reports.

Where availability and access to quality health services is poor implement the continuing response health activities listed in Type I:

- Continued assessment of availability and quality of health services in areas of operation
- Provision of medicines, medical supplies, equipment and kits according to need and WV commodity list
- Support referral
- Structural rehabilitation of HFs damaged by disaster

- Provision of Mobile Medical Services (where appropriate) i.e. to reach displaced communities, including veterinary support where appropriate for pastoralists.
- Establishment / bolstering Health posts along corridors i.e. supporting displaced where they are travelling by foot for long distances by scaling up health posts with equipment and supplies along the route they are taking.
- Capacity building of MoH staff and CHWs
- Preventative public health measures
- Strengthen Reproductive and Maternal, Newborn and Child Health (RMNCH)
- Strengthen Mental Health and Psychosocial Support (MHPSS)
- Communicable disease preparedness (see type 4 for treatment)
- Strengthening health monitoring and surveillance

#### LINKAGES WITH OTHER SECTORS

- Food Security and Livelihoods: collaboration with causal analysis and surveys, assess how FSL interventions could improve nutrition outcomes, program targeting, linkages between nutrition and food assistance programmes, linkages between FSL and Health i.e. Veterinary pharmaceutical supply distribution, designing rations, joint design of food security and nutrition messaging/education, including topics such as crop selection (micronutrients, dietary diversity, micro-gardening), food storage, food preparation. Collaboration to address the issue of CHWs enrolling for CFW programs i.e. consider CHW activities as CFW during program cycle and reports – clinic or program are proof of work.
- Protection: collaboration on addressing increased violence and negative coping mechanisms due to limited resources and lack of community support structures. Collaboration on meeting the health and nutrition needs of vulnerable children i.e. separated or married early. Gender issues with family separation for work and targeting.
- Protection: i.e. during mass displacement collaborate to identify vulnerable beneficiary groups and to meet the needs of victims of SGBV. CFS incorporate space and support for IYCFs and health promotion activities
- WASH: coordination and collaboration on HF rehabilitation, health and hygiene campaigns, joint strategy in the event of a waterborne disease outbreak

#### PHASE OUT / RECOVERY

A sufficient time period to encompass the next rainy season and harvest. Phase out should be done in coordination with the MoH to ensure ownership.



## TYPE 3: COMPLEX

### Definition / sub-types

- National conflict (fighting between groups)
- International conflict
- Displaced populations

### WV H&N Response History (Annex I)

Syria response

South Sudan

### Response time-frame (after DDG) subject to change as specific timeframes are determined by RM, ND & Partnership stakeholders.

- Days → weeks for increased severity to the point of humanitarian action being required unless predicted offensive.
- 0-5 days 'first steps'
- 30 days 'emergency response'
- 30-90 days 'continuing response'
- Phase out

### Anticipated Health and Nutrition Specific Needs

- Trauma and injury
- Psychosocial first aid and care
- Access to all levels of healthcare for routine services i.e. maternal child health, reproductive health, nutrition, communicable and non-communicable diseases
- Health and nutrition information
- Protection from communicable diseases with outbreak potential i.e. vaccination, LLIN and access to clean water and sanitation facilities
- Support with IYCFe

## TYPE 3 RECOMMENDED RESPONSE PACKAGE

Consider adaptations for remote management where necessary.

### EMERGENCY → CONTINUING RESPONSE

#### COORDINATION

- Active participation in the Health Cluster, sharing information in regular meetings and 4W reports, active participation in any sub-cluster working



groups i.e. on RH or HIS, HeRAMS etc.

