World Vision®

GUIDE TO MATERNAL, NEWBORN AND CHILD HEALTH AND NUTRITION IN EMERGENCIES

GUIDE TO MATERNAL, NEWBORN AND CHILD HEALTH AND NUTRITION IN EMERGENCIES

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Cover photo: Mothers hold their babies during a distribution of mosquito nets in Kenya.

Executive Summary

In 2007, World Vision (WV) initiated a process of prioritising low-cost, evidence-based, measurable and preventive interventions in order to combat the primary causes of maternal and child mortality. The health and nutrition (H/N) 'Do, Assure, Don't Do' (DADD) guidelines helped to orientate effort and resources towards a strategic focus. This focus is primarily influenced by *The Lancet* study on child survival and is further shaped by existing human rights approaches, the right to survival, and the right to health treatment and care. WV's development and phased implementation of the 7-11 approach[1] (2010) is part of the process to strengthen expertise and competencies in key MNCH and nutrition interventions that fit with our organisational strategy and mandate. Strategic training on 7-11 interventions, building partnerships and recruiting experienced field health staff are part of WV's investment towards more consistent maternal, newborn and child health (MNCH) and nutrition interventions.

In emergencies, our commitment continues as we strive to save the lives of young children and mothers by focusing emergency response resources where they are critically needed. The 7-11 approaches are implemented where feasible, and in a phased manner. Some services that need to be met in an emergency cannot be provided by WV, as they are outside our remit, expertise and mandate. In such situations, it is our role to advocate for other agencies to complement the WV response and fill the gap.

The 2011 Health Nutrition and HIV DADDs[2] in large-scale emergencies, along with this guide to MNCH in emergencies, enable staff to implement more consistent MNCH and nutrition interventions, which are proven to save lives. This guide is WV's first attempt to provide additional guidance at operational and technical levels on what steps are necessary for preparedness and rapid response.

Humanitarian principles and core operating standards support the achievement of technical minimal standards in humanitarian situations. Therefore, **operational recommendations** include the following:

1. **Communication –** Develop an information-management strategy for internal and external stakeholders. Communication on the emergency situation with current and potential donors is vital to ensure that health services are accessible and offered free at the point of service delivery to the affected population for the duration of the disaster.

2. **Accountability –** Provide information, consult with communities, promote community participation, and collect and act on feedback and complaints to maintain transparency and accountability during emergency responses.

3. **Coordination –** Building and pre-positioning partnerships at the national level with other agencies implementing MNCH and nutrition can foster rapid responses during an emergency. During an emergency response, a designated staff member should attend H/N (and other relevant sector/cluster) coordination meetings and represent WV in these discussions, at both the national and sub-national levels. This person is vital in sharing WV's work and planning for joint assessments and operations, and in informing our staff on interagency developments, protocols, reporting requirements, etc.

4. **Supplies –** Pre-positioning supplies, such as clean delivery kits, oral rehydration solution (ORS), cholera treatment kits, hygiene kits and materials for thermal protection in cold climates, should be planned.

5. **Staff competencies –** Programme managers need to take stock of potential risks and human resources available to respond to MNCH and nutrition as well as related sectors such as food security and nutrition, water, sanitation and hygiene (WASH) and protection, since limited technical staff in development often hampers our immediate relief response. A variety of key training can be offered in non-emergency times to improve the emergency response capacity of staff.

6. **Information management –** Responses will be effective only if the process of assessment, monitoring and reassessment is used in each humanitarian context. A time frame for the completion of the response plan(s) should be agreed between the response manager(s) and national director, and shared with appropriate partnership stakeholders. Response plans will evolve over time as assessment and information increase and context changes.

1 World Vision International (2010). *7-11 Start-up Field Guide*. http://www.wvi.org/wvi/wviweb.nsf/11FBDA878493AC7A882574CD0074E7FD/$file/WV_FieldGuide_FINAL.pdf.

2 World Vision International (2011). *Working in maternal and child health, nutrition, HIV and AIDS, and water, sanitation and hygiene.* Available on wvcentral.org (log-in required).

This guide represents core activities along the continuum of care (life-cycle approach) for reproductive health issues, pregnancy, childbirth, maternal and newborn health and child health, which will save lives. WV resources and models, along with interagency protocols and guidelines, are referenced to support the implementation of the **key technical actions**, some of which are listed below:

1. **7-11 strategy –** World Vision aims to have elements of the '7-11 strategy' in place and prioritised according to the emergency context. In the start-up phase of an emergency, WV strives to implement the 7-11 strategy in an appropriate, resourced and phased manner. Initial action should start with priority interventions that address the causes of excess mortality (i.e. measles vaccination) and in a phased manner introduce additional services, as the situation becomes more stabilised.

2. **Referrals –** Technical staff should strive to determine who offers clinical services and how to refer clients to these services, as World Vision typically does not offer clinical services.

3. **Wider health system improvements –** Where WV operates health clinics, ensure these do not function in isolation from wider health system improvements.

4. **Sexually transmitted infections (STI)/Human immuno-deficiancy virus (HIV) –** While World Vision emphasises abstinence outside of marriage and fidelity within marriage, we recognise that consistent and correct use of condoms prevents HIV infection. We recommend correct and consistent use of condoms for harm reduction, and this should be done as an integrated programme approach rather than a stand-alone intervention. In some emergency settings, it may be appropriate to make condoms available in hygiene kits, along with providing sensitisation and information regarding proper use and disposal.

5. **Sexual and gender-based violence (SGBV) –** While WV does not provide clinical health services for victims of rape, staff can provide immediate psychosocial support (psychosocial first aid); raise awareness among communities on prevention, reporting and available services; and assure effective referrals to appropriate clinical services.

6. **Family planning (FP) –** Post-rape kits, which include post-exposure prophylaxis (PEP) and emergency contraception, should be accessible in an emergency. Experience shows that women want to continue their contraceptive method during emergencies. Basic contraception, including condoms, should be available from the onset of the crisis to meet demands of continued family-planning methods of choice. These methods should not require comprehensive medical procedures or follow-up.

7. **Pregnancy –** Emergency responses generally may not provide focused antenatal care (ANC) until the humanitarian situation stabilises. World Vision can establish communication messages on the importance of childbirth by skilled birth attendants (SBAs) and referral procedures for emergency obstetric cases. Food security programming, community-based management of acute malnutrition (CMAM), or distribution of food aid can be an opportunity to provide this information and promote maternal, neonatal and child health beneficial practices and services. Where delivery by an SBA is not accessible, clean delivery kits should be distributed to visibly pregnant women, along with registration of these women for maternal and newborn care visits and postpartum services.

8. **Childbirth –** Primary health-care facilities need SBAs, neonatal resuscitation and basic emergency obstetric and newborn care (BEmONC) in order to prevent maternal and newborn mortality and morbidity. If women are not able to access a health-care facility, WV can distribute clean delivery kits to visibly pregnant women. WV also works with the community to establish a referral system for obstetric and newborn complications. Traditional birth attendants (TBAs) should be mobilised to be part of this referral system and promote newborn care (thermal care, benefits of colostrum and early initiation of breast-feeding) but should not be equipped or trained to perform deliveries.

9. **Maternal and newborn care –** World Vision plays an important role in educating the community on newborn care and the benefits of seeking skilled support for childbirth and newborn care. Through the registration of households with newborns, children under 24 months and breast-feeding/pregnant mothers, essential newborn and maternal care and food assistance can be planned and provided.

10. **Nutrition –** World Vision emphasises proactive activities to maintain and improve nutrition and growth at the community and health-facility level, which includes exclusive breast-feeding for six months; adequate complementary feeding with breast-feeding for two years; adequate intake of vitamin A, iron and iodine; and appropriate nutritional care of sick and severely undernourished children.

    A. *Breast-feeding* – World Health Organization (WHO) evidence shows that infant deaths can be averted through effective breast-feeding. Promoting immediate and exclusive breast-feeding must be done in all humanitarian settings. While women in emergencies undergo stresses and nutrition deprivation that may affect breast milk supply, this is usually temporary. Breast-feeding can be continued and even restarted (relactation) with proper education and support, such as women- and infant-friendly spaces (WAIFS). For those women who meet criteria for breast-milk substitutes (BMS) and have done so prior to the onset of the emergency, BMS should be provided in ways that follow the International Code[3] and WV milk policy.

    B. *As part of emergency preparedness,* WV should ensure that staff have competencies to screen for and manage acute malnutrition, and in infant and young child feeding (IYCF) counselling and specific emergency response approaches, such as integrating IYCF into CMAM.

    C. *In situations where the nutritional needs of the general population are not met,* WV advocates for a general ration to be distributed, which is appropriate in quantity and quality for young children's complementary food needs and for the specific needs of pregnant and lactating women (PLW). In situations where supplementary foods are available, PLW should be considered as a primary target group. Even if PLW are receiving fortified foods, the United Nations Children's Fund (UNICEF) and WHO recommend a daily multiple micronutrient formula to meet the daily requirements of this special group. World Vision staff should work with the UN World Food Programme (WFP) within the humanitarian context to determine the appropriate and acceptable rations and micronutrient supplementation for PLW.

11. **Child health –** Health education is an essential component of World Vision's prevention and outbreak response. Consultation and collaboration with WASH are essential in planning the 'hardware' components necessary to support prevention behaviours.

    A. *Diarrhoea* – Once an outbreak is detected, WV should aim to minimise the spread through prevention approaches and ensuring access to treatment. Pre-positioning of ORS, cholera treatment kits and the early use of oral cholera vaccine should be considered.

    B. *Acute respiratory infection (ARI)* – WV assures appropriate treatment for acute lower respiratory infection (ALRI) pneumonia within 24 to 48 hours of symptoms. Some offices are promoting community-based treatment of pneumonia by community health workers (CHWs). If this is the situation in the area, then this approach should be promoted during emergency response.

    C. In *malaria-endemic areas*, World Vision has the goal of universal coverage of long-lasting insecticidal nets (LLINs) and prioritises the distribution of LLINs to severely malnourished people enrolled in CMAM and members of their households, pregnant women and children under 2 years of age.

These bundled interventions and integrated issues will have a greater impact than if done in isolation, enabling WV to operate in a more sustainable manner. **As WV moves forward, we must evaluate the interventions for effectiveness, efficiency or impact in emergency settings. These evaluations and adapting the guide accordingly will give WV a more credible voice when speaking and advocating on child and maternal health.**

3 World Health Organization (1981). *International Code in Marketing Breast-milk Substitutes*. http://www.who.int/nutrition/publications/code_english.pdf.

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PART FOUR

Abbreviations

ADP	Area development programme
AFRH	Adolescent-friendly reproductive health
ALRI	Acute lower respiratory infection (pneumonia)
ARI	Acute respiratory infection
ARV	Antiretroviral
ART	Antiretroviral therapy
ANC	Antenatal care
BEmONC	Basic emergency obstetric and newborn care
BF	Breast-feeding
BMS	Breast-milk substitutes
BRAT	Basic rapid assessment tool
CAP	Consolidated Appeals Process
CCD	Control of communicable disease
CAP	Consolidated Appeals Process
CH	Child health
CHAP	Common Humanitarian Action Plan
CEmoC	Comprehensive emergency obstetric care
CERF	United Nations Central Emergency Response Fund
CHW	Community health worker
CMAM	Community-based management of acute malnutrition
CMR	Child mortality rate
CSB +	Corn Soya Blend (fortified) for children over 2 years, adolescents and adults
CSB ++	Corn Soya Blend (fortified) for children 6–24 months
DADD	Do, assure, don't do
EBF	Exclusive breast-feeding
ECP	Emergency contraceptive pill
EHS	Essential health services
EmOC	Emergency obstetric care
EmONC	Emergency obstetric and newborn care
EPRF	Emergency Preparedness Response Fund, for WV
EWARS	Early warning and response system
FP	Family planning
FPMG	Food Programming Management Group
FSN	Food security and nutrition
GAM	Global acute malnutrition
GBV	Gender-based violence
GIK	Gifts-in-kind
GPRN	Global Pre-positioning Resource Network
HAP	Humanitarian Accountability Partnership
HEA	Humaitarian and Emergency Affairs
HIV	Human immuno-deficiency virus
H/N	Health and nutrition
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group
ICT	Information and communication technology
IDSR	Integrated Disease Surveillance and Response
IRA	Initial rapid assessment
IYCF	Infant and young child feeding

IYC	Infant and young children
LBW	Low birthweight
LLIN	Long-lasting insecticidal net
MAM	Modern acute malnutrition
MCH	Maternal and child health
mhGAP	WHO Mental Health Gap
MHPSS	Mental health and psychosocial support
MISP	Minimum initial service package (for emergency response to reproductive health)
MNCH	Maternal, newborn and child health
MNP	Micronutrient powder
MoH	Ministry of Health
MUAC	Mid-upper arm circumference
NDPP	National Disaster Preparedness Plan
NEPRF	National Emergency Preparedness Response Fund (for WV national offices)
NFI	Non-food item
NGO	Non-governmental organisation
NO	National office
ORS	Oral rehydration solution
OTP	Outpatient therapeutic programme
PEP	Post-exposure prophylaxis
PFA	Psychological first-aid
PHC	Primary health care
PLW	Pregnant and lactating women
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PSS	Psychoscoial support
RH	Reproductive health
RUSF	Ready-to-use supplementary food
RUTF	Ready-to-use therapeutic food
SAM	Severe acute malnutrition
SBA	Skilled birth attendant
SC	Stabilisation centre
SFP	Supplementary feeding programme
SGBV	Sexual and gender-based violence
SO	Support office
SRH	Sexual and reproductive realth
STI	Sexually transmitted infection
TBA	Traditional birth attendant
U5MR	Under-5 mortality rate
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UPA	Ulipristal acetate
VCT	Voluntary counselling and testing
WAIFS	Women- and infant-friendly spaces
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

About the Guide

PURPOSE OF THE GUIDE TO MNCH AND NUTRITION IN EMERGENCIES

World Vision is committed to responding to maternal, newborn and child health (MNCH) and nutrition issues in emergencies. In keeping with WV's emphasis on MNCH and nutrition, this guide is expected to help WV achieve child well-being aspirations and outcomes[4] during disaster and humanitarian responses. While WV has numerous community-based health and nutrition programming models, not all have been evaluated for effectiveness, efficiency or impact, nor have they been applied to emergency settings. Further programming guidance and operational research are needed during emergency responses in order to develop an integrated approach to maternal newborn child health and nutrition.

The emergency guide aims to

- better define **focus areas of response** for direct humanitarian programming and advocacy in **acute phase of an emergency** (which may be within stable or complex/chronic emergency settings, or a fragile context)
- build consistency around a discrete 'package' of effective MNCH and nutrition services delivered by WV in an acute phase of a disaster
- provide a clear rationale for expanded approaches and interventions for more comprehensive MNCH and nutrition, which may require operational research, strategic training, collaborative partnerships and more stable situations.

This guide is the **beginning of a process** for World Vision to strengthen expertise in a small number of core MNCH functions that have a proven impact on reducing maternal, newborn and child morbidity and mortality. Additional options are presented within this guide; however, these expanded interventions for humanitarian situations require competent and experienced clinical health staff, strategic training and partnerships, and more stable situations. National offices (NOs) should be able to design their responses based on existing humanitarian conditions and staff competencies.

This guide was developed in collaboration with various stakeholders, including the Global Health and WASH team, Health & HIV in Emergency Interest Group, Humanitarian and Emergency Affairs (HEA) technical team, Nutrition Centre of Expertise, and WASH. Individuals contributed to the outline of this guide via interviews and document reviews. The WV Reference Group provided expert advice and recommendations to help shape the guide.

4 Aspiration: Children enjoy good health. Outcomes: Children are well nourished, Children are protected from infection, disease and injury, Children and their caregivers access essential health services.

STRUCTURE

World Vision's HEA *Disaster Management Standards*,[5] *7-11 Start-Up Field Guide* and CMAM project model are some of the key internal materials referred to in this guide. A number of interagency technical field manuals are also referred to throughout. Sphere standards,[6] and the technical principles of the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*[7] and *Infant and Young Child Feeding in Emergencies*[8] provide some of the technical guidance important for implementation of this guide.

Part one provides a **background** to maternal, newborn and child morbidity and mortality as well as an introduction to various humanitarian situations and their health implications. This section describes World Vision's thresholds for defining an emergency and outlines the Adaptive Response framework to ensure that timely and efficient emergency responses are planned and implemented.

Part two outlines WV's **operations and humanitarian principles**, which must be taken into account for an effective MNCH and nutrition response. These include communication and accountability, coordination, staff competencies and information management (assessment/monitoring).

Part three discusses **essential 7-11 interventions for WV emergency response** along the lifecycle/continuum of care spectrum. Technical issues along the continuum of care and key actions are presented in WV's Do, Assure, Don't Do (DADD) format. Integration of other sectors (i.e. food security, WASH, HIV, mental health and psychosocial support [MHPSS] and protection) is also considered.

Part four shares practical **tools** for assessing the likely health implications of the emergency and becoming familiar with DADD actions, and presents questions for preparedness and responses for both operations and technical teams.

Information for project planners, logistics teams and disaster-response managers

Information for project health staff and community volunteers

Information for health coordinators, advisors or health programme managers

Highlights key issues and interventions for communication, advocacy, policy decisions and fundraising (which may be done by project staff, managers or communication/advocacy specialists)

5 Available on wvcentral.org (log-in required).
6 The Sphere Project (2011). *The Sphere Handbook.* http://www.sphereproject.org/content/view/720/200/lang,english/.
7 Inter-agency Working Group on Reproductive Health in Crises (2010). *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. http://www.iawg.net/resources/field_manual.html.
8 Emergency Nutrition Network (2007). *Infant and Young Child Feeding in Emergencies*. http://www.ennonline.net/resources/6.

PART ONE

Introduction to MNCH and World Vision's Approaches

CHAPTER 1. MNCH AND NUTRITION VULNERABILITIES AND RISKS IN EMERGENCIES

Globally, in 2010 7.6 million children under the age of 5 died – that's around 21,000 children each day.[9] Some 40 per cent, or roughly 3 million of these deaths, occur within the first 28 days of life.[10] Two-thirds of the deaths are from preventable causes, including pneumonia, diarrhoea, malaria, under-nutrition and neonatal causes.[11]

The vast majority of childhood deaths in emergencies are caused by diarrhoeal diseases, measles, malaria, acute respiratory infection and pneumonia or acute malnutrition,[12] which are the same conditions that kill children in non-emergency settings in least-developed countries. 'It is not the type of illness but rather the incidence and high mortality rates that make these populations remarkable.'[13] Early initiation of breast-feeding could prevent an estimated 22 per cent of child deaths.[14] Mortality rates among children under 5 are considerably higher in fragile states and emergency-affected populations due to the synergy of a high prevalence of malnutrition and increased incidence of communicable diseases. Even for children who are mildly malnourished, the risk of death from a bout of illness is twice that of well-nourished children.[15] The risk is greater still for those who are severely malnourished.

Globally, more than 350,000 women die each year during pregnancy or from childbirth-related complications.[16] That is one woman each minute and a half. Girls 15–19 years of age are twice as likely to die during childbirth as women in their twenties. When a mother dies, small children are up to three times more likely to die within the next year.[17]

Women and children account for a large proportion of people affected by an emergency. During an emergency, one in five women of child-bearing age, or roughly 4 per cent of the disaster-affected population, is likely to be pregnant.[18] Unpredictable complications requiring emergency obstetric care, both during pregnancy and at the time of delivery, occur in approximately 15 per cent of all pregnancies.[19] Approximately 5 per cent to 15 per cent of all deliveries will require surgery.[20] Maternal deaths during an emergency are caused by pregnancy-induced hypertension, haemorrhage, complications of unsafe abortion, infection and obstructed labour. Emergency settings increase the risk of pregnancy-related death as nutritional status (iron and micronutrients) deteriorates, susceptibility to infectious disease increases, and prenatal medical care, assisted deliveries and emergency obstetric care become unavailable.[21]

> The vast majority of childhood deaths in emergencies are caused by the same conditions that kill children in non-emergency settings in least-developed countries. The direct causes of maternal morbidity and mortality are the same in emergency and non-emergency situations. It is not the type of illness but rather the incidence and high mortality rates that make these populations remarkable.

World Vision's H/N responses in emergencies recognise that displacement causes women and girls to be vulnerable to sexual abuse, fleeing populations generally have a high proportion of unaccompanied minors, and conflict has been linked to increased risk of rape. In addition, youth in refugee camps tend to become sexually active at an earlier age. We draw upon our strengths as a community-based organisation and partner with others to ensure that prevention activities and curative health services are available. In addition, WV is developing a complementary module for MNCH programming in fragile contexts to improve responses in these challenging contexts.

9 World Health Organization (2011). 'Global Health Observatory.' http://www.who.int/gho/child_health/en/index.html.
10 World Health Organization (2011). *World Health Statistics 2011*.
11 World Vision International (2010). *7-11 Start-up Field Guide*. Data from UNICEF, WHO, MACRO demographic and health surveys.
12 World Health Organization (2004). *Guiding principles for feeding infants and young children during emergencies*. http://whqlibdoc.who.int/hq/2004/9241546069.pdf.
13 Toole, M.J., and R.J. Waldman (1990). 'Prevention of excess mortality in refugee and displaced populations in developing countries,' *Journal of the American Medical Association,* 27 June, 263(24):3296–3320. PubMed PMID: 2348541.
14 Ibid.
15 World Health Organization (2004). *Guiding principles for feeding infants and young children during emergencies*.
16 Women Deliver. 'Improve Mental Health.' http://www.womendeliver.org/knowledge-center/facts-figures/maternal-health/.
17 World Vision International (2010). *7-11 Start-up Field Guide*. http://wvi.org/wvi/wviweb.nsf/11FBDA878493AC7A882574CD0074E7FD/$file/WV_FieldGuide_FINAL.pdf.
18 The Sphere Project (2011). *Humanitarian Charter and Minimum Standards in Humanitarian Response*.
19 Ibid.
20 Ibid.
21 United Nations Population Fund (2006). *Women Are the Fabric: Reproductive health for communities in crisis*.