- Active participation in the Nutrition Cluster where it is a standalone sector or a subsector under Health
- Regular meetings with MoH at national and district level for progress updates and requests on both sides
- Regular meetings with donor technical representatives for sharing information on interventions, planning, intelligence and advocacy
- Regular meetings with INGOs to establish opportunities for collaboration

Regular meetings with national and CBOs to assess opportunities for partnership and capacity building.\

#### ASSESSMENT

- **Continued assessment of availability and quality of health services in areas of operation by type. Specifically assess the following services looking at availability, accessibility, human resourcing, equipment and medicines:**
  - Trauma and injury
  - maternal health: ANC, delivery care including EmONC, postpartum care, care of the newborn
  - Child Health and immunization: EPI, IMCI
  - Reproductive health
  - Nutrition: prevention, assessment and treatment (CMAM / IMAM) and IYCF support; prevention and treatment of micronutrient deficiency
  - Communicable disease treatment and control: prevention, diagnosis, treatment, vaccinations, surveillance and reporting
  - Non-communicable disease prevention and management (includes chronic disease, mental health & disability services).
- Where there is a breakdown in government health services, conduct an assessment of private clinics and their available services.
- Assess access to and cost of quality essential medicines, equipment and medical supplies (availability in pharmacies and needs for stock piling).
- Use assessment for advocacy with MoH, clusters, donors and other NGOs and to determine direct support WV will provide within PHC remit (training, incentives and provision of health and nutrition resources).

#### HEALTH SYSTEMS STRENGTHENING - PRIMARY HEALTHCARE

- **Improve access with temporary measures in the event of health system collapse or where communities are unable to access health services** i.e. as a result of insecurity, fear of movement or remote locations, or where population is living in camps with no access to transport or communications - Establish MMS and temporary HFs providing PHC services where required with national clinicians according to Sphere and WV guidelines in conjunction with national / local authorities and the health cluster. Consider Health cash/voucher schemes where appropriate i.e. Vouchers or Conditional Cash Transfers (CCT) for predictable health needs (pregnancy related, chronic illness, etc.) or Pre-payment schemes/premiums into pooled (insurance) funds. Undertake structural rehabilitation of HFs damaged by disaster i.e. water and sanitation, electricity supply (solar panels) for cold chain, repair of infrastructural damage, furnishing etc.
- **Human resourcing and capacity building** – Where Health cadres are insufficient in number, consider alternatives such as partnering with

other aid agencies that deploy clinicians on jointly supported clinics, consider working with Red Crescent and consider partnering with expatriate clinician associations and societies in whose origin and medical training is from the country of emergency. When looking at partnering, consider local medical staff from areas outside the affected area. Address knowledge gaps through resourcing and/or leading trainings in all primary health and nutrition topics for MoH HWs and CHWs. Provision of incentives for MoH staff and volunteers required to work additional hours, relocate or take on additional responsibility according to national protocol and in consultation with MoH, donors and the Health Cluster. Work with the DHO to recruit and train CHWs and help to manage prioritization of their workload. In contexts with no CHW networks, hire national staff to focus on community mobilization and education.

- **Provision of medicines, medical supplies and equipment** from WV commodity list to CHC, PHC, Health posts according to need including kits such as IEHK, Italian Trauma Kits, UNFPA RH kits, clean delivery kits, diarrheal disease kits (where appropriate). Provision of PHC standard medicines. Provision of hygiene materials for Infection Prevention and Control. If transportation is not feasible, consider local purchase as donor rules and regulations allow. Hire pharmaceutical logistics staff and develop systems to monitor supply and usage.
- **Strengthen referral** through provision of vehicles (designated referral vehicles without ambulatory equipment but on call i.e. for EmONC). Provision of cash transfers for referrals and medical treatment (deliveries and child health, immunization) esp. if private services. Provision of communication equipment at all health facility levels (phones, radios and Satellite phones). Ensure communities know how to contact health staff in the event of an emergency. Strengthen promotion of referral networks through training / mobilization of HF staff and CHWs where they are operating. Advocacy with the Health Cluster to identify referral pathways for specialized services. Provide Ambulances to designates HFs where needed in partnership with MoH / partners such as local red-crescent movement.
- **Activate Rapid Response Mechanism** – where appropriate and safe, deploy H&N RRM team to investigate changes in the situation in different geographical areas in coordination with clusters and other NGOs. Provision of basic H&N services, health promotion and related NFIs during each deployment as well as planning to meet health and nutrition needs on a longer term basis.
- **Strengthen Reproductive and Maternal, Newborn and Child Health (RMNCH) at supported HFs** –in line with WV reproductive health policy and MNCH in Emergencies guidelines:
  - Provide Reproductive Health Kits: (blocks 1-5) to CHC and PHC
  - Support essential maternal and newborn care: where possible and feasible locate and mobilise SBAs and establishing referral links. Support referrals for appropriate services i.e. EmONC which vehicles and resourcing where appropriate. Support SBAs to undertake home visits within critical 24 to 48 hours after birth and to provide community education on essential newborn and maternal care (thermal care, benefits of colostrum and early initiation of breast-feeding). Where SBAs are not accessible provide clean delivery kits to visibly pregnant women. In contexts where there is no community health network, hire and train national staff with a community health focus that can conduct camp and HH visits and provide support to women with maternal and newborn care.
  - Support family planning services: where culture / controlling entities allow, provide condoms for STI prevention to HFs and CHWs for appropriate distribution; provision of post-rape kits including (PEP) – RHK 3. Support family planning education at all levels of health facilities and through health posts through training and job aids and ensure this education is tailored to local culture and customs.
  - STI / HIV prevention and management: prevent and control STIs/HIV through safer sex and condom programming and awareness raising