CHAPTER 2. HUMANITARIAN CONTEXT CONSIDERATIONS

> World Vision lives out the humanitarian imperative as the right to give and receive unimpeded humanitarian assistance; working with children, families, communities and other partners we will reduce vulnerabilities and enhance abilities to cope with and recover effectively from disasters while contributing to ensuring resilience in case of disasters and conflict.[22]

An emergency is a situation that threatens the lives and well-being of a large portion of the population, calling for extraordinary action to ensure the survival, care and protection of those affected. Emergencies may occur suddenly in time (quick onset natural or human-made), or they may develop over a period of time (slow onset due to nature or human activity). In the initial onset of a disaster there are competing priorities and needs. The focus should be on provision of adequate shelter, water, sanitation, food, nutrition and health care. Delivering a set of priority reproductive health (RH) services defined as the minimum initial service package (MISP) can prevent and manage the consequences of sexual violence, reduce the transmission of HIV, and prevent excess maternal and newborn morbidity and mortality in the initial phase of the emergency, until it becomes more feasible to provide comprehensive reproductive health.

Appropriate responses to MNCH and nutrition will vary according to the context. No one particular MNCH and nutrition response strategy fits all types of crises; adaptations are vital. Before any response is made, it is important to know the type of humanitarian context (whether the population is concentrated or scattered, urban or rural), existing vulnerabilities, health status and risk, available services and health-system performance, and who is the most vulnerable.

TYPE OF HUMANITARIAN CONTEXT AND HEALTH IMPLICATIONS

In *slow-onset disasters,* such as droughts or famines, the quantity and quality of potable water for humans and animals can decrease, compromising food and nutrition, which often leads to increased incidences of illness and disease. As families migrate in search of food and water, their ability to cope and care for their health diminishes. Access to health services decreases. All of this combined contributes to an overall increase in morbidity and mortality.

In **sudden-onset disasters,** such as earthquakes or floods, there may be a high demand for life-saving services, rendering regular services such as assisted deliveries, antenatal/postnatal care and routine vaccinations difficult to access. If routine immunisation coverage is low, the risk of transmission of vaccine-preventable diseases such as measles and polio may increase. If mothers cannot maintain access to adequate nutrition, water and rest, and continue frequent nursing sessions, breast-milk supply can diminish, thereby making their infants more susceptible to communicable diseases such as acute lower respiratory infection (ALRI).

Urban disasters can pose particular debilitating effects and challenge the typical rural-based humanitarian approach. As rapid urbanisation occurs, significant numbers of people, many of whom are undocumented migrants, live in informal, densely populated settlements with changing social structures. Resources and services can be concentrated in particular areas, which could be completely destroyed by the disaster or remain as vital operating services for those affected by the crisis.

Communicable diseases, alone or in combination with malnutrition, account for most deaths in **complex emergencies**. The major causes of mortality during complex emergencies, such as conflict, are diarrhoeal diseases, acute respiratory infections, neonatal causes and malaria, where endemic. For further reading on the health implications of particular disasters, please refer to World Vision's *Disasters and Emergencies and their Public Health Implications*,[23] September 2010 document and see Part Four: Technical Tools of this guide.

22 World Vision International (2010). *Humanitarian and Emergencies Affairs Strategic Intent 2010 – 2015.*
23 World Vision International (2010). *Disasters and Emergencies and their Public Health Implications*. Available on wvcentral.org (log-in required).

WV HEA RESPONSE PRINCIPLES

World Vision's Humanitarian and Emergency Affairs has built systems and capacity to respond to emergencies throughout the globe. Due to the trend of more frequent and higher-impact disasters, these systems are under strain. In response, a more adaptable approach to programming, planning, capacity building, funding and risk management is being developed. This Adaptive Response framework[24] defines

- **adaptive planning:** emergent strategy process aligned to organisational priorities and evidence-based operations
- **iterative assessment:** constant assessment process for evidence-based programming with timely data and analysis, such as the basic rapid assessment tool (BRAT[25])
- **flexible funding:** funding that is available where and when required and which can be reprogrammed where and when required (principal sources of funding[26] for NOs)
- **capacity and competency:** response capacity doubled with standardised, scalable response structure and competency system (emergency management system roles and responsibilities and budget[27] for MNCH and nutrition responses)
- **enabling environment:** supportive organisational culture with appropriate risk-management processes and leadership behavioural change.

WV HEA *DISASTER MANAGEMENT STANDARDS*

Procedures, roles and responsibilities, and ways of working in emergencies are defined in the World Vision HEA *Disaster Management Standards* (2011 revised version) and the WVI Board *Policy on Disaster Management*.[28] The specific health indicators and threshold ranges, criteria for declaring an emergency and informtion on how to initiate national or global response (Figure 1) can be found in the *Disaster Management Standards* and *Triggers for Action*[29] documents.

Thresholds and emergency declaration categories

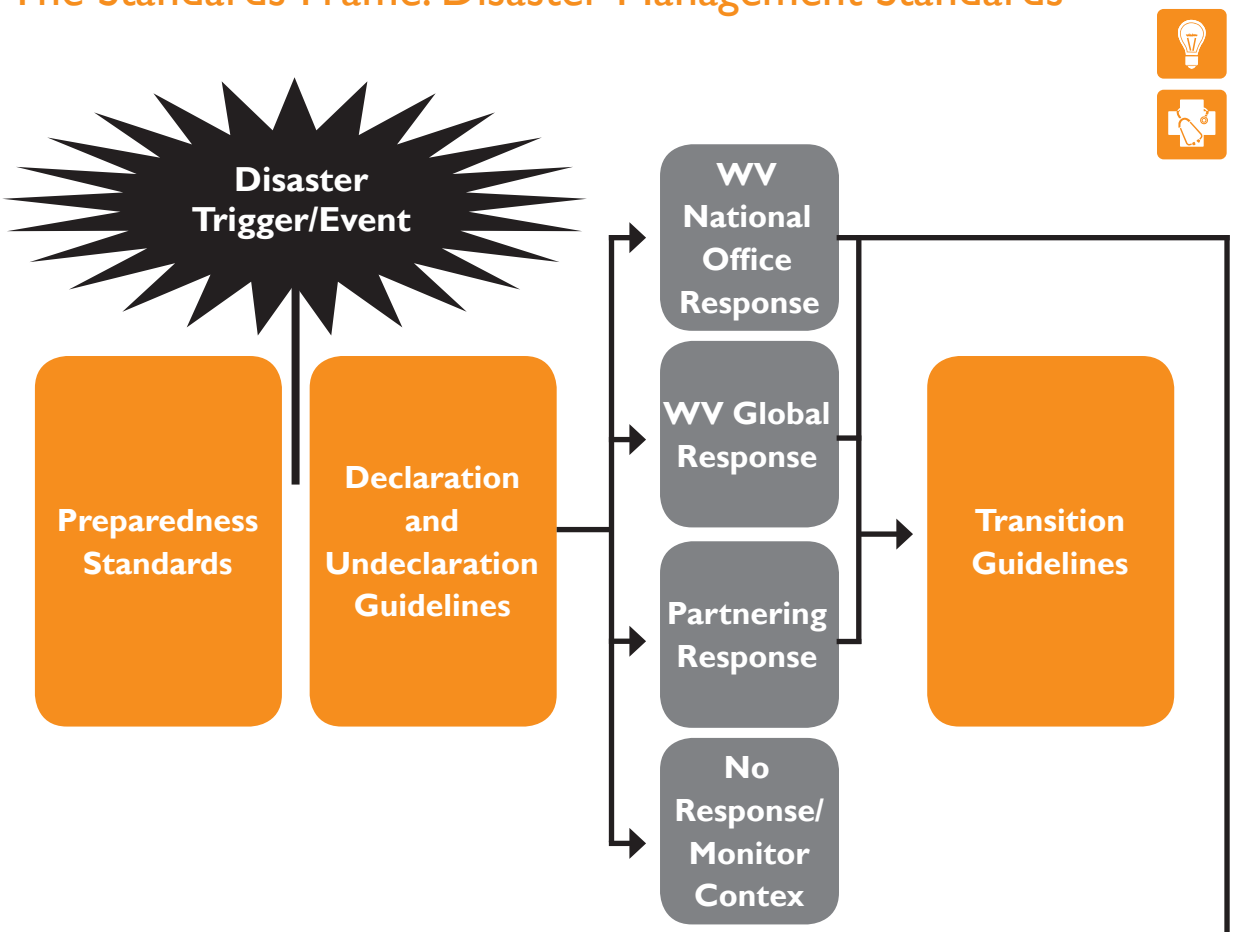
When designing an emergency MNCH response, **priority must be given to proven interventions that will prevent and reduce excess morbidity and mortality**. Keep in mind, 'It is not the type of illness but rather the incidence and high mortality rates that make these populations remarkable.'[30] Mortality is a key criterion for WV's declaration of an emergency and is the main driver for initiating emergency interventions. World Vision categorises humanitarian situations and response by several criteria, including specific health-indicator thresholds and the number of people affected and mortality rate.

24 World Vision International (2010). *Adaptive Response Business Case*. Available on wvcentral.org (log-in required).
25 Available on wvcentral.org (log-in required).
26 World Vision International. *Summary of principal funding sources for emergency response*. Available on wvcentral.org (log-in required).
27 See the Emergency Health Interest Group site, available on wvcentral.org (log-in required).
28 World Vision International (2011). *Disaster Management Standards*. Available on wvcentral.org (log-in required).
29 World Vision International (2011). *Triggers for Action: Priority Indicators for Health, Nutrition, HIV&AIDS and WASH*. Available on wvcentral.org (log-in required).
30 Toole, M.J., and R.J. Waldman, 1990. 'Prevention of excess mortality in refugee and displaced populations in developing countries', *Journal of the American Medical Association*, 27 June, 263(24):3296-3320. PubMed PMID: 2348541.

Table 1. Emergency declaration categories

CAT IV	CAT III	CAT II	CAT I
An event that has a humanitarian impact across multiple continents, and/or an event that has an impact across multiple regions, and/or an event in a country, region or globally that puts business continuity at risk.	Primary criteria 1. Over 1 million people (or over 50% of the population) are affected or potentially affected by the emergency. 2. High immediate or projected death rates (CMR greater than 1/10,000/day; under-5 mortality rate [U5MR] greater than 2/10,000/day) or doubling of the baseline CMR and U5MR per country/geographic affected area.	Primary criteria 1. 100,000 to 1 million people (25% to 50% of the population) are affected or potentially affected by the emergency 2. The emergency has an impact on one to two sectors. 3. CMR up to 1/10,000/day and/or U5MR up to 2/10,000/day or projected increased level of mortality compared to what is considered normal for the country.	Primary criteria 1. Up to 100,000 people are affected or potentially affected by the emergency. 2. ADP/WV activities are directly affected/threatened. 3. Livelihoods are threatened. 4. Development potential is threatened. 5. Increase in mortality. 6. Significant increase in incidence of violence/abuse towards children, women, and other vulnerable groups. 7. Impact on infrastructure and basic services.
	Any one of these criteria requires the declaration of CAT III emergency.	**Any one of these criteria requires the declaration of CAT II emergency.**	**The combination of any four of these criteria leads to the declaration of CAT I emergency.**

Figure 1. Action matrix, from national office perspective



An emergency where WV has a national office				
Information management			**Communication**	**Declaration group**
Pre-disaster risk monitoring +	National office health implication and assessment (see Tools) +	Government and partner situation reports and secondary data →	Alert communication to WV partnership →	Evaluate emergency magnitude and decide response model
• What is known of situation? • What are priority health risks and problems? • What were services and behaviour prior to emergency?			Immediate communication to • technical H/N staff at regional SO level and • sector specialists for the global rapid response team, if appropriate	

Activate initial health and nutrition response plan (national contingency/disaster-management plan, if one exists)

Supplies

- Team on site with pre-positioned supplies (tents, trauma kits, clean delivery kits, ORS, hygiene kits, etc.)
- Essential supplies and equipment consistently available

Staff

- Capacity within NO to lead response?
- Mobilise and deploy additional staff, if needed
- Competent team with MNCH and nutrition expertise on site

Funding

- Use up to 10% of ADP budget, if appropriate
- NEPRF
- EPRF Partnership Response
- Flash Appeal
- CERF

Communication

Statements for

- fundraising unit
- donors
- advocacy among implementation agencies for appropriate responses

Accountability

Affected population

- where to go
- what services are available
- how to lodge complaints

Coordination

- Global and regional health and nutrition
- World Vision support offices
- Local authorities and agencies
- United Nations health and nutrition clusters and other relevant cluster/subsectors
- Current and potential donors

Information Management, including Monitoring

- Ongoing rapid/joint assessments
- Situation monitoring, health surveys, health service performance
- Disease outbreak and nutrition early warning and surveillance

Design and implement initial H/N response plan (based on above information)

Information management and design

- What are health priorities and gaps?
- Does WV have the capacity; does it fit within our mandate, to fill priority gaps?
- How can WV bring about necessary changes? (Response strategy and adjustment of initial response plan)
- What funding is required?
- Is advocacy necessary to call for appropriate responses among implementing agencies and donors?

Monitoring design and implementation

Supplies

- Are essential medicines and supplies meeting demands of increased case load?

Staff

- Has initial H/N team been mobilised, deployed and functioning?

Funding

- Is fundraising taking place to mobilise resources to provide free health services at the point of delivery to the affected population for the duration of the disaster?

Communication

- Are communication alert/situation reports shared with partners and donors?

Accountability

- Is there public awareness creation on what MNCH and nutrition services are available, where these can be accessed, and how to lodge complaints?

Coordination

- Is the WV team aware of who does what and where? within the health response?
- Have assessment and response plans been conducted jointly with local partners, if possible?

PART TWO
Key Emergency Principles and Operations for MNCH and Nutrition

HUMAN RIGHTS, HUMANITARIAN PROTECTION PRINCIPLES

World Vision's work is grounded by human rights principles such as the Universal Declaration of Human Rights,[31] UN Convention on the Rights of the Child[32] and the Convention on the Elimination of All Forms of Discrimination against Women.[33] In addition, we endorse the Sphere standards and commit to upholding the Humanitarian Charter and Protection Principles. These can be summarised as follows:

- All people have the right to life with dignity.
- All people have the right to receive humanitarian assistance.
- All people have the right to protection and security.

Any humanitarian action shall

- avoid exposing people to further harm as a result of your actions
- ensure people's access to impartial assistance – in proportion to need and without discrimination
- protect people from physical and psychological harm arising from violence and coercion
- assist people to claim their rights, access available remedies and recover from the effects of abuse.

World Vision also abides by the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organisations in Disaster Relief [34] (referred to as the Code of Conduct) and upholds the Management Policy on Christian Commitments in Emergency Response and Disaster Management.

CORE OPERATING STANDARDS

The core standards, as laid out in the Sphere Handbook, are relevant for all sectors. The process described by the core standards is essential to achieving technical minimal standards. WV has various frameworks, models and tools to strive towards achieving these core standards.

1. **People-centred humanitarian response** – People's capacity and strategies to survive with dignity are integral to the design and approach of humanitarian response. WV's Programme Accountability Framework describes our approach to Core Standard 1.
2. **Coordination and collaboration** – Humanitarian response is planned and implemented in coordination with the relevant authorities, humanitarian agencies and civil society organisations engaged in impartial humanitarian action, working together for maximum efficiency, coverage and effectiveness. See Chapter 4 for further details on WV's approach to Core Standard 2.
3. **Assessment** – The priority needs of the disaster-affected population are identified through a systematic assessment of the context, risks to life with dignity and the capacity of the affected people and relevant authorities to respond. Chapter 7 describes some of WV's assessment techniques.
4. **Design and response** – The humanitarian response meets the assessed needs of the disaster-affected population in relation to context, the risks faced and the capacity of the affected people and state to cope and recover. See Chapter 7.
5. **Performance, transparency and learning** – The performance of humanitarian agencies is continually examined and communicated to stakeholders; projects are adapted in response to performance.
6. **Aid worker performance** – Humanitarian agencies provide appropriate management, supervisory and psychosocial support, enabling aid workers to have the knowledge, skills, behaviour and attitudes to plan and implement an effective humanitarian response with humanity and respect. See WV's Adaptive Response framework and Chapter 6 for more information.

31 http://www.un.org/en/documents/udhr/index.shtml.
32 http://www.unicef.org/crc/files/Rights_overview.pdf.
33 http://www.un.org/womenwatch/daw/cedaw/cedaw.htm.
34 ICRC (1994). *Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief.* http://www.icrc.org/eng/resources/documents/publication/p1067.htm.

CHAPTER 3. COMMUNICATION AND ACCOUNTABILITY

COMMUNICATION AND RESOURCE MOBILISATION

World Vision acknowledges that multiple stakeholders requiring information during an emergency response (beneficiaries, fundraising, media, health-cluster partners, members of the WV Partnership) can put pressure on the response team to address these individual requests. We, therefore, encourage the response team to develop an information management strategy for internal and external stakeholders. This plan for engagement may include such steps as uploading situation reports to wvrelief and mobilising an advocacy response group to coordinate messages and approaches among national, regional and support offices.

– *See World Vision **HEA Disaster Management Standards 9 and 10** for a national office response.*

Communication on the emergency situation with current and potential donors is vital to ensure that health services are accessible and offered free at the point of service delivery to the affected population for the duration of the disaster. There are a variety of principal funding sources for an emergency response, depending upon the scale of the disaster, the capacity to respond, and whether it is a NO or a partnership response.

NO and smaller-scale financing mechanisms[35]

In an emergency, NOs are authorised to release up to 10 per cent of area development programme (ADP) sponsorship budgets for immediate disaster response. Support office (SO) approval is not required if the emergency response is within an ADP area. However, SO approval is required if an NO wishes to allocate more than 10 per cent of budget, if the disaster occurred outside the ADP area, or if an NO wishes to transfer private non-sponsorship funds.

NOs are strongly encouraged to develop their own National Emergency Preparedness Response Fund (NEPRF) to be used for preparedness, pre-positioning and rapid response. The NEPRF is managed locally and can be released without delay. Generally, the fund does not exceed 3 per cent of the NO annual budget, or US$400,000, and is financed from a variety of sources, included ADP budget. In addition, an SO may also have reserves for NO emergency responses.

For an NO response to the emergency, local embassies (e.g. New Zealand, United States, United Kingdom, Canada) often support simple disaster response proposals varying from US$20,000 to $200,000. The flash appeal, triggered by the UN humanitarian coordinator, can be another source of funding for an NO. This is normally completed within five to seven days of the onset of the emergency, and the appeal is issued by the Office for the Coordination of Humanitarian Affairs in Geneva about 48 hours later. While non-governmental organisations (NGOs), cannot apply directly for the United Nations Central Emergency Response Fund (CERF), WV can apply for grants through local UN agencies such as the Population Fund (UNFPA), WFP, or UNICEF. These grants may take up to 28 days to be approved and vary in size from $25,000 to $250,000.

35 World Vision International (2009). *National Emergency Preparedness Response Fund Policy.* Available on wvcentral.org (log-in required).

Partnership and larger-scale financing mechanisms[36]

In large-scale emergencies, involving a Partnership response, the EPRF[37] can be requested for $100,000 to $2 million and is usually approved within 48 hours. HEA can also approve an immediate budget of up to $5 million within the first 24 hours of the emergency. Subsequent grant funding raised by the Partnership for the response will cover this rapid response allocation. Other financing opportunities within WV for large-scale disaster responses include SO marketing campaigns, gifts-in-kind, services-in-kind, and Global Pre-positioning Resource Network (GPRN) deploying supplies and equipment. Financing outside of WV can come from government and foundation grants, grants from UN agencies, and developed country government-led inter-agency fundraising (Disasters Emergency Committee in the UK, the Aktion Deutschland Hilft in Germany, Japan Platform, and Samenwerkende Halporganisaties in the Netherlands).

In addition to the CERF (see above), the UN has a strategic foundation called the Common Humanitarian Action Plan (CHAP) for developing a Consolidated Appeals Process[38] (CAP) for funding an emergency response. The CHAP is a participatory process to provide a common analysis of the humanitarian context, an assessment of needs, various scenarios (most likely, best, worst), identification of who does what and where (roles and responsibilities), a monitoring framework, and discussion of long-term objectives. The CAP is a tool used by aid organisations to plan, coordinate, fund, implement and monitor humanitarian activities. It can foster cooperation among government, donors and local and international actors.

PROGRAMME ACCOUNTABILITY FRAMEWORK

As a member of the Humanitarian Accountability Partnership (HAP), WV is committed to a process of continuous improvement in compliance with *The 2010 HAP Standard in Accountability and Quality Management.*[39] We recognise the importance of community involvement and participation in activities and plans that affect people's lives. We reaffirm our commitment to receive and respect community opinions in development programming and during humanitarian interventions. Our Programme Accountability Framework[40] defines how we engage with communities. Efforts should be made during initial emergency responses to inform communities about WV's mandate and role, planned activities including start and end dates, targeted beneficiaries, and their right to complain.