through health facilities. At the health-service level, ensure comprehensive STI case management through provision of medicines and supplies.

- **Support to victims of Sexual and Gender-based violence:** Ensure supported HFs (including temporary structures) have a private space and at least one trained staff member who can provide immediate PFA to victims of SGBV – this could be incorporated into WAYCS as an alternative. Provide specific training for MoH HWs on PFA for victims of SGBV. If SGBV is a sensitive issue with the community / controlling entity, work with key community members on establishing communication channels appropriate for the context for incident reporting and confidential support services available. Provide referrals to clinical management and counselling for rape survivors / those exposed to SGBV.
- **Strengthen Mental Health and Psychosocial Support (MHPSS)** – At the HF level: train MoH HWs in Psychological First Aid (PFA) to respond appropriately to distress and refer as required. Improve basic mental healthcare at PHC by also training MoH HWs on improving case management (i.e. mhGAP) and supporting the scale up of group counselling (IPT-G). In temporary clinics ensure space for privacy. Ensure at least one staff member of MMS is trained and able to provide PFA. At the community level: MHPSS programs through training and support for CHWs however if MHPSS is a sensitive issue or if there is no CHW network then train and equip national staff with a community health focus to provide PFA and basic psychosocial support at the HH level or through WAYCS.
- **Communicable disease preparedness** (see type 4 for treatment)
  - Communicable disease preparedness planning with national and district level MoH. Where there is no functioning MoH, collaborate with other agencies to ensure continuity and sharing of resources.
  - Implement health and hygiene promotion activities through PHCs, temporary health structures and MMS which include information about disease risk transmission and preventative behaviours / methods. Provide resourcing for trainings for HWs in coordination with the MoH to improve knowledge of case definitions and reporting procedures. Equip staff with appropriate IEC materials and NFIs. Ensure CHWs prioritise and are trained and equipped to deliver health and hygiene promotion on HH visits. Where there is no health post or CHW network hire, train and equip national staff that are respected community members to provide camp and HH visits. Ensure treatment of STI and HIV are prioritized due to higher risk behaviours, including transactional sex.
  - Enhance control methods i.e. by distributing PPE to health facilities and supporting medical waste disposal and enhancing vector control measures i.e. fumigation campaigns (esp. after a flood). Preposition reserve stocks of materials and supplies at HFs that support personal and household protection i.e.: LLINs, water-treatment tablets, insect repellent, soap, and disinfectant and hand sanitizer.
  - Support the country disease surveillance system by engaging health workers in case definitions, reporting and referral mechanisms and protocols. Identify closest laboratory and ensure all stakeholders are aware. Provide HFs with test kits. Support with transportation of samples as required. Ensure WV-run health facilities are contributing to the HIS and EWARN - monitor weekly or monthly morbidity/mortality rates and liaise with MoH, clusters and partners about cases of disease with outbreak potential.
  - Support emergency vaccination campaigns with provision of vehicles, fuel, incentives and sustenance for vaccination teams.
- **Preventative public health measures** – Ensure health post / CHW coverage and continuation of community level health and nutrition activities by assessing the number / proportion functioning and level of function. Work with District Health Office to actively recruit where gaps

exist and security allows. Additional support to ensure they offer the full range of services through training, provision of job aids, IEC, supplies, communication devices and incentives where appropriate. Support health promotion initiatives, education and distribution of commodities to target groups i.e. LLIN, hygiene products, aquatabs. Where coverage is non-existent, ensure MMS are providing health promotion and community education. Where there is no CHW network, hire and train national staff to undertake community and camp visits.

- **Strengthening health monitoring and surveillance** – ensure supported health facilities contribute to existing HIS and EWARN; where necessary conduct assessments and surveys to gather additional information. Ensure HFs use standardized case definitions for all reportable morbidities in conjunction with the cluster and other agencies. Calculate accurate population catchment figures and estimated proportions by age and sex. Submit surveillance and HIS data to the Health Cluster on a regular basis as required and advocate for any required changes in regards to priority diseases and health conditions. Use supplementary data consistently from other relevant sources, such as surveys, to interpret surveillance data and to guide decision-making. Provide support to HFs with accurate data collection avoiding double counting beneficiaries where information is manually tallied (cross check data entry with paper records at HFs). Where there is no functioning HIS work with the MoH and Health Cluster to implement a database i.e. DHIS2, openMRS as decided by the working group. Ensure HFs in areas of operation contribute to HeRAMS where implemented.
- **Nutrition surveillance** through observation, supporting active case finding mechanisms, Rapid SMART surveys or full SMART where feasible, HF and CHW records and reports showing # screened and # admissions over time. Monitor and report violations of the BMS code of conduct.
- **Strengthen access to nutrition curative services** – where appropriate i.e. establishment / improvement of IMAM / CMAM where malnutrition has previously been a health problem or if anticipated food aid shortages (as per type 1)
- **Strengthen IYCFe initial WAYCS interventions** – (same as listed in type 1 and 2) Strengthen IYCFe support services already provided at HFs and in the community such as breastfeeding corners, counseling and education for PLW, and skilled breastfeeding support, including for re-lactation. Support existing services to offer the full range of support to women as detailed in the WAYCS model by providing HWs and volunteers already engaged in these activities with refresher training, and resources such as infant feeding models and IEC materials. Establish women, adolescent and young child spaces (WAYCS) as standalone facilities where there is need and adapt for cultural issues (i.e. in MEER it may not be appropriate for standalone WAYCS and authorities may insist services are adjoined or incorporated into a HF. Where this is the case create a women's health clinic in a separate room with as much privacy as possible. Ensure messaging and support is in line with the context and the components of support are as mentioned in Type 1 and 2. Use local terminology for WAYCS model i.e. Breastfeeding space.

#### LINKAGES WITH OTHER SECTORS

- WASH: coordination and collaboration on HF rehabilitation, health and hygiene campaigns, joint strategy in the event of a waterborne disease outbreak. Where water supply and trucking is required collaboration to ensure inclusion of health facilities.
- Protection: identifying vulnerable beneficiary groups, collaboration on meeting the needs of victims of SGBV, CFS incorporate space and support for IYCFe. Youth friendly services and observation of the increase in CHH and FHH
- Livelihoods: cash / voucher program collaboration



**PHASE OUT / RECOVERY**

If recovery stage is anticipated to last longer than 4 months, recommend to expand and continue above interventions. Phase out should be done in coordination with the MoH to ensure ownership and MoUs should detail the handover at the close of the project.

## TYPE 4: DISEASE OUTBREAKS / EPIDEMICS (to be revised further after March 2017)

*Often Disease outbreaks and epidemics occur during Type 1-3 emergencies and should be dealt with the same urgency and level of focus. Preparedness activities should be incorporated into any Type 1-3 emergency.*

### Definition / sub-types

A disease outbreak is the occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season.