Minimum standards of **accountability and transparency** during emergency responses include the following:

- **Provide information** so communities are informed about WV's mandate, core values and its role; planned activities including start and end dates; targeted beneficiaries and criteria; and the right to complain.
- **Consult with communities** to sensitise the population about the right to be consulted about key project decisions; to discuss project activities through community meetings and project assessments.
- **Promote community participation** in the development of targeting criteria and selection processes; in project inputs such as labour, skills and materials; and through identification of community capacities during the planning and assessment phase.
- **Collect and act on feedback and complaints,** ensuring that communities are sensitised about their right to provide feedback and complain, and that feedback is welcomed, recorded, analysed and acted upon.

36 Ibid.
37 See World Vision International (2008). Emergency Preparedness & Response Fund (EPRF) E-Brochure, Vol VI, Issue 2, July 2008. Available on wvcentral.org (log-in required).
38 See http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-swg_cap-cap#The%20Common%20Humanitarian%20Action%20Plan%20(CHAP).
39 Human Accountability Partnership (2010). *The 2010 HAP Standard in Accountability and Quality Management.* http://www.hapinternational.org/pool/files/2010-hap-standard-in-accountability.pdf.
40 Available on wvcentral.org (log-in required).

Examples of humanitarian accountability: Help desks and suggestion boxes

'In Haiti, the humanitarian accountability team worked closely with communities living in several camps to provide camp residents with information on who we are, how we work, and what we are doing in the target location as well as communicating how children and adults can be protected from exploitation.

Community consultations were undertaken frequently through assessments, household visits, beneficiary registrations and verification, project design, camp management committees and conflict mediation. Many front-line staff and community mobilisers were hired within project locations and provide regular input into programme implementation, including dissemination of feedback forms to capture complaints and feedback each day. Suggestion boxes were installed in project sites to build safe and strong communication channels.'

– *Source: World Vision. 'Myth #2: Aid Agencies Are not Accountable or Transparent'.* http://www.worldvision.org/content.nsf/about/20101214-myths-of-aid-2.

After the onset of the internally displaced people crisis in eastern Democratic Republic of Congo in September 2008, the CMAM centres established help desks and feedback mechanisms to provide a conduit for information to and from the community about the project. This dialogue revealed that no one (including NGOs working in the areas) had ever listened to or consulted the community about how they would like a project to be implemented.

We have learned the importance of

- ensuring that all staff understand the importance of accountability and the role of a humanitarian accountability team or community mobilisers
- helping community understand that they have a voice
- being transparent about services, timelines and targeting criteria.

CHAPTER 4. COORDINATION AND PARTNERSHIP

A well-coordinated response 'can improve efficiency, effectiveness and speed of response, enable strategic decision making and problem solving and help avoid gaps and duplication in services. It can generate a multiplier effect that results in expanded coverage and efficient use of resources and can compensate for any single agency's limited expertise, staff, resources or range of activities.'[41]

During an emergency response, a designated staff member should attend H/N (and other relevant sector/cluster) coordination meetings and represent WV in these discussions, at national and sub-national level. This person is vital in sharing WV's work and planning for joint assessments and operations, and in informing our staff on interagency developments, protocols, reporting requirements, etc.

COORDINATION AMONG OFFICIAL BODIES

Service providers, from doctors to CHWs and TBAs, need to coordinate to ensure that quality care is available at all levels of the health system.

> Emergency operations should be implemented in a timely, efficient and well-coordinated manner that ensures high technical standards of quality and accountability. National offices may continue, adapt or suspend regular area development programming in disaster-affected areas. Emergency responses should coordinate with existing local partners in a way that builds the capacity of local communities and organisations.
>
> *– See World Vision Disaster Management Standard 3 for a national office response.*

PART 2

Coordination must occur across various agencies, in order to improve the response to the health and nutritional needs of women and children in emergencies. Complementary relationships with various organisations during more stable situations will facilitate the ability to partner with others during a crisis. The *Principles of Partnership*[42] developed by the Global Humanitarian Platform describe effective humanitarian partnerships through mutual respect, transparency and complementarity. Prepositioning these partnerships with others involved in MNCH responses (creating strategic relationships with other agencies during times of stability) is important to building World Vision's emergency response capacity. Useful partnering tools can be found on wvcentral (log-in required). Coordination can be done in a phased approach by[43]

- sharing information on organisational mandates, roles, capacities, areas of operation, data and perception of general situation
- working together on assessing needs, setting standards, mobilising external resources and building local capacity
- implementing joint operations through planning and sharing of experts, security systems and logistical arrangements.

41 Inter-agency Working Group on Reproductive Health in Crises (2010). *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*.

42 Global Humanitarian Platform (2007). *Principals of Partnership.* http://www.icva.ch/pop.html.

43 World Health Organization (2009). *Inter-Agency Standing Committee Global Health Cluster Guide: A practical guide for country-level implementation of the health cluster.*

CLUSTER SYSTEM

Coordination compensates for limited expertise

Even though WV Zimbabwe was largely unprepared for a health emergency, WV used its good relations with the government ministries and other NGOs/health cluster agencies to penetrate and work in a challenging political environment. This positive relationship was built prior to the emergency. WV Zimbabwe hosted a partnership delegation, which provided an opportunity to engage and strengthen the relationship with the government and advocate for the needs of the disadvantaged community. The suspension of NGO operations was declared in May 2008 and lifted in July 2008 before the cholera outbreak. In October, the health cluster was activated, agencies started responding to the crisis, and WVZ established a response team just in time for the first large cholera epidemic. WVZ used the NEPRF to establish a cholera response while waiting for funding and waiting for the government to declare a health emergency. By using the ADP structure and community-based partners, WVZ was able to respond more effectively to the needs of the affected people.

Coordination in a humanitarian crisis is ideally led by the national government, but may be facilitated by the United Nations Humanitarian Coordinator in consultation with the government. The cluster approach is the current mechanism aimed at helping to enhance the quality of humanitarian action within and across sectors. It is part of a wider humanitarian reform process that seeks to confer greater predictability and accountability; and it provides a way to ensure that agencies (including NGOs) are accountable to the beneficiaries they serve, to their peers, to their donors and to the humanitarian coordinator. Each cluster is headed by a cluster lead agency whose role is to facilitate a coordinated response in support of national capacity. An inter-cluster coordination group composed of cluster coordinators meets to facilitate inter-cluster coordination.

Once the humanitarian cluster system is activated, the health cluster lead agency will facilitate communication and information management on who is where, when and doing what. The health cluster will communicate with other clusters, such as food security and agriculture, education, nutrition, shelter, protection and WASH to share information and coordinate efforts. Within the health cluster, a reproductive health focal point lead agency is selected and will support, promote and advocate for key reproductive actions, including sub-areas of sexually transmitted infections (STIs) and HIV, maternal and newborn health, and sexual violence.

CHAPTER 5. SUPPLIES AND LOGISTICS

Some supplies, such as components of the clean birth kit and hygiene kit, do not have expiration dates and can be pre-positioned within the NO. This should be a component of emergency preparedness planning.

WHO, UNFPA, and UNICEF developed a list of priority medicines for mothers and children[44] to help countries and partners select and make available medicines that will have the greatest impact on reducing maternal, newborn and child morbidity and mortality. Child medicines include treatment for pneumonia, diarrhoea, malaria, neonatal sepsis, HIV and AIDS, and vitamin A deficiency. Priority medicines for mothers include drugs to treat complications during pregnancy and childbirth such as postpartum haemorrhage, high blood pressure and maternal sepsis. Treatments for STIs and prevention of preterm birth are also included.

The *Interagency Emergency Health Kit*[45] (2006) is a standard kit containing essential drugs, supplies and equipment for primary health-care services in humanitarian settings. The 2011 version is currently in production. While it does contain mental health and psychosocial support (MHPSS) drugs (except for narcotics), midwifery kits, emergency contraceptive pills and PEP treatment, it does not have all of the supplies needed to implement MISP. This kit is useful for setting up initial basic health services and mobile clinics, but additional medicines and equipment to fulfil WV's MNCH priority 7-11 interventions are needed. For example, retinol for vitamin A, de-worming drugs and ready-to-use supplemental foods are additional to the emergency health kit. See WV's medical supplies for emergencies for further guidance.[46]

The *Inter-Agency Reproductive Health Kits for Crisis Situations*[47] contains the drugs and supplies needed to implement priority reproductive health services and components of MISP. World Vision is mainly concerned with 'Block 1', which targets community-level and primary health care-level supplies such as clean delivery packages, post-rape supplies, STI treatment, oral and injectable contraception and condoms.

Note: While World Vision has strong expertise in raising awareness, providing protection and offering health advice and referral, there may be instances where WV is providing clinical services. World Vision has developed a resource, medical supplies for emergencies, for mobile clinics and emergency health centres. This document specifically lists Kit 2 – clean delivery – and Kit 3 – post-rape. The full Block 1 (Kits 1– 5) needs to be available for any basic MNCH response to ensure that basic contraception, including condoms, is provided and that those presenting with STIs can be treated. It should be noted that newborn resuscitation supplies are available in Block 2, Kit 6.

44 World Health Organization (2011). *Priority medicines for mothers and children 2011*. http://www.who.int/child_adolescent_health/documents/emp_mar2011.1/en/index.html.

45 World Health Organization (2006). *The Interagency Emergency Health Kit*. http://whqlibdoc.who.int/hq/2006/WHO_PSM_PAR_2006.4_eng.pdf.

46 Available on wvcentral.org (log-in required).

47 Inter-Agency Working Group (IAWG). (2008). *Inter-Agency Reproductive Health Kits for Crisis Situations*. http://www.rhrc.org/resources/rhrkit.pdf.

CHAPTER 6. STAFF COMPETENCIES

As part of WV's Adaptive Response framework, competencies and job descriptions are being developed for key staff required for key emergency MNCH and nutrition interventions. Suggested staffing needs for an H/N response for a targeted population of 20,000 people are listed in Annex 1. **Programme managers need to take stock of potential risks and human resources available to respond to MNCH and nutrition**, as well as in related sectors such as food security and nutrition, WASH and protection, as limited technical staff in development often hampers our immediate relief response. **Various key training can be provided in stable phases to improve the emergency response capacity of staff.**

In addition, a draft budget template has been developed for the possible staff and supplies required for each type of three-month health intervention.

Key emergency staff should have core competencies to be able to

- conduct rapid assessments
- collate and analyse health information to inform response strategy
- design initial strategy, project objectives, activities, timelines, budget, staffing needs, etc.
- write situation/advocacy reports to various stakeholders
- liaise with donors
- coordinate with emergency stakeholders (government, clusters, NGOs, UN)
- manage projects, finances and staff in stressful, rapidly changing humanitarian settings:
    - implement operational WV policies (RH, milk, health)
    - assess staff capacity and assist HR in development of staff structure, organisational charts, job descriptions, etc.
    - plan medical supply consumption and ordering of supplies
    - monitor MNCH and nutrition project activities and rapidly adapt plans accordingly
- train and supervise community mobilisers in mid-upper arm circumference (MUAC) measurement and referral, IYCF, and health and hygiene promotion messages
- manage IYCH component of health centres and/or WAIFS
- conduct public health/outbreak investigation and surveillance
- implement MISP in the initial stage of an emergency
- establish a referral system for at-risk and emergency obstetric cases from community to health unit
- establish support mechanisms to promote early breast-feeding and optimal infant and young child feeding.

CHAPTER 7. INFORMATION MANAGEMENT

Information is needed on health status and risks, availability of health resources and services, and the performance of the health system. Some indicators for measuring the context and effect of the projects are listed in Technical Tools in Part Four of this guide. WV has a variety of resources such as LEAP – DME framework, HEA score card, Emergency Capacity Building Project baseline, annual review and peer review, and *Impact Measurement and Accountability in Emergencies: The Good Enough Guide*[48] that can better inform the design, monitoring, and evaluation process in emergencies.

ASSESSMENT

Assessment is a process, not a single event, which allows WV staff to get a picture of the needs and how responses need to meet the **changing needs** of communities. Responses will be effective only if the process of assessment, monitoring and reassessment is used in each humanitarian context.

> Response plans will evolve over time as assessment information increases and context changes. An agreed time frame by which to complete the response plan(s) is to be agreed between the response manager and the national director, and shared with appropriate Partnership stakeholders.
>
> *– See World Vision Disaster Management Standard 4 for a national office response.*

Basic rapid assessment tool (BRAT)

Initial and rapid assessments, such as the World Vision basic rapid assessment tool (BRAT) provide the basis for more in-depth subsequent assessments. BRAT is designed to be used by any WV staff on site during an emergency, in the initial one to two days of a rapid-onset disaster, or in the first week of a slow onset. The tool can be used when WV is trying to get a sense of the following:

- the scale of the humanitarian situation, (area, population groups and numbers)
- changes in the context caused by the disaster
- new factors that create or increase vulnerability
- the needs of the community and likely impact on health and the health system
- which organisations are working the area and where World Vision can be best placed.

> In disaster-affected areas where ongoing development programmes exist, assessments and response recommendations should be conducted jointly with existing local partners, wherever possible.
>
> *– See World Vision Disaster Management Standard 5 for a national office response.*

This does not, however, replace interagency or sector-specific assessments, but can provide information to these broader more comprehensive assessments.

48 Oxfam GB and World Vision International (1997). *Impact Measurement and Accountability in Emergencies: The Good Enough Guide*. http://www.allindiary.org/pool/resources/good-enough-guide-impact-measurement-and-assessment.pdf.

Rapid assessment

The initial rapid assessment[49] (IRA) provides valuable primary data that inform response objectives and operations and that will be compared to subsequent data to measure humanitarian response effectiveness. The IRA should be tailored to the local emergency context while maintaining universal standards and assessment best practices. A template for collecting primary data (IRA tool) and guidance notes are available. In addition, the Inter-Agency Standing Committee Needs Assessment Task Force has recently released operational guidance for coordinated assessments in humanitarian crises (provisional version February 2011), providing guidance for multi-cluster IRAs.

Detailed health-sector or subsector assessments/surveys should be planned to further investigate important issues identified by the IRA. The in-depth health-sector survey may include information such as mortality rates (CMR and U5MR) and morbidity rate; main causes of death, injury and disease and their distribution among the population; psychosocial impact on the population, health staff and relief workers; and available human and material resources to assure health services in the interim.

Surveys

Representative surveys may be feasible in the initial phase of an emergency. Knowledge, attitude and practices can be assessed at the beginning and end of the emergency response, as a way to measure impact of interventions. Refer to Table 2 below for required skills and methods.

Surveillance

While the Ministry of Health (MoH) and WHO have the overall responsibility for carrying out surveillance activities, implementing agencies such as World Vision may be involved with data collection and reporting and implementing control measures. The essential elements of an early warning and response system (EWARS) or integrated disease surveillance and response (IDSR) include the following:

- consensus on a short list of priority conditions to be monitored and a standard reporting format
- reliable and rapid means of communication
- criteria and threshold guidelines for which they should make the alerts and specified action
- training of clinical workers in the operation of the system
- laboratory capacity and clear procedures for taking and handling biological samples
- stockpiles of sampling kits, drugs and vaccines
- contingency plans for comprehensive response to epidemics, including isolation wards in hospitals.

49 WHO. 'Global Health Cluster Tools'. http://www.who.int/hac/global_health_cluster/guide/tools/en/.

Table 2. Information and data collection methods

	Assessment	Survey	Surveillance
Objective	Rapid appraisal to inform a preliminary response strategy for the first few days (BRAT) To be followed by initial rapid assessment in days 4 to 15	Medium-term appraisal to refine ongoing projects and detailed strategic response plan to inform project proposals and consolidated appeal	Continuous appraisal
When	Onset of new disaster or access to a new area during ongoing operation First one to two days of sudden onset First week of slow onset	Within 15 to 45 days of sudden onset	30 days onward of sudden onset
Data type	Qualitative cross-sectional 'snapshot'	Quantitative preferred, can be qualitative cross-sectional 'snapshot'	Quantitative longitudinal trends
Method	Observational – Drive/walk through, satellite imagery Rapid secondary data review Key informants at national and local level	Sample with survey instruments	Periodic, standardised data collection
Knowledge and skills needed	Local knowledge of area and pre-existing situation Knowledge of the impact of a similar disaster in other contexts Skills in collecting and analysing secondary data	Skills in design, collection and analysing of primary and secondary data	Skills in in-depth subsector assessments (i.e. nutrition, RH assessment, health-facility surveys)

MONITORING

Ongoing collection, analysis and reporting of data are necessary from the onset of a humanitarian response. If the health information system has been disrupted by the emergency or does not exist, the health cluster will typically implement an emergency system to monitor disease incidence and trends.

WV monitors its projects to measure progress against intended plans (objectives and indicators). This information can guide project approaches and targeting criteria, and determine whether aid is reaching the intended people. Suggested monitoring indicators are found in the Technical Tools section of this guide.

In addition to continuous monitoring and evaluation, WV often conducts 'real-time learning events' (ideally with other partners and NGOs) that measure changes in people's lives resulting from our work, and apply this learning to improving our impact.

– See World Vision Disaster Management Standard 6 and 7 for a national office response

PART THREE
Preventing Maternal and Newborn Morbidity and Mortality

CHAPTER 8. KEY EMERGENCY ACTIONS FOR MNCH CONTINUUM OF CARE

> World Vision provides credible leadership, speaks with authority... and provides robust evidence and critical analysis. WV partners and leads in innovative approaches to common challenges while strengthening understanding of why and how changes are needed to improve support and humanitarian outcomes.[50]

World Vision MNCH and nutrition activities aim to prevent and reduce excess mortality. We seek to protect and improve the H/N of women and children during emergency responses, and to build resilience in communities to deal with shocks. **Our strength lies in supporting community-based responses and outreach for interventions that have a proven impact in saving lives and improving maternal and child health.**

Within the breadth of health-service needs, we focus on primary health services for mothers and children (including provision of basic medical supplies and nutritional interventions) to ensure that lives are saved and communities have access to health care.

HEALTH AND NUTRITION 7-11

To encourage widespread adoption within World Vision of core focus programming, the Global Health and Nutrition Team developed an initial package of evidence-based, integrated interventions called '7-11' (overview of *Start-Up Strategy 7-11*[51]). The Health and Nutrition 7-11 Strategy aims to improve H/N outcomes for mothers and children younger than 5 years old. Seven interventions focus on the maternal issues while 11 key interventions are focused on children under 2 years of age (Table 3). The 2010 WV Health and Nutrition *7-11 Start-up Field Guide* provides implementation guidance to field staff. World Vision staff implement key '7-11' MNCH programming interventions in stable conditions, and are able to adapt these interventions in emergency contexts, given that most causes of morbidity and mortality are the same as in non-emergency contexts.

Table 3. 7-11 Priority interventions

Pregnant women 0–9 months	Children 0–24 months
1. Adequate diet 2. Iron/folate supplements 3. Tetanus toxoid immunisation 4. Malaria prevention, treatment access and intermittent preventive treatment 5. Birth preparedness and healthy timing and spacing of delivery 6. De-worming 7. Access to maternal health services: antenatal care (ANC), postnatal care (PNC), delivery by skilled birth attendant (SBA), prevention of maternal-to-child transmission of HIV, HIV/tuberculosis, sexually transmitted infection (STI) screening.	1. Appropriate breast-feeding 2. Essential newborn care 3. Hand washing with soap 4. Appropriate complementary feeding 5. Adequate iron 6. Vitamin A supplementation 7. Oral rehydration therapy (zinc) 8. Prevention and care seeking for malaria 9. Full immunisation for age 10. Prevention and care seeking for acute respiratory infection (ARI) 11. De-worming (+12 months)
Note: In the start-up phase of an emergency, WV strives to implement the above in an appropriate, resourced and phased manner. Initial action should start with priority interventions that address the causes of excess mortality (i.e. measles vaccination); and, in a phased manner, introduce additional services as the situation becomes more stabilised.	

50 World Vision International (2010). *Humanitarian and Emergencies Affairs Strategic Intent 2010 – 2015.*
51 World Vision International (2009). *Start-Up Strategy 7-11.*
http://www.wvi.org/wvi/wviweb.nsf/11FBDA878493AC7A882574CD0074E7FD/$file/Global_Health_and_Nutrition_Start-Up_Strategy.pdf.

EMERGENCY RESPONSE, USING 7-11 APPROACH

World Vision aims to have elements of the 7-11 strategy in place and prioritised according to the emergency context. The focus during the initial stage of the emergency should be on priority H/N interventions that are effective in addressing the causes of excess maternal newborn and child mortality and morbidity, such as ARI, diarrhoeal diseases, malaria, neonatal causes, and a lack of access to skilled birth care.

World Vision prevents common causes of maternal and child morbidity and mortality in emergencies by[52]

- applying community mobilisation, health promotion and disease-prevention strategies (may result in better health seeking behaviour, creation of demand for the facility service)
- supporting primary health care (PHC) services and facilitating outreach activities
- preventing and controlling communicable diseases
- supporting evidence-based reproductive health services, starting with elements of MISP (such as encouraging referral links between community health services and health facilities)
- encouraging optimal infant and young child feeding practices
- addressing malnutrition using the community-based management of acute malnutrition (CMAM) approach
- supporting the health system by ensuring availability of essential medicines and medical devices, contraceptives and micronutrient supplies.

During emergencies and in particular situations where others cannot provide services, it may be necessary for World Vision to provide health services to prevent and reduce avoidable morbidity and mortality and control diseases of epidemic potential. We provide these services until the government or health authorities can carry out these activities.