Categories:

#### Airborne / person to person

Influenza, Meningitis, Measles, Ebola / Marburg

#### Waterborne (Faecal – oral)

Cholera & AWD / ABD, Poliomyelitis, Typhoid, Leptospirosis

#### Vector

Dengue Fever, Zika, Yellow fever, Malaria, Leishmaniasis

### WV H&N Response

### Response time-frame (after DDG) subject to change as specific timeframes are determined by RM, ND & Partnership stakeholders.

- 0-72 hours 'first steps'
- Up to 30 days 'emergency response'
- 30-90 days 'continuing response'
- Phase out

Outbreaks may last for days or weeks or years.

The alarm is usually triggered either by analysis of trends or formal or informal notification of an increased number of cases. Once an investigation is done the MoH must declare an outbreak and

### Anticipated Health and Nutrition Specific Needs

- Awareness of prevention and the importance of early diagnosis to reduce transmission and mortality
- Vaccinations – timely and good coverage
- Access to care and treatment for suspected and confirmed cases at the appropriate facility level
- Holistic health support for critical illness and recovery
- Access to routine health services during outbreaks
- Access to clean water and sanitation facilities
- Protection from Mosquitos for high risk vulnerable groups i.e. PLW, children <5years and older people
- Psychosocial support
- Support with IYCF practices monitoring of nutritional status for children under 5
- Factual information amidst controversy and rumour through the appropriate channels

<p><b>History:</b> Sierra Leone – Ebola, LACRO – Zika, Zimbabwe – Cholera, Sudan – Yellow Fever</p>	<p>action will be taken. Sometimes several steps happen simultaneously. An emergency response may begin without health authority declaration.</p>	
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## TYPE 4 RECOMMENDED RESPONSE PACKAGE

### EMERGENCY → CONTINUING RESPONSE (BY OUTBREAK CATEGORY)

#### AIRBORNE / PERSON TO PERSON

#### **INFLUENZA (includes avian flu (type A – HA and NA subtypes), Swine, SARS, MERS etc.) MEASLES AND MENINGITIS**

- **Coordination:** liaise with MoH, WHO, epidemic committee / rapid response team at national level, Health Cluster and other NGOs. Establish WV's role and contribution to the response. Arrange and sign MoUs with the MoH for support. Participate in national and district level meetings with all stakeholders.
- **Surveillance:** Review epidemiological data and immunization program in order to identify the cause(s) of the outbreak and geographic areas at highest risk. Identify and support sentinel sites and designated HFs at all levels (District Hospital, CHC, PHC, Health posts), ensure staff and volunteers are trained on case definitions and reporting protocols and are doing proactive surveillance, ensure accurate and regular data collection in HIS / EWARN. Ensure supported HFs at all levels have means of communication. For Meningitis, specific focus on the types and age groups affected.
- **Vaccination:** For avian flu, if H5N1 vaccine is available support national vaccination campaign efforts in areas of operation with resources i.e. vehicle provision and vaccination team sustenance and incentives in affected areas of WV operation. For Measles and Meningitis, accelerated immunization in high risk areas and supplementary vaccinations in unaffected areas; Vaccination campaigns should be within 4 weeks of crossing the epidemic threshold. Support routine immunization programs, ensure PHCs and CHCs in areas of operation are providing EPI (including MMR and PCV10 vaccines) where necessary provide refrigeration, solar panels, cold boxes etc. in collaboration with the MoH.
- **Case management:** in liaison with MoH scale up capacity of supported HFs at all levels in case management through provision of medicines, medical supplies and equipment i.e. oseltamivir, peramivir, or zanamivir etc. Support the establishment of isolation wards where appropriate. In the case of Measles provide: immune serum globulin, acetaminophen, ibuprofen or naproxen, antibiotics and Vitamin A and in the case of Meningitis: ceftriaxone for treatment and Ciprofloxacin for prophylaxis in HH contacts. Support the establishment of isolation wards where appropriate. Support required trainings on effective case management in collaboration with the MoH.
- **Capacity building:** Work with MoH to estimate and ensure appropriate staff and volunteers for response, where appropriate provide incentives to volunteers and health staff with additional responsibility as a result of the outbreak. Provide resources for trainings.

- **Protection** (feasible human-to human transmission): Support HFs at all levels with Infection, prevention and control measures i.e. standard operating procedures, provision of PPE and hygiene materials, isolation ward establishment etc. in conjunction with WASH.
- **Laboratory:** identify closest laboratory and ensure support with transportation of samples where HFs are in remote areas or lack transportation means, ensure supported HFs have stockpiled RT-PCR testing for patients meeting exposure and clinical criteria. Ensure supported HFs have Measles and Mumps tests (RT-PCR) and stockpiled blood tests and spinal tap CSF testing.
- **Behaviour Change Communication:** public communication campaigns using a variety of media i.e. radio, engagement of faith communities, community level events using existing structures i.e. schools, HFs at all levels. Scale up health post community education and awareness raising through training and equipping CHWs with educational job aids on disease prevention and IEC on early recognition of signs and symptoms and the importance of health seeking behavior and routine clinic attendance, for Measles and Meningitis adherence to EPI. Formation of prevention volunteer groups addressing safe food preparation and hygiene. Specific focus on the age groups affected for Meningitis.
- **Advocacy:** for response resources as required, longer term prevention and control plans, vaccine development if none available for specific strain, limitation of livestock movement. For Measles and Meningitis response resources as required including prompt and sufficient vaccine supply, longer term prevention and control plans i.e. scale up of EPI.
- **Monitoring & supervision:** Intensive influenza surveillance (weekly reporting, including reporting that no cases have occurred – zero reporting) and ensuring all suspected cases are being investigated. Monitoring of case fatality rates at supported HFs. Ensure all aspects of the response are following best practices, protocols and SOPs with supportive supervision. Ensure accurate and timely reporting of activities and monitoring of medicine and supply usage. Monitoring of key health indicators i.e. service coverage. Monitoring of nutritional status, ensuring prompt referral for identified cases with acute malnutrition.
- **Ensure access and continuation of BPHS (Basic Package of Health Services):** continued support to national and district level MoH to ensure continuation of routine Primary health services and referral at CHC, PHC, Health posts through provision of medicines, medical supplies and equipment, resourcing trainings for health staff and provision of incentives as appropriate.

#### LINKAGES WITH OTHER SECTORS

- Mental Health: Ensure access to MHPSS services if case fatality rates are high for patients and families
- Nutrition: Ensure Specific IYCF-e messaging as per emergency guidelines for the disease outbreak. Monitoring of nutritional status - particularly for children recovering, ensuring prompt referral to identified cases of acute malnutrition.

#### EBOLA AND MARBURG

Due to the required scale, cost and complexity of Ebola Treatment Centres / Units and level of focus required, response should focus on maintaining and supporting existing primary and secondary health services at all levels where they are considered to be insufficient for population needs or anticipated to be affected by public fear, loss of staff and reduced resourcing. Specifically:

- **Coordination:** liaise with MoH, WHO, epidemic committee / rapid response team at national level, Health Cluster and other NGOs. Establish



WV's role and contribution to the response i.e. in restoring access to and improving Primary and Secondary healthcare. Arrange and sign MoUs with the MoH for support. Participate in national and district level meetings with all stakeholders.