Mobile companionship and care – Haiti

The remaining health facilities were overwhelmed by the massive injuries and consultations needed after the 2010 Haiti earthquake. Communities could not easily access the necessary medical attention. The WV-supported mobile clinics provided basic health services, elements of MISP (level 1 kits provided by UNFPA), nutritional surveillance for under-5 year olds and antenatal check-ups, and referred patients needing further medical care to secondary-level facilities. Patients were followed up regardless of whether they received care at the mobile clinic or referral centre. WV worked closely with the referral-level facilities to ensure that essential medicine and supplies were available. The 10 mobile clinics were staffed by qualified nurses and doctors who treated more than 3,800 patients from 22 February to 8 March. Staff provided antenatal care for expectant mothers who could not access regular appointments, treated traumatic injuries, broken bones, diarrhoea, skin infections, upper respiratory infections and high blood pressure. But we are seeing mental illness that goes into the psychosocial trauma suffered by the population. They need our support, efforts, companionship, and solid work.

– Dr Manuel Roberto Calderon, MD, MP, Regional Health Advisor for World Vision Latin America & the Caribbean Region.

52 World Vision (2010). *Disasters and Emergencies and their Public Health Implications and Possible Health Responses.*

Support existing health system through mobile clinics

According to the context and needs, World Vision may establish **mobile clinics**, usually linked through the health cluster or MoH, when people cannot access functioning health centres. In countries where mobile clinics are likely to be used during emergency responses, arrangements with MoH and national/regional health partners should be made in advance as part of the national preparedness plan. Mobile clinics have been proven vital to increase access to treatment and control outbreaks in some humanitarian situations with limited access to health services (isolated or mobile/nomadic populations or where people seek refuge). Studies have shown mobile clinics to be useful for a short period of time and to have better lasting effects when the mobile clinic activities (health promotion and prevention and screening), support an established health care facility.[53] **Thus, World Vision does not use mobile clinics in isolation from wider health system improvements.**

Safe motherhood

World Vision uses the 7-11 approach, which supports all the components of the safe motherhood initiative. The four pillars of the safe mother initiative are addressed in this guide in the following ways:

Pillar 1. Family Planning – Chapter 9: Reproductive Health, Family Planning section

Pillar 2. Antenatal Care – Chapter 10: Pregnancy

Pillar 3. Clean-Safe Delivery – Chapter 10: Pregnancy and Chapter 11: Childbirth and Maternal and Newborn Care

Pillar 4. Essential Obstetric Care – Chapter 11: Childbirth and Maternal and Newborn Care

In the initial phase of an emergency, safe motherhood focuses on a limited number of practices proven to decrease infant and mother deaths, such as MISP (Chapter 9).

53 DuMortier, S., & R. Coninx (June 2007). 'Mobile Health Units in Emergency Operations: A methodological approach'. *Human Practice Network,* Number 60.

CHAPTER 9. REPRODUCTIVE HEALTH

World Vision, typically, does not offer clinical services, yet we should strive to know **who offers these services and how to refer clients to these services**.

MISP

The minimum initial services package is a priority set of life-saving activities to be implemented at the onset of every humanitarian crisis. It forms the starting point (minimum requirements) for sexual and reproductive health programming and should be sustained and built upon with comprehensive sexual and reproductive health services throughout protracted crises and recovery. MISP addresses reproductive health needs at the onset of an emergency and defines which RH services are most necessary in order to prevent morbidity and mortality, especially among girls and women. **There is no need to do an assessment prior to MISP implementation**. WV can DO and deliver many elements of MISP. However, some of the MISP is outside WV's mandate and expertise and we will ASSURE that these elements are undertaken by other agencies. The five objectives of MISP are as follows:

1. Ensure that the health sector/cluster identifies an organisation to lead implementation of MISP.
2. Prevent and manage the consequences of sexual violence.
3. Reduce HIV transmission.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Plan for comprehensive RH services, integrated into primary health care as the situation permits.

Management policy on reproductive health

All staff must be familiar with the WV RH policy. Key points include the following:

- World Vision does not promote or undertake reproductive health interventions that are abortive in nature.
- World Vision staff members ensure the confidentiality and privacy of all beneficiaries, offer services in a non-judgemental manner, and take every measure to avoid and reduce stigma.
- World Vision programmes offer beneficiaries complete, accurate, unbiased, updated and comprehensive information disseminated in a caring, respectful, empowering, culturally and age-appropriate manner.
- Information, education, communication and social and behaviour change activities are critical components of World Vision's reproductive health programmes, emphasising prevention, wellness and responsible, informed decision making.
- In accordance with World Vision's Gender Policy, World Vision's reproductive health programmes strengthen the partnership between men and women in their shared responsibilities; increase sensitivity to understand and overcome the lack of equity in the relationship between women and men, girls and boys; promote understanding of gender roles and gender equity; and work towards improving the social and economic empowerment of women.

ADOLESCENT REPRODUCTIVE HEALTH

MISP does not cater specifically to adolescents' needs; however, World Vision and other health partners can ensure that RH services are implemented in a youth-friendly way. **Currently WV does not have much, if any, expertise in the area of adolescent sexual reproductive health. With additional strategic intent, national programming, staff training and operational research, addressing adolescent reproductive health in emergencies could be a future focus area for World Vision.**

SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV

World Vision supports a comprehensive approach to STI/HIV prevention and management and integrates these efforts into all emergency relief programmes. World Vision's strategic goal for integrating HIV in emergencies includes STI/HIV prevention care and advocacy measured by

- reducing the transmission and impact of HIV on children, their families and communities within an emergency
- implementing policies, programmes and interventions to enable an appropriate response to HIV in low and high HIV-prevalence contexts in CAT II and III emergencies
- retaining a Christian identity and ensuring that children's needs are met and their well-being enhanced
- ensuring communities are empowered and their resilience improved during the emergency.

Reducing STI/HIV transmission is a key component of MISP. As part of the health cluster, WV can assure safe blood transfusion practice; improve the quality of, access to and coverage of STI management, including screening and diagnostic services; provide prompt recognition and treatment of infections with counselling and follow-up; ensure integration of prevention education into treatment services along with discussing the individual's increased risk of acquiring HIV; and provide prevention and treatment of STI-related complications. WV can facilitate and enforce respect for standard precautions, and ensure that free condoms are available.

While World Vision emphasises abstinence ouside of marriage and fidelity within marriage, we recognise that consistent and correct use of condoms prevents HIV infection. We recommend correct and consistent use of condoms for harm reduction and this should be done as an integrated programme approach rather than a stand-alone intervention. In some emergency settings, it may be appropriate to make condoms available in hygiene kits, along with sensitisation and information regarding proper use and disposal. Comprehensive STI programming is not part of MISP; however, STI syndromic treatment should be available for those presenting with symptoms at the onset of the emergency. WV facilitates syndromic treatment where directly offering health services; however, HIV screening is not performed in emergencies.

After the initial phase of the emergency, WV may apply a community-based approach to prevent and control STIs/HIV through safer sex and condom programming and public awareness of STIs and available clinical services. At the health-service level, comprehensive STI case management should be planned and integrated into other clinical services.

SEXUAL AND GENDER-BASED VIOLENCE

Protection mechanisms are considered in the design of any WV project: food security, shelter, WASH, education and health services. MISP seeks to prevent and manage the consequences of sexual violence. World Vision contributes the fulfilment of this objective by

- **promoting protection mechanisms to prevent sexual violence**
- **building community awareness of the available clinical services**
- **referring clients to specialised services/NGOs offering confidential clinical care for rape survivors.**

While WV does not provide clinical health services for victims of rape, we must develop relationships with partner NGOs that provide these services, as soon as possible in the initial response. In addition, staff can provide immediate psychosocial support (psychosocial first aid); raise awareness among the community on prevention, reporting and available services; and ensure effective referrals to appropriate clinical services. Psychological first aid training is encouraged for staff primarily working with young girls and women. In addition, World Vision raises staff awareness of SGBV and requires all humanitarian staff to sign and abide by the Child Protection Policy and the Humanitarian Code of Conduct.

FAMILY PLANNING

Experience shows that women want to continue their contraceptive method during emergencies. Basic contraception, including condoms, should be available from the onset of the crisis to meet demands of continued family planning methods of choice. These methods should not require comprehensive medical procedures or follow-up.

Post-rape kits, which include PEP and emergency contraception, should be accessible in an emergency. Our latest knowledge and evidence shows that emergency contractive pills (ECPs) do not cause abortion and do not affect an existing pregnancy. Emergency contraceptive methods that affect any of the events that precede fertilisation and do not interfere with implantation of a fertilised egg or harm the healthy development of an existing pregnancy (i.e. fertilised ovum, zygote, blastocyst) are contraceptives that support the WV reproductive health policy. The recommended regimen of levonorgestrel-only pill and ulipristal acetate (UPA) has fewer side effects than the combined oestrogen-progesterone pill.

Table 4. DADDs for reproductive health in emergencies

	Preparation	Start-up phase (30–90 days)		Don't do
		Do	Assure	
Reproductive health (general)	• Staff understand RH policy. • Train male and female volunteers to provide RH messages (prevention and where to go for services) at contact points. • Establish workplace policy for occupational exposure, including PEP. • Train staff in universal precautions. • Train staff in psychological first aid. • Pre-position RH supplies, if appropriate.	• Encourage health-seeking behaviours and reduced risk taking. • Provide referrals for appropriate services and ensure that the community knows where to go for treatment and support. • Staff and service providers sign and abide by Code of Conduct. • Establish and implement staff workplace policies for occupational exposure, including availability of PEP. • Enforce universal standard precautions (gloves, protective clothing, sharps disposal) for infection control. • Request RH supplies, if appropriate.	• Safe blood transfusion practice. • Consultations and linkages with WASH, shelter, MHPSS team/sector in relation to health facility site planning, WASH hardware and health-promotion messages and psychosocial support (PSS) for women and children. • Humanitarian Code of Conduct against sexual exploitation and abuse, reporting mechanisms, and punitive measures is in place for humanitarian workers and service providers.	• Undertake reproductive health interventions that are abortive in nature. • Procure, distribute, or provide any medications, reagents, remedies or services not within the national/ WHO essential medicine list. • Invest in expatriate medical teams for clinical care and MHPSS. • Provide secondary and tertiary health care including trauma care and surgery.

Table 4. DADDs for reproductive health in emergencies (continued)

	Preparation	Start-up phase (30–90 days)		Don't do
		Do	Assure	
RH: Adolescent -friendly RH	• Train staff on adolescent-friendly RH counselling; mobilisation techniques to reduce prevalence and incidence of STIs, including HIV; prevention of unwanted pregnancies.	• Encourage dual protection and condom availability, if appropriate. • Encourage health-seeking behaviours and reduced risk taking. • Offer referrals for RH services.	• RH services are sensitive to adolescent needs and social culture. • Improved access to and usage of youth-friendly services through liaising with local service providers, health cluster partners, or the health system.	
RH: STI/HIV	• Provide education for staff and community on HIV transmission, prevention behaviour and demand for services. • Train staff on universal precautions and equipment use for infection control.	• Staff provides psychological first aid, where appropriate. • Provide STI prevention (e.g. condoms, education), including PEP where appropriate. • Integrate STI management in antenatal, delivery, and postpartum period, including PEP where appropriate. • Where appropriate, initiate preventive HIV programmes, including condom promotion.	• Prevention of STI/HIV with free condoms. • Syndromic STI treatment and PEP are available. • Comprehensive STI case management is available at the health-service level. • Antiretroviral therapy (ART) available to those already taking treatment, including prevention of mother-to-child transmission of HIV (PMTCT.) • HIV awareness mainstreamed into all sector activities to ensure that project designs do not increase vulnerability to HIV. • Family planning is available.	• Free condom distribution, without proper sensitisation and information. • Actively search for new HIV cases and provide voluntary counselling and testing (VCT) or ART to newly diagnosed beneficiaries.

Table 4. DADDs for reproductive health in emergencies (continued)

	Preparation	Start-up phase (30–90 days)		Don't do
		Do	Assure	
RH: Sexual and gender-based violence	• Build staff awareness of risks of SGBV in this context. • Train male and female volunteers to provide these SGBV messages to populations via contact points. • Hire female service providers and programme staff.	• Use communication channels to inform population of the availability of confidential services and support, importance of rapid SGBV incident reporting and immediate care. • Provide referrals to clinical management and counselling for rape survivors/those exposed to gender-based violence (GBV). • Prevent sexual violence through protection mechanisms (e.g. separate male and female latrines and washing areas, adequate path lighting to secure WASH facilities; safety while girls are carrying out household duties; hiring female service providers, CHWs and programme staff; safe areas for women and children, etc.). • Staff provides psychological first aid, where appropriate.	• Clinical and psychosocial services to care for victims of rape are available. • Humanitarian Code of Conduct is in place. • PEP and post-rape kit and counselling are available. • Confidential counselling and testing for STIs and HIV are in place (stabilisation). • Safe areas for women and children.	• Provide clinical services for victims of rape. • Provide trauma counselling or psychological debriefing.
RH: FP		• Provide basic contraception, including condoms, where appropriate. • Emergency contraception is accessible.		• Provide contraception that is abortive in nature or requiring comprehensive medical interventions or follow-up.

CHAPTER 10. PREGNANCY

Antenatal care is a component of the 7-11 strategy, and usually includes at least two doses of tetanus toxoid vaccination, iron and folic acid supplementation, management of syphilis/STIs, management of pre-eclampsia, intermittent preventive treatment for malaria in pregnancy and insecticide-treated mosquito nets, prevention of mother-to-child transmission of HIV, and birth and emergency preparedness at home. However, **emergency responses generally may not provide focused ANC until the humanitarian situation stabilises.** Nutritional requirements for pregnant and lactating women can be found in Chapter 12.

BIRTH PREPAREDNESS

World Vision can establish communication messages on the importance of childbirth by skilled birth attendant and referral procedures for emergency obstetric cases. Food security programming, CMAM or distribution of food aid can be an opportunity to provide this information and promote maternal, neonatal, and child health beneficial practices and services. Where delivery by a SBA is not accessible, clean delivery kits should be distributed to visibly pregnant women, along with registration of these women for maternal and newborn care visits and postpartum services.

Table 5. DADDs for pregnancy in emergencies

	Preparation	Start-up phase (30–90 days)		Don't do
		Do	Assure	
Pregnancy	• Pre-position materials for clean delivery kits.	• Provide LLIN in malaria-endemic areas. • Locate pregnant women, TBAs and midwives to enable messaging on safe delivery, childbirth by SBA and referrals. • Locally source/ procure, and provide clean delivery and information kits to visibly pregnant women and midwives, along with registration of pregnant women. • Provide support programmes for women (and infants).	• Assure pregnant and newly delivered mothers are prioritised for non-food item (NFI) distribution (i.e. shelter). • Antiretrovirals are available to those already on treatment. • Partners are planning for antenatal care (prevent and treat malaria – intermittent preventive treatment of malaria during pregnancy, syphilis and HIV screening, tetanus toxoid , disease prevention, de-worming, health promotion, birth preparedness).	• Isolate TBAs, as they may be an important link between community and facility-based SBA.
Nutrition actions for pregnant and lactating women are found within the nutrition DADD.				

CHAPTER 11. CHILDBIRTH, AND MATERNAL AND NEWBORN CARE

Clean delivery practice, delivering with a skilled attendant and access to quality emergency obstetric and newborn care are key interventions to prevent maternal and neonatal death. MISP seeks to prevent excess maternal and newborn morbidity and mortality. World Vision contributes the fulfilment of this objective by

- **assuring availability of emergency obstetric and newborn care services**
- **establishing a referral network to facilitate transport and communication from the community to the health centre and between the health centre and the hospital**
- **providing clean delivery kits and information packages to visibly pregnant women, where access to trained professional/facility is not possible**
- **educating the community on the importance of childbirth by skilled attendant, immediate newborn care, and early breast-feeding.**

World Vision plays an important role in educating the community on newborn care and the benefits of seeking skilled support for both childbirth and newborn care. WV also works with the community to establish a referral system for obstetric and newborn complications. TBAs should be mobilised to be part of this referral system and promote newborn care (thermal care, benefits of colostrum and early initiation of breast-feeding), but should not be equipped or trained to perform deliveries. Through the registration of households with newborns, children under 24 months and breast-feeding/pregnant women, essential newborn and maternal care and food assistance can be planned and provided.

Primary health-care facilities need SBAs, neonatal resuscitation and basic emergency obstetric and newborn care (BEmONC) in order to prevent maternal and newborn morbidity and mortality. If women are not able to access a health-care facility, clean delivery kits should be given to visibly pregnant women.

Table 6. DADD for childbirth and maternal & newborn care in emergencies

	Preparation	Start-up phase (30–90 days)		Don't do
		Do	Assure	
Childbirth, maternal and newborn care	• If slow onset, identify agency providing emergency obstetric and newborn care (EmONC) and comprehensive emergency obstetric care (CEmOC). • Train staff and volunteers on maternal and newborn care and appropriate messaging.	• Locate TBAs, if not already known, and train them to assist with all elements of the project. • Establish referral link. • Provide referrals for appropriate services, e.g. EmONC. • Promote and plan essential newborn and maternal care and promote home visits within critical 24 to 48 hours after birth. • Provide education to community on essential newborn care (cord and eye care, colostrum and exclusive breast-feeding (EBF), thermal care – skin-to-skin contact, delayed bathing for 24 hours) and the importance of seeking care. • Provide LLIN in malaria-endemic areas.	• Availability of emergency obstetric and newborn care (EmONC, CEmOC) 24/7. • This includes SBAs and supplies for normal deliveries and management of obstetric and newborn emergencies at the facility level. • Above services are sensitive to adolescent needs and social culture. • Partners are planning for postpartum care services (prevent and detect complications; anaemia prevention; information on nutrition; safe sex, family planning; promotion of LLIN). • Birth notification.	• Isolate TBAs, as they may be an important link between the community and facility-based SBA.

CHAPTER 12. NUTRITION

While humanitarian responses may focus on food security and distribution methods, and such programmes must be considered as component of WV response and efficiently implemented, **WV has strength in community-based nutrition education and behaviour change communication**. Messages can be provided at food-distribution points, CMAM, through mobile phone devices, at WAIFS, at mobile clinics, or through person-to-person outreach. Our role is to provide education on the importance of early and exclusive breast-feeding to protect their children from diseases, the benefits of continued breast-feeding during emergencies, methods to improve lactation, demonstrations on hygienic food preparation, storage and serving, and optimal timing and nature of complementary foods for young children.

NUTRITION FOR EXPECTANT AND LACTATING MOTHERS

In situations where nutritional needs of the general population are not met, WV advocates for a general ration to be distributed, which is appropriate in quantity and quality for young children's complementary food needs and for the specific needs of PLW. In situations where supplementary foods are available, PLW should be considered as a primary target group.

If the acute malnutrition level is above the WHO benchmark, World Vision coordinates with the nutrition cluster for possible initiation of CMAM.[54] On an individual basis, women with middle-upper arm circumference of less than 21 cm are admitted to the supplemental feeding programme, but there is debate as to whether this threshold is sensitive enough for PLW.[55]

Even if PLW are receiving fortified foods, UNICEF and WHO recommend a daily multiple micronutrient formula to meet the daily requirements of this special group. World Vision staff should work with WFP within the humanitarian context to determine the appropriate and acceptable rations and micronutrient supplementation for PLW.

Advocating for appropriate food rations for pregnant and lactating women

NutVal is a useful tool when planning a food basket and allows food-distribution planners to take into account the additional needs and any cultural food taboos of PLW. General food rations are based on 2,100kcal/person/day, with 10 per cent of total energy from proteins and 17 per cent of total energy from fats. Pregnant women require an additional 285kcal/day and lactating women require an additional 500kcal/day, plus additional micronutrients such as iron and folic acid. World Vision can play a role in ensuring that food rations help meet the daily requirements of PLW.

Note: Milk products cannot be distributed as a single commodity within general food distribution and must be in accordance with World Vision's Milk Policy, the Operational Guidance on Infant Feeding in Emergencies (IFE), the International Code of Marketing of Breast-Milk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions.

54 Currently there is not an agreed benchmark for starting CMAM for PLW. Malnourished individual PLW are targeted in CMAM programmes if the CMAM is already operational due to a high level of acute malnutrition in children under 5.
55 In Indonesia MUAC under 23.5 cm is used for pregnant women as admission criteria; others suggest using 26 cm.

Infant and young child feeding

Optimal infant and young child feeding starts within one hour after birth. World Vision emphasises proactive activities to maintain and improve nutrition and growth at the community and health-facility level, which includes exclusive breast-feeding for six months, adequate complementary feeding with breast-feeding for two years, adequate intake of vitamin A, iron and iodine, and appropriate nutritional care of sick and severely undernourished children. According to UNICEF[56] IYCF needs to be addressed in emergencies for the following reasons:

- The risk of death increases markedly in emergencies for vulnerable children. Breast-feeding is safe, free and a crucial life-saving intervention.
- The risk of diarrhoea and other illnesses in older children increases in emergencies, and continued breast-feeding reduces this risk.
- The high risk of under-nutrition during emergencies can be reduced with optimal IYCF practices.
- Emergencies exacerbate the risks of not breast-feeding or of mixed feeding.
- Distribution of BMS undermines breast-feeding and cause illness and death.
- Safe, adequate and appropriate complementary feeding, which significantly contributes to the prevention of under-nutrition and mortality in children after 6 months of age, is often jeopardised during emergencies and needs particular attention.

Use of mother-to-mother support to promote optimal IYCF

Raising awareness of positive feeding practices and risks of artificial feeding, and broadcasting information on the available services is part of WV's role in establishing a supportive environment for IYCF. During a crisis, traditional and informal support for breast-feeding may diminish. Using community advocates to reach women and establishing support groups (breast-feeding corners) have been successful approaches in various emergency settings. Peer-support group facilitators can be selected from the community. Ideally, these women have

- experience in breast-feeding their infants for at least one year
- the desire to share breast-feeding and infant feeding information with other women
- good communication skills
- been supported by family and local health-care providers to be community advocates.

Further guidance on establishing breast-feeding corners can be found in the 'What happens in WAIFS' section (p40).

Breast-feeding

Breast milk alone provides ideal nutrition for young infants and can also contribute significantly to the nutrition of older infants and young children. Breast milk provides valuable protection from infection and its consequences. Exclusively breast-feeding for six months could prevent 13 per cent of all child deaths.[57] However, many communities and humanitarian responders carry the misconception that mothers cannot breast-feed during a crisis, and therefore do little to protect and promote breast-feeding.

WV's IRA should include the review of practices of breast-feeding mothers and the use of BMS. In some contexts, mothers are using BMS[58] and will need to source these products during an emergency to continue to feed their babies, if they are not lactating. Breast-feeding and relactation should be promoted, and staff should be trained prior to an emergency to provide qualitative support to mothers. Mothers who established replacement feeding prior to the emergency need to be supported to continue this method. We need to ensure that our response procedures reflect World Vision's Milk Policy[59] and the International Code of Marketing of Breast-Milk Substitutes.[60]

56 UNICEF (2011). Nutrition section, *Programmes, Programming Guide Infant and Young Child Feeding.*

57 Save the Children (2010). *Department of Health and Nutrition Overview.*

58 Example criteria for temporary or long use of BMS include absent or dead mother, very ill mother, relactating mother until lactation is re-established, HIV-positive mother who has chosen not to breast-feed, infant rejected by mother, mother who was artificially feeding her infant prior to the emergency, rape victim not wishing to breast-feed. Care should be taken that no stigma is attached to choosing to use infant formula.

59 Available on wvcentral.org (log-in required).

60 The International Code, adopted by the World Health Assembly, aims to protect and promote breast-feeding by ensuring proper use of breast-milk substitutes when these are necessary, and to ensure that adequate information and appropriate marketing and distr bution are provided. http://www.who.int/nutrition/publications/infantfeeding/9241541601/en/.

This can be done by establishing a supportive environment for breast-feeding (privacy, building confidence in women in their ability to produce milk), ensuring access to adequate nutrition and hydration to stimulate milk supply and preventing untargeted distribution of BMS and milk products.

For HIV-positive mothers, adhering to antiretroviral (ARV) treatment while breast-feeding can reduce postnatal HIV transmission. The protection effects of breast milk against communicable diseases in emergencies increase the likelihood of survival of infants born to HIV-infected mothers, even in areas where ARVs are not readily available.

Breast-feeding mothers of severely malnourished infants under 6 months should receive a supplementary ration, regardless of their own nutritional status. If mothers meet the criteria for treatment of severe acute malnutrition, then they too, should be admitted for treatment.

WAIFS strategic approach

Women- and infant-friendly spaces[61] (WAIFS) is one approach used to ensure support to mothers and breast-feeding women. It provides a safe place for young children and mothers immediately after an emergency, while other family members see what can be salvaged from their homes and livelihoods, locate family members who have been separated in evacuation or flight, and register for emergency support. WAIFS should be established as part of our first response.

WAIFS are not the exclusive approach of WV, as other organisations such as UNICEF, Save the Children and *Action contre la Faim* use similar women and child-friendly spaces. Experience from Pakistan and Haiti WAIFS are informing the development of WV's operational guidelines, which are forthcoming. Further operational research is needed to determine the impact of WAIFS.

WAIFS success

WAIFS in Pakistan and baby-friendly areas in Haiti were successful largely due to cooperation with the health and nutrition clusters, Departments of Health and WV's WASH, food, protection and health sectors.

In both responses, the WAIFS were linked closely with mobile or static health clinics to ensure that medical treatment was accessible. Staff followed up referrals for treatment of malnutrition and obstetric care to ensure that women and their children made use of the specialist services. In order for women to be able to access health services and be able to leave the seclusion of their tents, WV Pakistan, in collaboration with the camp committee, set up women-friendly space as a waiting room and safe areas for women to meet in privacy to share with each other and receive treatment. Because of this safe place, other activities for women were conducted, which assisted with their psychological well-being as well as their physical health.

61 For further information, see wvcentral.org (log-in required).

What happens in WAIFS?

WAIFS provide shelter and space for women and children and promote a sense of community, an approach particularly needed in densely populated urban crisis or in situations where women's freedom and/or protection are limited. WAIFS provide an opportunity for women to build a community of social support so they can better attend to their children's needs.

WAIFS require support from the local community (males and females) and a local facilitator to support the programme and keep the space clean and interesting (e.g. a social worker, nurse, teacher, mother or grandmother). Facilitators should be trained in psychosocial first aid on how to reduce stress and counter depression, as maternal depression has been linked with a fourfold increased risk of babies being underweight at 6 months.[62] The enclosed and covered space must be clearly marked and safely accessible. Clean drinking water, water for bathing and washing utensils and clothing as well as sanitation and waste disposal facilities should also be available at the WAIFS.

Main features of a WAIFS include

- quiet and secure place for breast-feeding along with support and advice for women to breast-feed, relactate, and reduce existing breast-feeding practices that are inappropriate
- advice and supplies for improved infant feeding and weaning practices
- nutrition surveillance and growth monitoring (weighing scales, MUAC tape) and referral for supplementation, where required, along with child care and parent-child development education and materials (items and privacy for bathing children, toys, materials to assist with parent-child bonding, play, exercise, language growth and cognitive stimulation)
- women's self-care (feminine hygiene materials, high-energy snack foods)
- basic medical services or regular visits from health professionals for ANC/PNC checks
- staff who can identify conditions requiring referral to affordable (or free) health care, including emergency transport for critical cases (where medical services are not offered in the WAIFS)
- health and hygiene education (materials, posters, dialogue sessions on IYCF and nutritional advice for pregnant and lactating women)
- informal psychosocial support through discussion groups for issues women face (positive coping strategies, child protection, malnutrition, early forced marriage and other forms of sexual and gender-based violence)
- referral to further mental health support for women who are not coping or are exhibiting symptoms of distress
- other culturally acceptable and desired activities (sewing machines, basket-weaving materials, cooking utensils).

62 Rahman et al. (2004). 'Impact of Maternal Depression on Infant Nutritional Status and Illness: A Cohort Study', *Archives of General Psychiatry,* 61:946–52.

COMMUNITY MANAGEMENT OF ACUTE MALNUTRITION

World Vision acknowledges that deterioration of children's nutritional status may be a result of disease or shifts in caring behaviours during an emergency, and not only the result of poor access to and availability of food. We consider issues of hygiene and food preparation, safe water and feeding practices in order to determine which nutritional intervention is needed in the humanitarian context.

Food shortage, lack of diversity in food, poor breast-feeding and complementary feeding practices, along with high rates of communicable diseases in emergency settings greatly impact the child's nutritional status. Mortality rates among children under 5 are considerably higher in emergency-affected populations due to the synergy of a high prevalence of malnutrition and increased incidence of communicable diseases. Even for children who are mildly malnourished, the risk of death from a bout of illness is twice that of well-nourished children. The risk is greater still for those who are severely malnourished.

As part of emergency preparedness, WV should ensure that staff have competencies to screen for and manage acute malnutrition and in IYCF counselling and specific emergency response approaches, such as integrating IYCF into CMAM. Providing IYCF education within CMAM and at food-distribution points can help build a supportive environment for optimal feeding practices.

If the acute malnutrition level in children is above the WHO standard of 15 per cent,[63] World Vision coordinates with the nutrition cluster for possible initiation of CMAM. Further details on benchmarks and recommended action can be found in the annexed decision tree (Table 18).

WV will also work with the WFP to estimate the food deficit and the appropriate food-ration size, and to determine the appropriate and acceptable rations and/or ready-to-use supplementary foods for children under 5 years and the appropriate micronutrient supplementation for children within the humanitarian context.

Promoting appropriate complementary feeding

Each child's needs for complementary food will vary due to differences in breast-milk intake and growth rate. Further guidance can be found in the *Guiding Principles for Complementary Feeding of the Breast-fed Child*. The energy needs from complementary foods for infants with 'average' breast-milk intake in developing countries ranges from 200 kcal per day for 6- to 8-month-olds to 550 kcal/day for 1- to 2-year-olds. WHO recommends starting complementary foods at 6 months in addition to breast milk, initially two to three times a day between 6 and 8 months, increasing to three to four times daily for 9- to 11-month-olds, and introducing two snacks between meals for 12- to 24-month-olds.

Age	Texture	Frequency	Amount at each meal
6 months	Soft porridge, well mashed veggies, meat, fruit	2x per day plus frequent breast-feeds	2–3 tablespoons
7–8 months	Mashed foods	3x per day plus frequent breast-feeds	Increasing gradually to 2/3 of a 250 ml cup at each meal
9–12 months	Finely chopped or mashed foods, foods baby can pick up	3 meals plus 1 snack between meals plus breast-feeds	3/4 of a 250 ml cup or bowl
12–24 months	Family foods, chopped or mashed if necessary	3 meals plus 2 snacks between meals plus breast-feeds	A full 250 ml cup or bowl

63 If the prevalence of acute malnutrition is >=15 per cent in children 6 to 59 months, this constitutes emergency action. This is context specific, and aggravating factors such as crude mortality rate of greater than 1/10,000/day, epidemic of measles or whooping cough, high prevalence of ARI or diarrhoeal diseases should be taken into consideration.

Table 7. DADDs for nutrition in emergencies

	Preparation	Start-up phase (30–90 days)		Don't do
		Do	Assure	
Nutrition: PLW, IYCF and CMAM	• Disseminate and ensure familiarity with WV milk policy among staff. • Build awareness of cultural feeding practices. • Train staff on breast-feeding and relactation support. • Train staff on nutrition in emergency essentials. • Establish links with UNICEF, WFP to provide ready-to-use therapeutic food (RUTF), food rations. • Build relationship with WV FPMG.	• Create awareness among staff of WV milk policy, operational guidance on infant feeding in emergencies, the Code. • Establish protected, safe, supportive environment for women for breast-feeding and IYCF, where necessary (WAIFS). • Ensure availability of age-appropriate nutritionally adequate complementary foods. • Demonstrate hygienic food preparation, storage and serving. • Screen for and manage children and PLW for acute malnutrition and micronutrient deficiencies with CMAM or referral to appropriate services. • Ensure that de-worming drugs are available at CMAM sites. • Provide education in food-distribution points and in CMAM on importance of EBF, continued breast-feeding (BF), complementary foods. • Provide micronutrient supplementation, even if food rations are fortified. • Provide vitamin A supplementation for all children under 5 (and other micronutrient supplementation where required).	• Households with newborn children under 24 months and breast-feeding/pregnant women are registered and linked to food assistance programmes, assuring the mother has adequate nutrition during pregnancy and breast-feeding. Food-distribution planners take into account additional needs of PLW (food rations fortified). • Appropriate lipid-based nutrient supplement (Nutibutter, CSB++) for infants between 6–24 months and/or micronutrient powder for children under 5 and pregnant and lactating women are part of general food basket, where appropriate. • Acutely malnourished infants under 6 months are referred to skilled breast-feeding support and inpatient care. • Acutely malnourished children over 6 months are referred to appropriate intervention. • Mothers of malnourished infants under 6 months receive a supplementary ration, regardless of their nutritional status. • All nutrition and food aid supplies meet with WV policies, including milk policy.	• Accept unsolicited donations of BMS, bottles or teats/nipples. • Include BMS, or other milk products in general ration distribution (only to be given mothers and infants who meet strict criteria). • Implement centralised therapeutic feeding centre (in the absence of outpatient therapeutic care).

CHAPTER 13. CHILD HEALTH

Illness and death from communicable diseases tend to increase during disasters. Mortality from communicable disease among populations affected by emergencies is largely preventable.

Four major infectious diseases have been attributed to between 60 per cent and 90 per cent of deaths in many conflict settings (acute respiratory infections, diarrhoea, measles and malaria where endemic).[64] The increased risks of communicable diseases during a crisis and displacement are due to overcrowding, lack of safe water, poor sanitation, collapse of preventive public-health measures such as vector control and immunisations, lack of access to basic health services and poorly trained health staff.

Health education is an essential component of World Vision's prevention and outbreak response. Messages can be disseminated through community outreach mechanisms, home visits, radio and mobile phones. Community health education on prevention should include proper use of LLIN, food hygiene, hand washing, symptoms, and the importance of early care seeking and treatment of common childhood illnesses.

DIARRHOEA

Proper hygiene and food handling is critical for preventing diarrhoeal disease in young children. The incidence of diarrhoeal diseases peaks between 6 and 12 months of age, as the intake of complementary food increases.

Consultations and collaboration with WASH are essential in planning the 'hardware' components necessary to support prevention behaviours (protecting wells, chlorination of drinking water, adequate sanitation and proper waste management). The WASH cluster CD has hygiene promotion materials and training materials, and WV is in the process of developing a basic sanitation model, a full community-based WASH model, a WASH in schools model and a WASH in emergencies model approach.

Cholera

Cholera causes acute onset of watery diarrhoea and without treatment can lead to death within hours. Individuals with lower immunity, such as malnourished children and those living with HIV or AIDS are more susceptible to cholera and its effects. Prevention efforts (clean water, proper sanitation, health education on hygiene and hand washing with soap) are vital in emergency contexts. Once an outbreak is detected, WV should aim to minimise the spread through prevention approaches and ensuring access to treatment. Prevention and control of cholera should be part of the NO disaster preparedness plan. In addition to planning for health education and WASH measures, pre-positioning of ORS, cholera treatment kits and the early use of oral cholera vaccine should be considered.[65]

ACUTE RESPIRATORY INFECTIONS, PNEUMONIA

ALRIs are often seen in children less than 5 year of age. Risk factors such as lack of breast-feeding, upper respiratory infection in mother or siblings, inappropriate immunisation for age, low birthweight (LBW), and malnutrition increase the child's susceptibility to ALRI. In emergencies, overcrowding due to population displacement and in-door pollution from firewood are challenges. WV assures appropriate treatment for ALRI (pneumonia) within 24 to 48 hours of symptoms. Some offices are promoting community-based treatment of pneumonia by CHWs. If this is the situation in the area, then this approach should be promoted during emergency response.

MALARIA

In malaria-endemic areas, World Vision's goal is universal coverage of long-lasting insecticidal nets (LLINs). WV prioritises distribution of LLINs to severely malnourished people enrolled in CMAM and members of their households, pregnant women, and children under 2 years of age. Thereafter, those enrolled in supplemental feeding programmes, children under 5 years of age, and household members of pregnant women and children under 2 receive LLINs. Health staff provide education on proper use of mosquito nets during commodity distribution and follow up on use after distribution. In the longer term, community members can be trained and mobilised to take on this health education role.

64 The Sphere Project (2011). *Humanitarian Charter and Minimum Standards in Humanitarian Response,* 311.
65 World Vision International (2008). *Prevention and control of Cholera: Recommendations to WV National Offices.* Available on wvcentral.org (log-in required).

Table 8. DADDs for child health

	Preparation	Start-up phase (30–90 days)		Don't do
		Do	Assure	
Child health	• Reinforce staff skills in monitoring disease outbreak potential, developing outbreak preparedness plans based on risk assessment. • Establish links with MoH (and/or health cluster lead agency) disease surveillance unit.	• Work with community to ensure accurate and relevant health, HIV, nutrition and hygiene messages on prevention, early care-seeking and treatment. • Monitor diseases of outbreak potential based on epidemiologic risk and respond according to appropriate plans and protocols. • Report surveillance data to MoH and/or health cluster lead agency. • Community management of communicable diseases using WHO and/or MoH protocols. • Mobilise community for outbreak case identification and prevention activities. • Promote hand washing with soap. • Ensure ORS is available at home level along with zinc supplementation for children under 5 years with diarrhoea. • Work with partner organisation to mobilise community for measles vaccination programme. • Provide vitamin A supplement to children under 5 years. • Promote positive care-seeking, and provision of LLIN in malaria-endemic areas. • Provide hats/warm clothing in cold climate. • Collaborate with WASH and shelter sectors.	• Standardised case management protocols used in clinical settings. • Children with pneumonia have access to adequate treatment within 24 to 48 hours. • Outreach workers familiar with community case management of pneumonia. • Effective antimalarial treatment available for children and pregnant women (artemisinin-based combination therapy) where malaria is endemic. • Measles immunisation. • Access to clean water and sanitation facilities.	• Provide emergency H/N assistance only to sponsored children to the exclusion of children of similar status.

CHAPTER 14. INTEGRATION AND CROSS-CUTTING THEMES

When designing a technical MNCH response, it is vital to link with other sectors. For example,

- WASH: Positive hygiene practices to prevent childhood illnesses are dependent upon appropriate water and sanitation hardware, as well as ample hygiene promotion within the community to instil positive practices.
- Shelter: Site planning is important to reduce overcrowding, which is known to facilitate spread of communicable disease, as well as to prepare safe corridors to schools, health facilities and distribution points. Adequate shelter, with adequate ventilation and protection from vectors is important in maintaining aspects of health.
- Food Security and Livelihoods: There are many opportunities within food distribution, livelihood activities and management of malnutrition sites to incorporate MNCH health-promotion messages.

CHILD PROTECTION

World Vision takes special measures in emergencies to protect children from harm and enable equitable access to services. World Vision's holistic system approach to child protection aims to prevent and respond to neglect, exploitation and abuse for all children. A systems approach seeks to do the following:

- address child protection issues in a comprehensive and sustainable manner
- affirm the role of parents and caregivers as those first responsible for care and protection of children
- affirm the responsibility of states to guarantee the care and protection of children, through respecting, protecting and fulfilling their protection rights outlined in the Convention on the Rights of the Child and other international human rights instruments
- strengthen the protective environment for all children.

WV promotes child protection by preventing separation of families, enabling access to services, including unaccompanied minors, without discrimination and reducing the risk of gender-based violence through measures such as adequate shelter and lighting, and safe venues for women and children.

Use of information and communication technology to promote access to health information and services

After the December 2004 tsunami, only half of the midwives remained (600) to serve 226,000 people living in Aceh Besar district in Indonesia. World Vision distributed mobile phones to 120 midwives to facilitate communication between midwives and doctors within the 22 medical centres and to provide health advice and counselling in remote areas. A control group of 103 other midwives was also monitored. The midwives with mobile phones

- spoke more often to one other, their coordinators and doctors (especially during emergencies) to seek advice and information
- could provide patients with instant advice and diagnosis
- were more likely to turn to health-centre personnel for medical information than those in the control group
- increased their performance in standard procedures for childbirth processes as compared with their baseline test scores.

WV continues to explore information and communication technology (ICT) solutions through mHealth Alliance, which supports mobile-based or mobile-enhanced solutions for health services, and NetHope, which helps establish communication during emergencies and explores ways ICT can be used in health responses. You can stay informed by becoming a member of Health UnBound, a global online space to access information and dialogue about how ICT, particularly mobile phones, can improve MNCH outcomes in various contexts, including fragile contexts and emergencies.

HEALTH PROMOTION AND DISEASE PREVENTION

World Vision has strength in community empowerment, mobilisation and behaviour change communication. Activation of organised groups such as children's or adolescent clubs, and women's and infant-friendly spaces is an excellent way to share health information and promote positive health and caring practices. Messages on major maternal, neonatal and child health problems and symptoms, health risks and location of information, advice and services can be provided through community outreach and/or mass media, including the use of mobile phone messaging where feasible.

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

World Vision's experience with children and adolescents who are affected by a crisis is that children will usually display initial signs of distress, including memories of the event, nightmares, some social withdrawal, difficulty concentrating and sometimes regression to previous developmental behaviours (e.g. bed-wetting or thumb-sucking). Most children and adolescents regain normal functioning once their basic survival needs are met, safety and security have returned, and routines and regular activities (e.g. education and play) have been re-established. Most importantly, they will respond best when they are engaged in familiar or family contexts, with appropriate care and protection from their regular caregivers and feel a sense of belonging within their community.[66]

WAIFS provide an opportunity for women to build a community of social support so they can better attend to their children's needs. These programmes also offer an ideal opportunity to support and teach women to interact and play with their infants and children in ways that stimulate their development and enhance attachment between mother and child.

All staff working with children and adults affected by crises should be trained in basic psychological first aid so that they can provide care for people experiencing emotional distress. Further training guidance can be found in *Psychological first aid: Guide for field workers*.[67]

The WHO places mental health within the primary healthcare package and recommends training healthcare providers at first- and second-level facilities to identify and manage a number of priority conditions, such as depression, psychosis, bipolar disorders, epilepsy, developmental and behavioural disorders in children and adolescents, dementia, alcohol use disorders, drug use disorders, self-harm/suicide and other significant emotional or medically unexplained complaints. The WHO *Mental Health GAP (mhGAP) Intervention Guide*[68] provides further details about how this care can be provided.

66 Inter-Agency Standing Committee (IASC) (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, Geneva.

67 World Health Organization (2011). *Psychological first aid: Guide for field workers*. http://whqlibdoc.who.intpublications/2011/9789241548205_eng.pdf.

68 World Health Organization (2010). *mhGAP Intervention Guide: for mental, neurological and substance use disorders in non-specialized health settings*. http://whqlibdoc.who.int/publications/2010/9789241548069_eng.pdf.

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007) encourages well-integrated psychosocial care which builds on existing capacities, upholds cultural norms and reaches more people than stand-alone services. MHPSS for people affected by crisis is an important consideration for World Vision.

Interventions addressing MHPSS fall into four categories:[69]

1. **Basic services and security.** The well-being of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs. An MHPSS response to the need for basic services and security may include: advocating that these services are put in place with responsible actors; documenting their impact on mental health and psychosocial well-being; and influencing humanitarian actors to deliver them in safe, dignified, socio-culturally appropriate ways that promote mental health and psychosocial well-being.