- **Surveillance:** Consider support to contract tracing efforts from ADP staff and volunteers at the community level as appropriate in conjunction with CDC. Monitor all non-Ebola morbidities, case fatality rates and other key indicators (national MoH reports, HF reports in areas of operation and community reports). Ensure supported HFs at all levels and key personnel and volunteers have means of communication.
- **Vaccination:** support STRIVE national vaccination campaign efforts with resources i.e. vehicle provision and vaccination team sustenance and incentives in affected areas of WV operation.
- **Basic Package of Health Services (BPHS)** - support services at levels as required by MoH (District Hospital, CHC, PHC, Health posts): structural rehabilitation, provision of Medicines, medical supplies and equipment. Ensure full range of basic services: Maternal and Newborn Health (ANC, delivery care, PNC, family planning, newborn care); Child health and immunization (EPI, IMCI); Nutrition (prevention, assessment and treatment of malnutrition – CMAM / IMAM where appropriate); other communicable disease control and treatment (Malaria, TB, HIV/AIDS); Scale up of MHPSS (Mental health education and awareness, case detection, identification and treatment); Disability services. Ensure SOPs in place at HFs for if admissions are suspected Ebola cases to reduce risk of clinic transmission (support the set-up holding centres where appropriate). Where utilization is low consider extending services out to the community with MMUs in hard-to-reach locations.
- **Capacity building:** address the issue of lower numbers of health cadres as a result of deaths and treatment centres by incentivizing those in standard HFs to work additional hours, consider engaging MTI and supporting a small number of expatriate health staff in designated HFs. Encourage and incentivize health posts to continue their activities, training on risk reduction and adapting for no touch policy i.e. rolling out mother-led MUAC.
- **Protection:** Support Health facilities at all levels with Infection, prevention and control (IPC) measures i.e. standard operating procedures, provision of PPE and hygiene materials in conjunction with WASH. IPC training for HWs in conjunction with MoH.
- **Behaviour Change Communication:** health and hygiene public and community campaigns using media, faith communities, community level structures and health posts to encourage health seeking behaviour and utilization of WV supported HFs for PHC and SHC services, Ebola awareness raising i.e. signs, symptoms and prevention.
- **Advocacy:** response resources as required, investment in health system strengthening activity and gaps, prioritization of BPHS services
- **Monitoring & supervision:** support data collection on all morbidities at each level of health system, weekly data analysis and assessment of utilization, health needs assessments, engagement of MoH in HF visits and coordination of activities. Monitoring of medicine and supply usage. Monitoring of key health indicators i.e. service coverage.

#### LINKAGES WITH OTHER SECTORS

- Nutrition: Ensure Specific IYCF-e messaging [http://files.enonline.net/attachments/2176/DC-Infant-feeding-and-Ebola-further-clarification-of-guidance\\_190914.pdf](http://files.enonline.net/attachments/2176/DC-Infant-feeding-and-Ebola-further-clarification-of-guidance_190914.pdf). Implement mother led MUAC (no touch policy); ensure CMAM / IMAM programs are still functioning through supported facilities and promote HF services at the community level; safe and appropriate Breast milk substitute distribution to quarantined households where mother and infant are separated due to BF transmission route (i.e. where one of them is a suspect); scale up of CMAM through health posts during phase out. Monitoring of nutritional status - particularly for children recovering, ensuring prompt referral to identified cases of acute malnutrition.

- WASH: Structural rehabilitation of HFs and on all IPC activities at HFs

### WATERBORNE (FAECAL – ORAL)

#### **CHOLERA & AWD / ABD, POLIOMYELITIS, TYPHOID, LEPTOSPIROSIS (NB, historically cholera outbreaks have had late declarations due to government stigma)**

- **Coordination:** liaise with MoH, WHO, epidemic committee / rapid response team at national level, Health Cluster and other NGOs. Establish WV's role and contribution to the response. Arrange and sign MoUs with the MoH for support. Participate in national and district level meetings with all stakeholders.
- **Surveillance:** Review epidemiological data and immunization history in order to assess the cause, extent and spread of the outbreak and geographic areas at highest risk. Identify and support sentinel sites and designated HFs at all levels (District Hospital, CHC, PHC, Health posts), ensure staff and volunteers are trained on case definition and reporting protocols and are doing proactive surveillance, ensure accurate and regular data collection in HIS / EWARN. Ensure supported HFs at all levels have means of communication.
- **Vaccination:** Accelerated immunization in high risk areas; support vaccination campaign and monitoring efforts with resources i.e. vehicle provision and vaccination team sustenance and incentives in affected areas of WV operation. Support routine immunization programs, ensure PHCs and CHCs in areas of operation are providing EPI (including OPV) where necessary provide refrigeration, solar panels, cold boxes etc. in collaboration with the MoH.
- **Case management:** in liaison with MoH scale up capacity of designated HFs to function as Cholera Treatment Centres (CTCs) through provision of tents, diarrheal disease outbreak kits, IPC hygiene items, cholera beds, medicines and medical waste disposal equipment. Consider establishing MMU rapid response vehicles. Work with WASH team to ensure HFs have appropriate sanitation facilities and safe water supply. Develop SOPs for all aspects of CTC management if no MoH guidelines exist. Ensure MHPSS for staff, survivors and community when mortality rates are high.
- **Capacity building:** Work with MoH to estimate and ensure appropriate staff and volunteers for response, where appropriate provide incentives to volunteers and health staff with additional responsibility as a result of the outbreak. Provide resources for trainings in case definition and management as well as IPC.
- **Protection:** Support HFs at all levels with Infection, prevention and control measures i.e. standard operating procedures, provision of PPE and hygiene materials in conjunction with WASH
- **Laboratory:** identify closest laboratory and ensure support with transportation of samples where HFs are in remote areas or lack transportation means, ensure supported HFs have stockpiled stool sample test kits.
- **Behaviour Change Communication:** Hygiene promotion campaigns using a variety of media i.e. radio, engagement of faith communities, community level events using existing structures i.e. schools, HFs at all levels. Scale up community awareness raising through training and equipping CHWs with job aids and IEC i.e. on optimal hygiene practices, signs and symptoms and routine clinic attendance / adherence to EPI. Use CHWs for active case finding through home visits and by using existing alert/warning form and engage them in finding the sources of transmission (Water, food). Provide CHWs with ORS and referral information for suspected cases identified at the community level.

- **Advocacy:** for response resources as required including prompt and sufficient vaccine supplies, longer term prevention and control plans i.e. scale up of EPI.
- **Monitoring & supervision:** Intensive surveillance of the respective disease i.e. AFP or Cholera (weekly reporting, including reporting that no cases have occurred – zero reporting) and ensuring all suspected cases are investigated and appropriately managed. Monitoring of case fatality rates at supported facilities. Ensure all aspects of the response are following best practices, protocols and SOPs with supportive supervision. Ensure accurate and timely reporting of activities and monitor supply usage. Monitoring of key health indicators i.e. service coverage. Monitoring of nutritional status, ensuring prompt referral for identified cases with acute malnutrition.
- **Ensure access and continuation of BPHS (Basic Package of Health Services):** continued support to national and district level MoH to ensure continuation of routine Primary health services at all levels (District Hospital, CHC, PHC, Health posts) through provision of medicines, medical supplies and equipment, resourcing trainings for health staff and provision of incentives as appropriate.

#### LINKAGES WITH OTHER SECTORS

- Mental Health: Ensure access to MHPSS services if case fatality rates are high for patients and families
- Nutrition: Ensure Specific IYCF-e messaging as per emergency guidelines for the disease outbreak i.e. continue BF, ensure appropriate diets for patients (i.e. solid, semi-solid or liquid according to SOP). Monitoring of nutritional status - particularly for children recovering, ensuring prompt referral to identified cases of acute malnutrition.
- WASH: Structural rehabilitation of HFs and on all IPC activities at HFs, hygiene promotion campaigns

#### VECTOR

#### **DENGUE FEVER, ZIKA, YELLOW FEVER, MALARIA, LEISHMANIASIS (similar response with adaptations)**

- **Coordination:** liaise with MoH, WHO, epidemic committee / rapid response team at national level, Health Cluster and other NGOs. Establish WV's role and contribution to the response. Arrange and sign MoUs with the MoH for support. Participate in national and district level meetings with all stakeholders.
- **Surveillance:** Review epidemiological data in order to assess extent of the outbreak and geographic areas at highest risk. Identify and support sentinel sites and designated HFs at all levels (District Hospital, CHC, PHC, Health posts), ensure staff and volunteers are trained on case definition and reporting protocols and are doing proactive surveillance, ensure accurate and regular data collection in HIS / EWARN. Ensure supported HFs at all levels have means of communication. Coordinate with health authorities by ensuring ADPs track and report suspected cases and rumors of infections, newborn with abnormal small heads and sudden paralysis.
- **Vaccination:** support vaccination campaign efforts with resources i.e. vehicle provision and vaccination team sustenance and incentives in affected areas of WV operation. Yellow fever requires high vaccination coverage >80%
- **Case management:** in liaison with MoH scale up capacity of supported HFs at all levels in case management through provision of medicines,