2. **Community and family supports.** The second layer represents the emergency response for a smaller number of people who are able to maintain their mental health and psychosocial well-being if they receive support to connect with key community and family supports. Useful responses at this layer include assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women's groups and youth clubs.

3. **Focused, non-specialised supports.** The third layer represents the supports necessary for a smaller number of people who also require more focused individual, family or group interventions by trained and supervised workers (but who may not have had years of training in specialised care and are ideally selected from within the culture or affected community). For example, survivors of gender-based violence might need a mixture of emotional and livelihood support from community workers. This layer also includes psychological first aid (PFA) and basic mental health care by primary health-care workers.

4. **Specialised services.** The top layer of the pyramid represents the additional support required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of primary/general health services.

69 Inter-Agency Standing Committee (2007).

PART FOUR
Technical Tools

Technical tools include the following:

- A summary table of 'Do' actions provides a quick snapshot of key WV actions in relation to Sphere standards.
- The assessment tool[70] describes some of the key health issues likely to arise from various forms of disasters. Staff needs to confirm the likelihood of these issues in an initial assessment. A high likelihood will automatically be a trigger for further investigation.
- Response tools comprise DADDs, preparation checklist, operations checklist and technical checklist.
- Monitoring indictors to assist programme staff in designing indicators with thresholds, frequency of collection, and data source for 'Do' and 'Assure' activities

TOOL 1. MNCH AND NUTRITION KEY EMERGENCY RESPONSE ACTIONS

DISCLAIMER: The summary table below represents World Vision's direct efforts in addressing MNCH and nutrition in emergency settings, the DOs. The table does not address the ASSUREs, emergency preparedness or early recovery efforts. Some approaches presented in the table require competent experienced emergency health staff, strategic training, and/or partnerships, which may not be available in all World Vision programmes at this time or may not be implemented until the emergency situation stabilises.

CCD – Control of communicable disease; CH – Child health; EHS – Essential health services; FSN – Food security and nutrition; IYCF – Infant and young child feeding; SRH – Sexual and reproductive health

Table 9. Summary of possible response actions linked to the Sphere standards

	Key emergency response actions (DO)	Sphere standards
Communication, accountability	Response has communication mechanisms with the community to describe project, access, lodge complaints (e.g. help desks).	Core standard 1: People-centred humanitarian response
Resource mobilisation	Health status updates inform fundraising in order to mobilise financial resources for providing free health services at the point of delivery to the affected population for the duration of the disaster.	Health system standard 4: Health financing
Coordination	Engage with internal and external coordination mechanisms.	Core standard 2: Coordination and collaboration
	Actively participate in national and sub-national coordination mechanisms.	Core standard 2: Coordination and collaboration
	Engage with the health cluster lead agency and specific subsector focal-point agencies and appropriate cross-cutting themes.	Health system standard 6: Leadership and coordination
Supplies and logistics	Support the health system to ensure consistent availability of essential medicines and equipment for the treatment of common illness.	Health system standard 3: Drugs and medical supplies
	Ensure that reserve stocks of essential medicines and material are available for potential outbreaks or can be procured rapidly from a pre-identified source.	EHS: Control of communicable diseases standard 3

70 World Vision (2010). *Disasters and Emergencies and their Public Health Implications and Possible Health Responses.*

Table 9. Summary of possible response actions linked to the Sphere standards (continued)

	Key emergency response actions (DO)	Sphere standards
Staff competencies	Services are provided by trained and competent health work-forces who have an adequate mix of knowledge and skills to meet the health needs of the population.	Health system standard 2: Human resources
	All staff use standard universal precautions when dealing with blood, bodily fluids and medical waste.	EHS – SRH standard 2: HIV and AIDS
	Staff plan and provide a systematic approach for health messages on major MNCH problems and symptoms, health risks and location of information, advice and services (at CMAM, food-distribution sites, activation of groups/ clubs, WAIFS and/or mass media, including the use of mobile phone messaging where feasible).	Water supply, sanitation and hygiene promotion standard – Hygiene promotion standard 1: Hygiene promotion implementation
Information management	Conduct rapid systematic assessment to identify the context, risks and capacity of affected people, available services and priority needs of the disaster-affected population.	Core standard 3: Assessment
	Design response to meet specific needs and reduce vulnerability to future hazards; with evidence-based information of why and how changes are needed to improve humanitarian outcomes.	Core standard 4: Design and response
Reproductive health STIs/HIV, SGBV, family planning	All health staff are aware of SGBV and assure referrals for clinical management and psychosocial support.	EHS – SRH standard 1: Reproductive health
	Integrate STI management in antenatal, delivery and postpartum period.	EHS – SRH standard 2: HIV and AIDS
	Establish and implement workplace policies for occupational exposure, including availability of PEP.	EHS – SRH standard 2: HIV and AIDS
	Encourage dual protection and condom availability, if appropriate (and consider targeting where adolescents meet).	EHS – SRH standard 2: HIV and AIDS
	Prevent sexual violence through integrated protection mechanisms.	
Pregnancy	Provide malaria prevention (LLIN) and promote care seeking for malaria Assure treatment access and intermittent preventive treatment in malaria-endemic region.	EHS – CCD standard 1: Communicable disease prevention
	Provide clean delivery kits and information package to visibly pregnant women, where access to trained professional/facility is not possible – MISP.	EHS – SRH standard 1: Reproductive health

Table 9. Summary of possible response actions linked to the Sphere standards (continued)

	Key emergency response actions (DO)	Sphere standards
Childbirth; Essential newborn & maternal care	Establish links, including communication and transport, to referral hospitals or centres for obstetric complications – MISP.	EHS – SRH standard 1: Reproductive health
	Provide essential newborn and maternal care within 24 to 48 hours after delivery by medical personnel (or trained CHWs) in facilities and through home visits.	EHS – CH standard 2: Management of newborn and childhood illnesses
Nutrition PLW IYCF CMAM	Ensure staff aware of WV milk policy, operational guidance on infant feeding in emergencies and the International Code of Marketing of Breast-Milk Substitutes and subsequent WHA resolutions (the Code).	FSN – IYCH standard 1: Policy guidance and coordination
	Ensure adequate diet and supplementation (iron, folic acid, micronutrient supplementation) for PLW. Provide management of acute malnutrition and micronutrient deficiencies.	FSN – IYCF standard 2: Basic and skilled support FSN – Food transfers standard 1: General nutrition requirements FSN – MAM and micronutrient deficiencies standard 1: Moderate acute malnutrition (MAM) and standard 2: Severe acute malnutrition SAM
	Support appropriate breast-feeding (establish IYCH safe space, such as WAIFS).	FSN – IYCF standard 2: Basic and skilled support
	Provide appropriate, safe and timely complementary feeding.	FSN – IYCF standard 2: Basic and skilled support
	Ensure an appropriate nutritional care for the undernourished (management of acute and severe malnutrition).	FSN – MAM & micronutrient deficiencies Standard 1 MAM and Standard 2 SAM
Child health	Promote prevention (LLINs) and care seeking for malaria; malaria treatment – recommended artemisinin-based combination therapy.	EHS – CCD standard 1: Communicable disease prevention
	Promote mass vaccination against measles (with vitamin A supplementation), as indicated.	EHS – CCD standard 1: Communicable disease prevention
	Ensure children with pneumonia have access to adequate treatment within 24 to 48 hours of symptoms.	EHS – CH standard 2: Management of newborn and childhood illnesses
	Provide ORS – available at home level, for the treatment of dehydration – with zinc supplementation.	EHS – CH standard 2: Management of newborn and childhood illnesses
	Provide vitamin A supplementation for all children under the age of 5.	FSN – Management of acute malnutrition and micronutrient deficiencies standard 3: MN deficiencies
	Promote hand washing with soap.	WASH – Water supply standard 3: Hygiene promotion standard 1

TOOL 2. HEALTH IMPLICATIONS ASSESSMENT TOOL

This tool is intended to be used as follows:

Where? Sudden-onset disasters.

Why? To identify risk factors requiring further investigation in rapid assessments and appraisals, such as the WV BRAT.

To identify health conditions of the population and possible key actions. Often, a number of risk factors are combined to lead to the suggested emergency responses.

Many of the likely risk factors are cross-cutting and contribute to multiple conditions. For example, 'displacement' can increase malaria (movement from low-risk zone to malaria-endemic areas, lack of LLINs); sexual abuse (unaccompanied minors, women and girls); unsafe childbirth (lack of health care and clean delivery kits); ARI (lack of shelter, adequate clothing, health care).

How? Use currently available secondary data reports, key informants at national and local level, observational (drive/walk through), satellite imagery, to inform your responses.

When? First one to two days of the sudden-onset disaster.

Who? NO managers and/or health coordinators.

According to your current knowledge of the situation (food, cyclone, hurricane, tropical storm, earthquake, volcano, drought, or conflict), apply the following guidelines:

1. Rank each situation as high, medium or low likelihood, or not applicable. **This ranking is relative, subjective and qualitative in nature.** Benchmarks and WV thresholds for action can be used once more information is gathered. **This is a snapshot in time and is likely to change.**
2. Any risk factors ranked as 'high likelihood' should be further investigated while immediate-priority responses are being planned and implemented.
3. Suggested priority actions are indicated in the table for consideration and contextualisation. **Remember, this is a snapshot in time and the situation and appropriate responses are likely to change.**

Table 10. Health risks after emergencies and possible responses

Injury What is the likelihood of these FSN-related risk factors in the current humanitarian situation?						
Risk factor	**High**	**Med**	**Low**	**N/A**	**May lead to**	**Possible WV responses in high-likelihood situations**

Injury 1.
High demand for life-saving services related to trauma
					• Undersupplied and overstretched health infrastructure to deal with increased case load of:
					  • Fractures, wounds and asphyxiation
					  • Wound infection (tetanus)
						• Establish basic first aid response
						• Establish temporary mobile clinics

Injury 2. Destruction or interruption of medical supplies and routine services					• Limited staff and supplies for trauma response and for routine services such as assisted deliveries, antenatal/postnatal care, immunisations	• Establish basic first aid response • Establish temporary mobile clinics
Injury 3. Foreign bodies in the eyes from ash or debris					• Conjunctivitis, corneal abrasions	• Respond with basic first aid • Ensure appropriate shelter
Injury 4. Contact with hot ash, gases, rock and magma, acid rain Inhalation of fine ash and chemicals including silicon dioxide, hydrochloric acid or hafnium, siliceous dust, crystalline silica					• Skin, eye, and lung burns, asphyxiation • Lung damage to small infants, elderly or those suffering from existing respiratory illnesses (from acid gas and ash) • Asthma, exacerbation of pre-existing lung irritation or disease • Silicosis, if heavy exposure for years	• Respond with basic first aid • Assure appropriate shelter planning to protect from debris, ash, gases, etc.

Table 10. Health risks after emergencies and possible responses (continued)

Food security and nutrition What is the likelihood of these FSN-related risk factors in the current humanitarian situation?						
Risk factor	**High**	**Med**	**Low**	**N/A**	**May lead to**	**Possible WV responses in high-likelihood situations**
FSN 1. Pregnant and lactating women have limited access to appropriate nutrition and water					• Malnutrition • Dehydration • Decreased supply of breast milk	• Support establishment of safe space, such as women/baby-friendly zone to support IYCF, such as breast-feeding and relactation • Register households with newborns, children under 24 months and breast-feeding/pregnant women, and link to food assistance • Link with nutrition team to establish CMAM (screen for and manage malnutrition) • Advocate that appropriate lipid-based nutrient supplement (Nutibutter, CSB++) for infants between 6 and 24 months be part of general food basket, where appropriate • Plan referral mechanism for acutely malnourished infants under 6 months to receive skilled breast-feeding support and inpatient care • Ensure that all nutrition and food aid supplies meet with WV policies, including milk policy • Work with food-distribution teams to ensure adequate nutrition in distributed food basket
FSN 2. Exclusive breast-feeding not supported or sustained during emergency					• Early weaning and initiation of inappropriate complementary foods • Malnutrition	
FSN 3. Optimal complementary foods not available					• Food shortage • Lack of food diversity • Micronutrient deficiencies • Malnutrition, associated with 1/3 of all childhood deaths • Weakened immune system, increased susceptibility to infection • Risk of death from a bout of illness for malnourished children under 5 (twice that of well-nourished children)	
FSN 4. Nutritionally diverse foods in low supply or not available						
FSN 5. Agriculture/cultivation can no longer be practised during emergency						
FSN 6. Agriculture produce spoiled, swept away or destroyed						
FSN 7. Livestock starved, swept away or destroyed						

Table 10. Health risks after emergencies and possible responses (continued)

Water-related diseases What is the likelihood of these FSN-related risk factors in the current humanitarian situation?						
Risk factor	**High**	**Med**	**Low**	**N/A**	**May lead to**	**Possible WV responses in high-likelihood situations**
WASH 1. Clean water scarcity					• Poor personal hygiene and sanitation • Poor utensil and food hygiene • Cholera • Typhoid • Hepatitis A and E • Shigellosis • Other diarrhoeal diseases • Malnutrition in children: Unsafe drinking water can cause diarrhoea and other water-related illnesses, interfering with the ability to eat and resulting in defective digestion, absorption or metabolism of food molecules. As a result, the immune system is weakened and the body is susceptible to infections, which could lead to malnutrition.	• Mobilise pre-position supplies (cholera treatment kits, ORS) • Initiate outbreak surveillance • Link with WASH programme for hygiene kits, health promotion, home-based treatment of water, hand washing and appropriate hardware, etc.
WASH 2. Contaminated drinking water						
WASH 3. Population in direct contact with polluted waters/ human faeces (human waste infiltrating ground and/or river water)						
WASH 4. Continuous moist, damp environment					• Dermatitis, conjunctivitis, and ear, nose and throat infections • Hypothermia	• Pre-position warm bedding, clothing, hats for distribution • Refer to clinical services
WASH 5. Exposed for too long to cold water						

Table 10. Health risks after emergencies and possible responses (continued)

Communicable dieease and childhood illness What is the likelihood of these WASH-related risk factors in the current humanitarian situation?						
Risk factor	**High**	**Med**	**Low**	**N/A**	**May lead to**	**Possible WV responses in high-likelihood situations**
CD/CH 1. Population displacement, overcrowding					• Easy person-to-person spread of diseases • Increased disease incidence • Measles • Diphtheria • Tuberculosis • Polio • Pertussis • Meningitis	• Advocate and work with partner organisation to mobilise community for measles (and other disease) vaccination programmes
CD/CH 2. Collapse of preventive public-health measures such as immunisation and vector control						
CD/CH 3. Malnutrition					• Increased disease-related mortality • Increased mortality rate among children under 5 due to the synergy of a high prevalence of malnutrition and increased incidence of communicable diseases	• Link with nutrition team to establish CMAM (screen for and manage acute malnutrition)
CD/CH 4. Cold weather, immersion in water					• ALRIs (affects children under five years) • Acute respiratory infection	• Consult with government and other actors to establish case finding • Ensure children with pneumonia have access to adequate treatment within 24 to 48 hours of symptoms
CD/CH 5. Lack of shelter and adequate clothing						
CD/CH 6. Lack of access to basic health services						

Table 10. Health risks after emergencies and possible responses (continued)

Vector-borne diseases What is the likelihood of these disease-related risk factors in the current humanitarian situation?						
Issue	**High**	**Med**	**Low**	**N/A**	**May lead to**	**Possible WV responses in high-likelihood situations**
V 1. Changes in habitat (landslide, deforestation, river damming, rerouting water)					• Increased mosquito breeding • Rapid increase in vectors • Malaria (where endemic) • Dengue (where endemic)	• Link with partners for vector control, site planning, clean-up campaigns
V 2. Vector breeding grounds flushed out for first six weeks; rapid increase after initial breeding cycle, as water and rubbish build up						
V 3. Changes in human behaviour (sleeping outside, no LLIN, pause in vector-control activities)					• Increased exposure to mosquito bites • Malaria (where endemic) • Dengue (where endemic)	• Plan for LLIN distribution along with care-seeking information and referral to treatment • Assure adequate protected shelter
V 4. Displacement from areas of low malaria risk to malaria-endemic areas					• Limited immunity within displaced community leading to high case load	
V 5. Humans in contact with damp soil, vegetation or water contaminated by bacteria-infected rodent urine					• Leptospirosis	

Table 10. Health risks after emergencies and possible responses (continued)

Sexual and reproductive health What is the likelihood of these disease-related risk factors in the current humanitarian situation?						
Issue	**High**	**Med**	**Low**	**N/A**	**May lead to**	**Possible WV responses in high-likelihood situations**
SRH 1. Lack of food, assets, protection					• Transactional 'survival sex': risky behaviours to get food and money	• Ensure that post-rape kits and PEP are accessible • Ensure that condoms are accessible (may be distributed via WV hygiene kits) • Identify referral system for SGBV • Use communication channels to inform affected population of the availability of confidential services and importance of rapid incident reporting and immediate care • Register violence (rapid incident reporting)
SRH 2. Fleeing population with high proportion of unaccompanied minors					• Women and girls being vulnerable to sexual abuse • Sexual exploitation and rape • Increased risk of rape • Sexually transmitted diseases, including HIV • Psychological consequences for survivors • Unwanted pregnancies	
SRH 3. Mass displacement						
SRH 4. Violence against civilian populations (acts of sexual and gender-based violence against women and girls)						
SRH 5. Sexual violence pervasive problem in community Unprotected sex					• Male peers raised without social and moral guidance, contributing to sexual violence • Early initiation of sexual activity for youth living in refugee camps	
SRH 6. Disrupted access to clean delivery					• Increase in unsafe home deliveries • Obstetric complications	• Mobilise pre-positioned clean delivery kits; plan for distribution • Connect with other agencies to assess who is doing EmONC • Establish links to referral hospitals or centres for obstetric and newborn complications
SRH 7. Disrupted emergency obstetric care						
SRH 8. Lack of trained midwives						

RESPONSE

The following tools (Emergency MNCH and nutrition DADDs and programming checklist) should be used:

Why? To summarise key interventions that WV should DO and ASSURE in the initial phase. These are in line with, and often reiterate, the Health Nutrition and HIV DADDs[71] for emergencies.

How? Compare the real situation with likely scenarios and interventions on the DADD matrix. Compare proposed actions with the DADD to ensure that plans are in line with WV's discrete set of MNCH and nutrition actions.

When? First week of response.

Who? NO managers, emergency response managers and/or health coordinators.

- The DADDs tool contains preparedness steps, Do and Assure actions for the start-up phase, along with scenario examples. This should be hung in your office space for easy referencing.
- The programming checklist contains a section on preparedness and operations, focusing on elements of communication, collaboration, supplies, staffing and information management. This tool also contains a technical section for programming staff.

Any 7-11 activities in place prior to the emergency should be continued, where feasible, with appropriate adjustments to their scale and extent.

The minimum responses during the start-up phase may last 30 to 90 days, depending upon the scale of the disaster, available services and numbers affected. Many of these activities will continue in the stabilisation, post-emergency phase. Once basic activities are in place, more comprehensive activities described in the 7-11 strategy can be planned for and implemented in the 'stabilisation' phase of the response.

71 Available on wvcentral.org (log-in required).

TOOL 3. EMERGENCY MNCH AND NUTRITION DADD

This table summarises preparedness steps and key actions for the initial phase of a sudden-onset emergency. The preparedness and interventions will depend on whether there is an established WV programme or whether WV is responding to a disaster in a new zone or country. 'Don't do' are activities that either contra-indicate WV policy and/or recognised international protocols or that have not received organisational investment (as other agencies already have competencies in these areas).

Once basic activities are in place, more comprehensive activities described in the 7-11 strategy can be planned for and implemented in the 'stabilisation' phase of the response.

Table 11. Key activities for preparedness and response based on the DADDS

Key World Vision MNCH and nutrition programming interventions in emergency contexts						
	Preparation	Start-up phase (30–90 days)		Sample activities		Don't do
		Do	Assure	Scenario	Likely intervention	
Reproductive health (general)	• Staff understand RH policy • Train male and female volunteers to provide RH messages (prevention and where to go for services) at contact points • Establish workplace policy for occupational exposure, including PEP • Train staff in universal precautions • Train staff in psychological first aid • Pre-position RH supplies, if appropriate	• Encourage health-seeking behaviours and reduced risk taking • Provide referrals for appropriate services, and ensure that the community knows where to go for treatment and support • Staff and service providers sign and abide by code of conduct • Establish and implement staff workplace policies for occupational exposure, including availability of PEP • Enforce universal standard precautions (gloves, clothing, sharps disposal) for infection control • Request for RH supplies, if appropriate	• Safe blood transfusion practice • Consultations and linkages with WASH, shelter, MHPSS team/sector in relation to health-facility site planning, WASH hardware and health-promotion messages, and PSS for women and child • Humanitarian code of conduct against sexual exploitation and abuse, reporting mechanisms, and punitive measures is in place for humanitarian workers and service providers	**Staff in potential contact with blood, or other body fluids**	• Staff workplace policy and enforcing universal precautions • Minimise risk and ensure rapid response to occupational exposure • PEP Kit (UNFPA Health Kit 3, part A and/or IARH Kit 3, Part B) • http://www.rhrc.org/resources/rhrkit.pdf	• Undertake reproductive health interventions that are abortive in nature • Procure, distribute or provide any medications, reagents, remedies or services not in the national/WHO essential medicine list • Invest in expatriate medical teams for clinical care and MHPSS • Provide secondary or tertiary health care including trauma care and surgery

Table 11. Key activities for preparedness and response based on the DADDS (continued)

Key World Vision MNCH and nutrition programming interventions in emergency contexts						
	Preparation	Start-up phase (30–90 days)		Sample activities		Don't do
		Do	Assure	Scenario	Likely intervention	
RH: Adolescent-friendly RH	• Train staff on adolescent-friendly RH counselling; implement mobilisation techniques to reduce prevalence and incidence of STIs, including HIV; prevent unwanted pregnancies	• Encourage dual protection and condom availability, if appropriate • Encourage health-seeking behaviours and reduced risk taking • Provide referrals for RH services	• RH services are sensitive to adolescent needs and social culture • Improve access to and use of youth-friendly services through liaising with local service providers, health cluster partners, or health system	**Assessment suggests high incidence of unprotected sex with high rates of STIs among youth**	• Syndromic STI treatment • Initiate specific health education HIV prevention project, targeting high risk, main transmission routes • Inter-agency RH Kit 3 Part A: ECP and STI treatment • Free male condoms as part of WV hygiene kit	
RH: STI/HIV	• Provide education for staff and community on HIV transmission, prevention behaviour, and demand for services • Train staff in universal precautions and equipment use for infection control	• Staff provide psychological first aid, where appropriate • Promote STI prevention (e.g. condoms, education), including PEP where appropriate • Integrate STI management in antenatal, delivery and postpartum periods, including PEP where appropriate • Where appropriate, initiate preventive HIV programmes, including condom promotion	• Prevention of STI/HIV with free condoms • Syndromic STI treatment and PEP is available • Comprehensive STI case management is available at health service level • ART is available to those already taking treatment , including PMTCT • HIV awareness mainstreamed into all sector activities to ensure project designs do not increase vulnerability to HIV • Family planning is available			• Provide free condom distribution, without proper sensitisation and information • Actively search for new HIV cases and provide VCT or ART to newly diagnosed beneficiaries

Table 11. Key activities for preparedness and response based on the DADDS (continued)

Key World Vision MNCH and nutrition programming interventions in emergency contexts						
	Preparation	Start-up phase (30–90 days)		Sample activities		Don't do
		Do	Assure	Scenario	Likely intervention	
RH: Sexual and gender-based violence	• Build staff awareness of risks of SGBV in this context • Train male and female volunteers to provide these SGBV messages to populations via contact points • Hire female service providers and programme staff	• Use communication channels to inform population of the availability of confidential services, importance of rapid SGBV incident reporting and immediate care • Offer referrals to clinical management and counselling for rape survivors • Provide psychological first aid, where appropriate • Prevent sexual violence through protection mechanisms (e.g. secure, well-lit shelter, WASH) • Provide psychological first aid, where appropriate	• Clinical and psychosocial services to care for victims of rape are available • Humanitarian Code of Conduct is in place • PEP and post-rape kit and counselling are available • Confidential counselling and testing for STIs and HIV is in place (stabilisation) • Safe areas for women and children	**Assessment suggests SGBV is common and increasing and/or high incidence of rape**	• Communication on SGBV (importance of rapid incidence reporting and immediate care) to whole population • Work with partners (skilled in GBV and protection) to assure availability of confidential services (referrals) and prevention measures • Put protection measures in place to prevent violence • Provide staff MHPSS to reduce likelihood of re-traumatising • Post-rape kit accessible	• Provide clinical services for victims of rape • Provide trauma counselling or psychological debriefing
RH: FP		• Provide basic contraception, including condoms, where appropriate • Emergency contraception is accessible				• Provide contraception that is abortive in nature or requiring comprehensive medical interventions or follow up

Table 11. Key activities for preparedness and response based on the DADDS (continued)

Key World Vision MNCH and nutrition programming interventions in emergency contexts						
	Preparation	Start-up phase (30–90 days)		Sample activities		Don't do
		Do	Assure	Scenario	Likely intervention	
Pregnancy	• Pre-position materials for clean delivery kits	• Provide provision of LLIN in malaria-endemic areas • Locate pregnant women, TBAs, midwives to enable messaging on safe delivery, childbirth by SBA and referrals • Locally source/ procure, and provide clean delivery and information kits to visibly pregnant women and midwives • Provide support programmes for women (and infants)	• Pregnant and newly delivered mothers are prioritised for NFI distribution (i.e. shelter) • Partners are planning for antenatal care (prevent and treat malaria – intermittent preventive treatment of malaria during pregnancy, syphilis and HIV screening, tetanus toxid, disease prevention, de-worming, health promotion, birth preparedness)	**Access to skilled birth attendant is limited or not available and/or not culturally acceptable**	• Provide clean delivery kits and information package to visibly pregnant women • Promote early identification of danger signs, referral to basic and comprehensive obstetric and newborn care • Facilitate postpartum/ newborn care home visit (or at facility) within the critical 24 to 48 hours after birth • Clean delivery kit, Inter-agency RH Kit 2, or procure supplies locally	• Isolate TBAs, as they may be an important link between community and facility-based SBA

Table 11. Key activities for preparedness and response based on the DADDS (continued)

Key World Vision MNCH and nutrition programming interventions in emergency contexts						
	Preparation	Start-up phase (30–90 days)		Sample activities		Don't do
		Do	Assure	Scenario	Likely intervention	
Childbirth, maternal and newborn care	• If slow onset, identify agency provide EmONC, CEmOC • Train staff and volunteers on maternal and newborn care and appropriate messaging	• Locate TBAs, if not already known, and train them to assist with all elements of the project • Establish referral links • Provide referrals for appropriate services, e.g. EmONC • Promote and plan essential newborn and maternal care and promote home visits within critical 24 to 48 hours after birth • Provide education to community on essential newborn care (cord and eye care, colostrum and EBF, skin-to-skin contact, delayed bathing for 24 hours) and importance of seeking care • Provision of LLIN in malaria-endemic areas	• Availability of emergency obstetric and newborn care (EmONC, CEmOC) 24/7 • This includes SBAs and supplies for normal deliveries and management of obstetric and newborn emergencies at facility level • Above services are sensitive to adolescent needs and social culture • Partners are planning for postpartum care services (prevent and detect complications, anaemia prevention, information on nutrition, safe sex, family planning, promotion of LLIN) • Birth notification	**Access to skilled birth attendant is limited or not available and/or not culturally acceptable**	• Provide clean delivery kits and information package to visibly pregnant women • Promote early identification of danger signs, referral to basic and comprehensive obstetric and newborn care • Facilitate postpartum/ newborn care home visit (or at facility) within the critical 24 to 48 hours after birth • Clean delivery kit, Inter-agency RH Kit 2, or procure supplies locally	• Isolate TBAs, as they may be an important link between community and facility-based SBA

Table 11. Key activities for preparedness and response based on the DADDS (continued)

Key World Vision MNCH and nutrition programming interventions in emergency contexts						
	Preparation	Start-up phase (30–90 days)		Sample activities		Don't do
		Do	Assure	Scenario	Likely intervention	
Nutrition: PLW,IYCF, CMAM	• Disseminate and ensure familiarity with WV milk policy among staff • Build awareness of cultural feeding practices • Train staff on breast-feeding and relactation support • Train staff on nutrition in emergency essentials • Establish links with UNICEF, WFP to provide RUTF, food rations • Build relationship with WV FPMG	• Create awareness among staff of WV milk policy, operational guidance on infant feeding in emergencies, the Code • Establish protected, safe, supportive environment for women for breast-feeding and IYCF, where necessary (WAIFS) • Ensure availability of age-appropriate nutritionally adequate complementary foods • Demonstrate hygienic food preparation, storage, serving • Screen for and manage children and PLW for acute malnutrition and micronutrient deficiencies with CMAM or referral to appropriate services • Ensure de-worming drugs availability at CMAM sites • Provide education in food-distribution points and in CMAM on importance of EBF, continued BF, complementary foods • Provide micronutrient supplementation to PLW, even if food rations are fortified • Provide Vitamin A supplementation for all children under 5 (and other micronutrient supplementation where required)	• Households with newborns children under 24 months and breast-feeding/ pregnant women are registered and linked to food assistance programmes • Food-distribution planners take into account additional needs of PLW women (food rations fortified) • Appropriate lipid-based nutrient supplements (Nutibutter, CSB++) for infants between 6 and 24 months and/ or micronutrient powder for children under 5 and PLW are part of general food basket, where appropriate • Acutely malnourished infants under 6 months are referred to skilled breast-feeding support and inpatient care • Acutely malnourished children over 6 months are referred to appropriate intervention • Moms of malnourished infants under 6 months receive a supplementary ration, regardless of their nutritional status • Supplemental feeding ration, along with BF and nutritional counselling, is available to acutely malnourished mothers • All nutrition and food-aid supplies meet with WV policies, including milk policy	**Early weaning, lack of access to appropriate complementary foods**	• Demonstrate hygienic food preparation, storage, serving • Households with newborns, children under 24 months and breast-feeding/ pregnant women registered and linked to food assistance programmes • Establish protected, safe, supportive environment for women for breast-feeding and IYCF	• Accept unsolicited donations of BMS, bottles or teats/ nipples • Include BMS, or other milk products in general ration distribution (to be given only to mothers and infants who meet strict criteria)
				Acute malnutrition	• Provide education in food-distribution points and in CMAM on importance of EBF, continued BF, and locally available appropriate complementary foods	• Implement centralised therapeutic feeding centre (in the absence of outpatient therapeutic care)

Table 11. Key activities for preparedness and response based on the DADDS (continued)

Key World Vision MNCH and nutrition programming interventions in emergency contexts						
	Preparation	Start-up phase (30–90 days)		Sample activities		Don't do
		Do	Assure	Scenario	Likely intervention	
Child health	• Reinforce staff skills in monitoring disease outbreak potential, developing outbreak preparedness plans based on risk assessment • Establish links with MoH (and/or health cluster lead agency) disease surveillance unit	• Work with community to ensure accurate and relevant health, HIV, nutrition and hygiene messages on prevention, early care seeking and treatment • Monitor diseases of outbreak potential based on epidemiologic risk and respond according to appropriate plans and protocols • Report surveillance data to MoH and/or health cluster lead agency • Implement community management of communicable diseases using WHO and/or MoH protocols • Mobilise community for outbreak case identification and prevention activities • Promote hand washing with soap • Make ORS available at home level along with zinc supplementation for children under 5 with diarrhoea • Work with partner organisation to mobilise community for measles vaccination programme • Provide vitamin A supplement to children under 5 • Promote positive care seeking, and provision of LLIN in malaria-endemic areas • Provide hats/warm clothing in cold climates • Collaborate with WASH and shelter sectors	• Standardised case management protocols used in clinical settings • Children with pneumonia have access to adequate treatment within 24 to 48 hours • Outreach workers are familiar with community case management of pneumonia • Effective antimalarial treatment is available for children and pregnant women (artemisinin-based combination therapy) where malaria is endemic • Measles immunisation • Access to clean water and sanitation facilities	**Overcrowding due to displacement, causing high incidence of communicable diseases (such as diarrhoea and ARI)**	• Link with shelter team in relation to site planning to prevent overcrowding, shelter with adequate ventilation, insect-proofed and away from standing water • Community health education on prevention, signs, early care seeking and treatment of common childhood illnesses • Promote continuation of community case management • Assure availability of antibiotics within 24 hours	• Provide emergency health and nutrition assistance only to sponsored children to the exclusion of other children of similar status

TOOL 4. CHECKLIST FOR MNCH AND NUTRITION OPERATIONS AND PROGRAMMING

Table 12. Preparedness checklist

Is the WV programme prepared to respond to MNCH and nutrition during a sudden-onset emergency?			
	Question	**If YES…**	**If NO…**
Communication and accountability, policy and advocacy			
Comm 1	Are communities aware of potential child-protection issues in disasters (i.e. separation of children from parents, households who lost income-earning family members, vulnerability of separated children or child-headed households)?		Advocacy and communications staff work with appropriate stakeholders and local media to share messages.
Comm 2	Do staff understand the importance of accountability within an emergency response?		Review 2010 HAP Standard in Accountability and Quality Management and WV Programme Accountability Framework.
Coordination and partnership Relationships with potential donors, partners and subcontractors should be built in advance. See World Vision Disaster Management Standard 4 for national office preparedness.			
Coord 1	Do we have a relationship with local health authorities, MNCH actors, and are we part of relevant health coordination/technical working groups?	Good for you! Continue with your positive partnerships.	Determine coordination structures, establish a network and get involved. See WV Partnering Tools, and Principles of Partnership,[72] from the Global Humanitarian Platform.[73]
Coord 2	Does WV have strong relationships with donors?	Keep the donors informed of situation and programme plans.	Build relationships in advance to understand how to access emergency funds for MNCH.
Coord 3	In countries where there is a likely need for emergency mobile clinics, have agreements with MoH or national/regional health partners been established?		If WV does not have presence, this may be part of initial start-up.

72 Global Humanitarian Platform (2007). *Principles of Partnership*. http://www.icva.ch/pop.html.
73 http://www.icva.ch/doc00002016.html.

Table 12. Preparedness checklist (continued)

Is the WV programme prepared to respond to MNCH and nutrition during a sudden-onset emergency?			
	Question	**If YES…**	**If NO…**
Supplies and logistics Systems and agreements are in place for NOs to pre-position and stockpile supplies, gifts-in-kind (GIK), and equipment. See World Vision Disaster Management Standard 7 for support office preparedness.			
Supp 1	Do logistics/procurement and health technical staff have a list of approved suppliers of medical equipment and medicines?	Interagency RH kits should be part of this list.	Refer to standard packages by WHO; GIK department has reviewed essential medical supplies and aligned with 7-11 package. See WV Medical Supplies for Emergencies.
Supp 2	Are permits in place for international procurement of goods?		Consult with finance and procurement.
Supp 4	Are supplies pre-positioned regionally/ nationally according to risk profile?	Are they accessible? Are road routes open, etc.?	Needs to be done before an emergency.
Supp 5	Are response kits (e.g. cholera treatment, local materials for safe delivery kits) pre-positioned?		NO can hold back some GIK for possible emergency use. SOs that deal in GIK have systems and agreements in place to support relief supplies and GIK pre-positioning or rapid diversion to disaster response use.

Table 12. Preparedness checklist (continued)

Is the WV programme prepared to respond to MNCH and nutrition during a sudden-onset emergency?			
	Question	**If YES…**	**If NO…**
Staff competencies An acceptable level of capacity and/or access to capacity should be maintained at NO level. See World Vision Disaster Management Standard 3 for national office preparedness.			
Staff 1	Are staff skilled in health promotion, community mobilisation and disease prevention?		Refer to Maternal Child Health (MCH) Dialogue and Timed and Targeted Counselling tools.
Staff 2	Do staff have scientifically proven knowledge and experience using the key interventions (high-impact activities) to reduce MNC morbidity and mortality?		Start building skills and obtaining personnel with appropriate expertise. Refer to WHO/Lancet series and WV *7-11 Start-up Field Guide*.
Staff 3	Do staff have an understanding of how other sectors (WASH, shelter, protection, MHPSS, early childhood development and education) aid in MNCH outcomes?	Include in assessments and initial planning.	Create opportunities for joint simulation training.
Staff 4	Are staff familiar with emergency standards such as Sphere, child protection, psychosocial first aid, security protocols?		Plan for integration of these issues in the NO staff-capacity and training strategy. Train staff in psychosocial first aid. Train staff in Sphere standards and WV MNCH and Nutrition Guide.
Staff 5	Are staff trained in adolescent reproductive health counselling?		Online UNFPA e-training module[74].
Staff 6	Are staff familiar with the WV milk policy and implications for emergencies and food distribution?		See revised WV milk policy.
Staff 7	Are trainers and materials in place to lead a rapid training on IYCF counselling and specific issue (e.g. how to establish and manage IYCF counselling sites and services, how to integrate IYCF into CMAM)?		See rapid training on IYCF[75] counselling and specific contextual issues.
Staff 8	Are local TBAs trained to assist with all elements of the project?		
Staff 9	Do staff have adequate training and experience to manage MHPSS as part of an essential health service, if not covered by another sector?		Provide training in psychological first aid and mhGAP.

74 Adolescent Sexual and Reproductive Health in Humanitarian Settings. http://www.rhrc.org/resources/arh/player.html.
75 ENN et al. (2007). *Infant Feeding in Emergencies*. http://www.ennonline.net/pool/files/ife/module-2-v1-1-complete-english.pdf.

Table 12. Preparedness checklist (continued)

Is the WV programme prepared to respond to MNCH and nutrition during a sudden-onset emergency?			
	Question	**If YES…**	**If NO…**
Information management Develop a NO disaster management (DM) strategy. See World Vision Disaster Management Standard 1 for national office preparedness.			
Info 1	Has regional office supported an annual risk and capacity assessment?		Include in annual plan.
Info 2	Do we and the community have a pre-paredness strategy (contingency plan)?		See WV disaster preparedness checklist.
Info 3	Does the disaster-preparedness plan include MNCH protocols?		Work with HEA to update the Natural Disaster Preparedness Plan (NDPP) to include health risks and response.
Info 4	Is basic information on MNCH indicators, available services and health-seeking behaviours readily available within WV or through secondary sources?	MNCH protocols and procedures available.	Contact MoH for available data. (Data may be out of date but it is better than nothing.)
Info 5	Have these indicators been compared against the triggers for action suggested thresholds?	Aware of BRAT, familiar with national emergency triggers, declaration processes?	

TOOL 5. OPERATIONS CHECKLIST

The following questions aim to focus WV health coordinators and teams on key interventions for MNCH and nutrition in a sudden-onset emergency. Questions focus on activities WV should DO and ASSURE (see Emergency MNCH and Nutrition DADD). Any ongoing 7-11 activities should be continued, where feasible, with appropriate adjustments to their scale and extent.

The minimum responses during the start-up phase may last 30 to 90 days, depending upon the scale of the disaster, available services and numbers affected. Many of these activities will continue in the stabilisation, post-emergency phase.

Once basic activities are in place, comprehensive services should be planned for and added as soon as feasible. These may run concurrently with the ongoing emergency response. Further details on comprehensive activities are found in the *7-11 Start-up Field Guide*.

Table 13. Operations checklist

Is the WV programme planning and implementing an appropriate MNCH and nutrition response?			
	Question	**If YES…**	**If NO…**
Communication and accountability, policy and advocacy			
Comm 1	Has communication alert/ situation report been shared with partners and donors?	Determine desired frequency.	Write a report with available information ASAP.
Comm 2	Has situation been discussed with current and potential donors?	Ensure that any changes in plans are communicated.	Update donors on situation and plans.
Comm 3	Is fundraising taking place to mobilise resources for providing free health services at the point of delivery to the affected population for the duration of the disaster?	Ensure that vital information continues to flow to fundraising unit.	Advocate with national/local government, cluster and implementing NGOs for accessible service with no user fees at point of use.
Comm 4	Are situation reports shared within WV Partnership?	Continue to work with communications and advocacy teams to ensure appropriate language in media releases, programming and advocacy briefs.	Upload reports to wvrelief for timely approval and use by media, marketing, advocacy and communication messaging.
Comm 5	Is there public awareness creation on what MNCH and nutrition services are available, where these can be accessed, and how to lodge complaints?	Continue with communications team to reach most vulnerable of population. Ensure that lodged complaints (via help desk, suggestion boxes) are being addressed with the project or via health partners.	Consider establishing help desk or communication channels with population. See WV Food Programming and Management Group *Complaint and Response Mechanisms: A Resource Guide*.[76]
Comm 6	Is WV advocating for services to marginalised groups (e.g. ethnic minorities, men having sex with men, sexually active youth)?		Brief advocacy and communications teams on needs of marginalised groups.

76 World Vision (2009). *Complaint and Response Mechanisms: A Resource Guide*. http://www.wvifood.org/docs/FPMG_CRM_Manual.pdf.

Table 13. Operations checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response?			
	Question	**If YES…**	**If NO…**
Comm 7	Have children and adolescents (as part of wider community) been asked what type of support, health services, and education they want?		Ensure that child protection and education teams are aware of health issues and request support in accessing their opinion.
Coordination and partnership Emergency operations should be implemented in a timely, efficient and well-coordinated manner that ensures high technical standards of quality and accountability. NOs may continue, adapt or suspend regular area development programming in disaster-affected areas. Emergency responses should coordinate with existing local partners in a way that builds the capacity of local communities and organisations. See World Vision Disaster Management Standard 3 for a national office response.			
Coor 1	Has NO coordinated with support offices?	Ensure that changes in plans are communicated.	National diretor/OM provide update to relevant SO and region.
Coor 2	Does WV have existing relationship with local health partners, government health sector, etc.?	Good for you! Continue with your positive partnerships.	During development of NDPP, ascertain links and begin relationship.
Coor 3	Have assessment and response plans been conducted jointly with existing local partners, if possible?	Share results with local partners.	See WV Disaster Management Standard 5 for national office response.
Coor 4	Is the WV team aware of who does what and where? within the health response? (Is World Vision responsible for all humanitarian responses in this geographic area? Or do we respond to particular technical interventions?)	Ensure that RH lead agency has been identified.	Seek out health cluster lead agency and get involved in meetings, planning, coordination and joint assessments (where appropriate) within health cluster, subsectors, and relevant other clusters – WASH, shelter, education, food security and nutrition.
Coor 5	Does coordination link various levels of service providers (doctor to community worker) and levels of care (hospital to health post)?	Check accessibility.	Work with coordinating body to clearly articulate these to the partners.
Supplies and logistics			
Sup 1	Has a supply list been created?	If planning for mobile clinics, ensure that tents and lockable chests are included.	See WV supply list.
Sup 2	Can some supplies be procured locally?	Ensure that procurement has agreements in place so that a bidding process is not required.	Check with procurement or GPRN as to nearest supplier and develop agreements.

Table 13. Operations checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response?			
	Question	**If YES…**	**If NO…**
Sup 3	Are permits in place for international procurement?		Work with procurement.
Sup 4	Is there appropriate storage for medical and food supplies?	Ensure that the storeroom is clean and temperature controlled, and warehouse staff can manage medical supplies.	
Sup 5	Have arrangements been made to access vehicles for assessments and to get staff into the field?		Work with logistics team to allocate vehicles or arrange for hiring.
Sup 6	Have emergency supplies arrived and been set up?		Coordinate with procurement and logistics team.
Sup 7	Are essential medicines and supplies meeting the demands of the increased case load?	Liaise with UN/NGO involved in distribution to improve and sustain access to essential medicines and health supplies.	GPRN can guide and assist with emergency logistics, preparedness and planning, NFI programming, and pre-positioning. This may include support for pre-agreements with suppliers at the global, regional or national levels.
Staff competencies			
Staff 1	Have staffing requirements to lead response been determined?	Ensure that new hires are oriented to WV polices and standards.	See WV staffing requirements.
Staff 2	Has initial H/N team been mobilised and deployed, and is it functioning?		NO may have capacity to respond. Communicate with regional or global teams if extra capacity is needed.
Staff 3	Is local and international staff recruitment ongoing, and have appropriate job descriptions been developed?		See WV staffing list and roles and responsibilities.
Staff 4	Are staff orientated to WV and the appropriate standards, e.g. Sphere, child protection, security, psychosocial first aid, etc.?		Work with P&C and HEA on staff orientation and capacity building around standards and policies.
Staff 5	In clinical settings, do staff have approved standardised case definitions and treatment protocols?		Contact MoH/WHO for standard guidelines.

Table 13. Operations checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response?			
	Question	**If YES…**	**If NO…**
Information management and project design World Vision acknowledges that multiple stakeholders requiring information during an emergency response (beneficiaries, fundraising, media, health cluster partners, members of the partnership) can put pressure on the response team to address these individual requests. We, therefore, encourage the response team to develop an information management strategy for internal and external stakeholders. This plan for engagement may include steps such as uploading situation reports to wvrelief and mobilising an advocacy response group to coordinate messages and approaches among national, regional and support offices. See World Vision Disaster Management Standards 9 and 10 for a national office response. Response plans will evolve over time as assessments and information increase and context changes. A timeframe for the completion of the response plan(s) should be agreed between the response manager(s), national director, and shared with appropriate partnership stakeholders. See World VisionHEA Disaster Management Standard 4 for a national office response.			
Info 1	Has the team collected and reviewed pre-disaster information? (What services were available and what was behaviour prior to emergency?)	Use this information to inform initial assessment and action plan.	Acquire data from within WV. Seek secondary information from local health partners, MoH, WHO.
Info 2	Has rapid assessment been conducted? What things are magnified or exacerbated by the emergency?	Ensure that assessment looked at priority health problems and risks (e.g. breast-feeding practices, adolescent RH practices).	Consider using WV BRAT within the first days of the emergency.
Info 3	Have emergency life-saving interventions begun?	Does this consider what coping capacity, skills and strategies the affected population is using?	Activate contingency plan. As soon as you see the problem, at least start something while looking for ongoing funding.
Info 4	Has initial H/N response been designed?	Ensure that plan prioritises actions to address the main causes of excess morbidity and mortality. Is it in line with MoH guidelines? Will programme meet the needs of the most vulnerable?	Use current information, as the initial plan, likely based on secondary data.
Info 5	Is there a draft budget for initial response?	Seek funding for the initial plan: up to 10% of the affected ADP's budget.	See WV budget sheet.

Table 13. Operations checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response?			
	Question	**If YES…**	**If NO…**
Info 6	Have you consulted other sectors for synergies and potential ways to collaborate?	Hats off to you!	Where appropriate, consider the implementation of MHPSS programme as part of health (WAIFS) if not covered in another sector. Consult with child protection team on the design of H/N actions, child-friendly spaces, organisation of clubs. Ensure adequate WASH facilities in health-related sites (clinics, WAIFS). Mainstream HIV awareness into all sector activities to ensure that project design does not increase vulnerability towards HIV.
Info 7	Is WV team involved in ongoing joint rapid assessments?	Are these rapid and in-depth assessments capturing views representative of all affected people, including vulnerable groups?	The time and situation may not allow.
Info 8	Is WV team involved in ongoing disease surveillance?	**Ensure…** *Sphere Health System Standard 5: Health Information Management* Early warning systems are in place for possible epidemics (e.g. AWD, ARI, malaria, etc.) with contingency plans *Sphere Health System Standard 5: Health Information Management* Reports sent in a timely manner to appropriate bodies (e.g. WHO, MoH, programming team). *Sphere Health System Standard 3: Drugs and Medical Supplies.* Disease reporting to appropriate channels, for restocking supplies, equipment and medicine.	This may not be applicable if WV is focusing solely on community communication.
Info 9	Is initial H/N response being monitored?	Clinical reports should also be sent to MoH or WHO.	Ensure access to CMAM database for CMAM reporting, and MoH/WHO reporting formats.
Info 10	Is MNCH data disaggregated by sex and age (proportion of STIs among under 18, proportion of births under 18, condom use)?		Ensure that reporting formats have been amended to include this information.

TOOL 6. TECHNICAL PROGRAMMING CHECKLIST

The following questions aim to focus WV health coordinators and teams on key interventions for MNCH and nutrition in a sudden-onset emergency. Questions focus on activities WV should DO and ASSURE (see Emergency MNCH and Nutrition DADD). Any ongoing 7-11 activities should be continued, where feasible, with appropriate adjustments to their scale and extent.

The minimum responses during the start-up phase may last 30 to 90 days, depending upon the scale of the disaster, available services and the numbers affected. Many of these activities will continue in the stabilisation, post-emergency phase.

Once basic activities are in place, comprehensive services should be planned for and added as soon as feasible. These may run concurrently with the ongoing emergency response. Further details on comprehensive activities are found in the *7-11 Start-up Field Guide*.

Table 14. Programming checklist

Is the WV programme planning and implementing an appropriate MNCH and nutrition response?			
	Question	**If YES…**	**If NO…**
Reproductive health (general)			
RH 1	Are our approaches encouraging health-seeking and reducing risk-taking behaviour?		Rethink strategy.
RH 2	Do staff know where to refer clients for appropriate services (who does clinical management of rape, who offers contraception, who can provide ART, etc.)?	Where possible, check if people are accessing services to which they are referred.	Get in contact with the health cluster lead and obtain 'Who does What' document. Attend the next health cluster meeting!
RH 3	Does the community know where to go for treatment and support?	Is there opportunity to lodge complaints (see Operations section).	Mobilise community outreach communication channels and consider mobile phone technology.
RH 4	Have new staff members signed Code of Conduct?		This should be part of the hiring process or be done when staff members are transferred from a stable work environment to an emergency setting.
RH 5	Has the workplace policy on occupational exposure, including PEP, been implemented/revised for the humanitarian settings?	Ensure that staff are aware of policy.	Work with human resource department and HIV focal person to activate the PEP policy.
RH 6	Do staff know about and implement universal precautions in community and clinical sites?		Refer to WHO protocols.
RH further references	IAWG (2010). *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. USAID/CDC (2007). Reproductive Health Assessment Toolkit for Conflict-Affected Women. Atlanta, GA: Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Coordinating Center for Health Promotion. UNFPA. Reproductive Health Kit for Emergency Situations.		

Table 14. Programming checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response?			
	Question	**If YES…**	**If NO…**
Reproductive health: Adolescent-friendly reproductive health (AFRH)			
AFRH 1	Are condoms available to youth and dual protection being encouraged?	Ensure availability at youth gathering 'hand-out' spots,	Provide free male condoms as part of WV hygiene kit, if culturally appropriate.
AFRH 2	Is WV encouraging health-seeking behaviours and reduced risk-taking among young people?		Consider initiating HIV prevention project targeting youth, where youth convene.
AFRH 3	Are adolescents involved in and/or leading community-health dialogue?		Engage with child-protection or education team.
AFRH 4	Does staff know where to refer youth to obtain sensitive and confidential RH services?	Ensure that STI syndromic treatment and basic contraception are available to young people.	Liaise with local service providers, health cluster partners or health system to identify site providing AFRH services.
AFRH 5	Where possible, are adolescents referred to project staff and health workers of the same sex?		Check gender balance in staff; work with people and culture team to rectify.
AFRH 6	Are RH services or referrals available from emergency education points (schools)?		Work with child protection or education team to facilitate.
AFRH 7	Is age-appropriate RH life-skills training available?		Consider this for stabilisation phase.
AFRH further references	UNFPA/Save the Children USA (2009) *Adolescent and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.* Online UNFPA e-training module: Adolescent Sexual and Reproductive Health in Humanitarian Settings. http://www.iawg.net/resources/index.html.		

Table 14. Programming checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response ?			
	Question	**If YES…**	**If NO…**
Reproductive health: STI/HIV			
STI HIV 1	Are free condoms available within the health-cluster partners and/or government services?	Ensure adequate sensitisation and information regarding proper use and disposal.	WV hygiene kit provides condoms and information brief. If this is not culturally acceptable, condoms can be removed and provided to the population in alternative methods.
STI HIV 2	Are outreach workers involved in campaigns to encourage early diagnosis and treatment of STIs?		Include HIV and STI awareness messages as part of health-promotion activities.
STI HIV 3	Is syndromic STI treatment available for patients presenting with symptoms as part of routine clinical services?		Advocate with partners for STI treatment where testing is unavailable.
STI HIV 4	Is STI management integrated into antenatal, delivery and postpartum care?		Consider planning for this as part of comprehensive response in stabilisation phase.
STI HIV 5	Are there adequate confidential testing, treatment and counselling protocols for comprehensive STI case management, including HIV?	Note: CCT is not part of MISP, but should be planned for.	Ensure that partners are planning for this as part of comprehensive response in stabilisation phase.
STI HIV 6	Are PMTCT services provided at delivery to pregnant women known to be HIV-positive?	Ensure that staff knows where to refer women.	Ensure that partners at the facility level can provide ART to known HIV-positive mothers in the initial stage of the emergency. This should be expanded during the stabilisation phase to include HIV testing of pregnant women of unknown status.
STI HIV 7	Is ART available to those already on treatment?		Advocate with partners within health cluster to do this.
STI HIV further references	World Vision Global HIV and AIDS Strategic Plan 2011–2015. World Vision International (2009). Global Health & Nutrition *Integrating HIV into Emergencies: World Vision's commitment to addressing HIV in humanitarian and emergency affairs.* World Vision International (2010). *Integrating HIV into Emergencies: Self-assessment Programmatic Checklist.* World Vision. HIV in Emergencies Reference Toolkit for Christian Faith-based Communities. Inter-agency Standing Committee (2009). Guidelines for addressing HIV in humanitarian situations, Revised version. NGO Code of Good Practice (2009). Self-assessment Checklist: HIV in Emergencies.		

Table 14. Programming checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response ?			
	Question	**If YES…**	**If NO…**
Reproductive health: sexual and gender-based violence			
SGBV 1	Can women and children and vulnerable/marginalised groups safely access the health facilities?		Link with protection and shelter cluster teams to facilitate equitable safe access.
SGBV 2	Are adequate water and sanitation facilities provided at the health facilities?	Ensure that facilities are culturally and gender-sensitive.	Consult WASH teams to plan appropriate hardware for health facilities and WAIFS.
SGBV 3	Are health personnel gender balanced?		Work with People & Culture on job advertising and hiring in gender-balanced way.
SGBV 4	Are staff members aware of the risk of sexual violence in this humanitarian context? Are they aware of approaches to prevent sexual exploitation and abuse (lighting, safe zones, etc.)?		Consult with protection team, conduct staff briefing, including as part of security training.
SGBV 5	Are there a confidential system of reporting SGBV? Are you familiar with this and ready to use it (even those cases perpetrated by humanitarians)?		Consult protection cluster for details of established reporting system for this humanitarian situation.
SGBV 6	Are staff using psychological first aid to provide immediate MHPSS?	Ensure that a clear referral system is in place for MHPSS.	Assess if staff is trained and competent in psychological first aid.
SGBV 7	Are staff providing referrals to clinical for rape victims and is PEP accessible?	Advocate with partners to include psychosocial and legal support along with clinical management.	Ensure that PEP kits are available. Advocate for clinical services to care for victims of rape with health cluster partners and/or government services, and that these services are sensitive to adolescent needs/social culture.
SGBV 8	Is WV using communication channels to inform affected populations of the availability of confidential services and the importance of rapid incident reporting and immediate care?	Ensure that referral to a primary-level health facility provides clinical management of rape/ violence based on national or WHO protocols.	Mobilise community outreach and consider mobile phone technology.
SGBV further references	IASC (2005). *Guidelines for Gender-based Violence Interventions in Humanitarian Settings.* IASC (2006). 'Women, Girls, Boys, and Men - Different Needs, Equal Opportunities' (chapters on health, nutrition, WASH), *The Gender Handbook in Humanitarian Action.* UNDP (2002). *Gender Approaches in Conflict and Post-Conflict Situations*. Bureau for Crisis Prevention and Recovery.		

Table 14. Programming checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response ?			
	Question	**If YES…**	**If NO…**
Reproductive health: family planning			
FP 1	Is there a demand to continue contraception methods used prior to emergency?	Provide basic contraception, including condoms.	Ensure that basic contraception is accessible.
FP 2	Is emergency contraception available?		Ensure that ECP is accessible, as the situation warrants.
Pregnancy			
Preg 1	Are supportive, safe places for women and infants and young children (IYC) available?		Consider a WAIFS or IYC intervention.
Preg 2	Are communication messages on the importance of childbirth by SBA and referral being shared by TBAs, midwives, community volunteers?		Mobilise community networks to start sharing messages on where to go for services.
Preg 3	Are clean delivery supplies provided to visibly pregnant women and midwives, along with registration of pregnant women?		Were supplies pre-positioned? May be able to locally source/procure. Check with logistics/procurement teams on guidelines for distribution of NFI.
Preg 4	In malaria-endemic areas, is WV providing LLINs and promoting care seeking for malaria?	Assure treatment access and intermittent preventive treatment in malaria-endemic region.	Consider including as part of programme.
Preg 5	Is WV screening for and managing acute malnutrition and micro-nutrient deficiencies with CMAM?		Assure referrals to appropriate services are in place.
Preg 6	Is daily micronutrient supplementation provided, where required?		Ensure that pregnant and breast-feeding women receive daily supplements, regardless of receiving fortified rations.
Preg 7	Are food rations fortified and taking into account additional needs of pregnant and lactating women?		Advocate with food distribution planners.
Preg 8	Are supplemental feeding rations, along with BF and nutritional counselling, available to acutely malnourished mothers?		Advocate with food distribution planners.
Preg 9	Are moms of malnourished infants under 6 months receiving a supplementary ration, regardless of their nutritional status?		Advocate with food distribution planners.
Preg 10	Is antenatal care being planned for?		Advocate with partners to establish antenatal care as soon as feasible (prevent and treat malaria – intermittent preventive treatment of malaria during pregnancy – syphilis and HIV screening, disease prevention, de-worming, health promotion, birth preparedness).

Table 14. Programming checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response ?			
	Question	**If YES…**	**If NO…**
Childbirth and maternal and newborn care			
MNC 1	Is WV working with communities to establish a communication mechanism for the referral of obstetric emergencies?	Referral should include communication and transport and be available 24/7.	Consult with community and RH lead within health cluster.
MNC 2	Do all health facilities, clinics, WAIFS, have the referral protocols clearly posted?		Ensure that lists of referral locations are collected from coordinating body and distributed to health and liaison staff.
MNC 3	Are TBAs assisting with home deliveries?	It is currently not recommended by WHO to train or equip TBAs to conduct deliveries. Speak with TBAs; discuss the importance of delivering at a facility and their role in specific RH issues and project approaches. Consider giving TBAs clean delivery packages and linking them to a health clinic and specific SBA.	In humanitarian settings, it is important to integrate TBAs into specific MNCH services, such as facilitating referrals, promoting RH, newborn care and organising community acceptance of facility services.
MNC 4	Is essential newborn and maternal care provided by medical personnel or trained CHWs during home visits (or in facility) within 24 to 48 hours of delivery?	Ensure that services are sensitive to adolescent mothers and social culture.	Trained CHWs and TBAs should be mobilised to provide home visits and be able to provide a range of services, such as thermal protection, promoting early and exclusive breast-feeding, treatment of neonatal sepsis, care of preterm and LBW babies (kangaroo care), basic neonatal resuscitation (using bag and mask to treat asphyxia).
MNC 5	Is vitamin A reaching women within 6 to 8 weeks of childbirth?		Ensure that vitamin A is available via home visits or at well-baby vaccination clinics.
MNC 6	Are education and information available on colostrum, EBF, clean birth, essential newborn care, kangaroo care and the importance of seeking newborn care?		Advocate for IEC material in local languages to be distributed to communities. Access MoH materials if available.
MNC 7	Are LLINs being provided to new moms in malaria-endemic areas?	Consider alternative distribution methods to ensure coverage.	Work with commodities team on targeting criteria.

Table 14. Programming checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response?			
	Question	**If YES…**	**If NO…**
MNC 8	Are skilled medical staff and supplies available at referral centres to handle normal deliveries and all obstetric and newborn complications (EmONC, CEmONC)?	Ensure that services are sensitive to adolescent needs and social culture.	Ensure that partners have services available 24/7. Is the context conducive to opening a WV mobile clinic for basic care, enabling specialist health staff to attend to obstetric cases at referral centres?
MNC 9	Are partners planning for postpartum care services (prevent and detect complications, prevent anaemia, provide information on nutrition, safe sex, family planning, promotion of LLIN)?		Advocate for this as part of comprehensive response in stabilisation phase.
MNC 10	Are WV staff aware of birth notification procedures?		Advocacy team ensure that all staff members know procedures.
MNC further references	IAWG (2010). *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* World Vision (2011). *A review of the inclusion of TBAs in WV programming and the global priority to scale up SBAs in developing countries*. DRAFT WHO (2006). *Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice*.		

Table 14. Programming checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response ?			
	Question	**If YES…**	**If NO…**
Nutrition: Infant and young child feeding			
IYCF 1	Is staff aware of WV's milk policy, *Operational Guidance*[77] *on Infant Feeding in Emergencies*, and the *International Code of Marketing*[78] *of Breast-Milk Substitutes* and additional WHA resolutions (the Code)?		Conduct rapid training on IYCF[79] counselling and specific contextual issues.
IYCF 2	Were mothers using BMS prior to the emergency?	Mothers will need to source these products if they are not lactating. Ensure that WV response procedures reflect WV milk policy and the *International Code of Marketing of Breast-Milk Substitutes*.	Protect and support breast-feeding and relactation. Consider integrating IYCF issues into existing health services or sites with nutritional services, such as CMAM. May need to conduct rapid training on how to integrate IYCF into SFP and CMAM.[80]
IYCF 3	Is there any evidence of a decline in infant feeding practices due to the emergency (reduction of breast-feeding initiation, reduction or cessation of exclusive breast-feeding of infants, lots of orphaned or unaccompanied children, major change in access to food or water for children, untargeted distribution of BMS)?	Consider stand-alone temporary baby-friendly tent or WAIFS. Raise awareness through communication channels to promote optimal infant feeding practices and promote available services.	Consider integrating IYCF issues into existing health services or sites with nutritional services, such as CMAM. May need to conduct rapid training on how to integrate IYCF into SFP and CMAM.
IYCF 4	Is the environment protective and supportive of optimal IYCF?	IYCF information can be integrated into CMAM, distribution points, etc.	Establish WAIFS.
IYCF 5	Is vitamin A supplementation available for all children under the age of 5 (along with other micronutrient supplementation where required)?		Determine if measles vaccination is planned, where vitamin A can accompany this campaign. Women should receive vitamin A within 6 to 8 weeks of childbirth.
IYCF 6	Are age-appropriate nutritionally adequate complementary foods available along with hygienic preparation and serving advice?	Monitor situation for consistent availability and adherence.	Work with nutrition cluster to assure appropriate lipid-based nutrient supplement (Nutibutter, CSB++) for infants over 6–24 months, as part of general food basket. With WASH, organise hygiene-promotion and food-preparation demonstrations.
IYCF 7	Are households with newborns children under 24 months and breast-feeding/pregnant women, registered and linked to food assistance programmes, where appropriate?		Work with food security and nutrition cluster to identify mechanisms.

77 IFE Core Group (2007). Infant and young child feeding in emergencies: Operational guidance for emergency relief staff and programme managers. http://www.who.int/nutrition/publications/emergencies/operational_guidance/en/index.html.
78 WHO (1981). *International Code of Marketing of Breast-Milk Substitutes*. http://www.who.int/nutrition/publications/infantfeeding/9241541601/en/.
79 ENN/IFE Core Group (2007). *Infant Feeding in Emergencies, Module 2 ,Version 1.1 for H/N workers in emergency situations, for training, practice and reference.*
80 IASC/IFE/ENN (2009). *Integration of IYCF Support into CMAM: Facilitator's Guide.*

Table 14. Programming checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response ?			
	Question	**IfYES…**	**If NO…**
Nutrition: Community management of acute malnutrition			
CMAM 1	Is WV screening for and managing moderate and severe acute malnutrition and micronutrient deficiencies with CMAM?	Ensure that the programme refers acutely malnourished infants under 6 months to skilled breast-feeding support and inpatient care, and those over 6 to the appropriate intervention.	Ensure that referrals to appropriate services are in place.
CMAM 2	Are de-worming drugs available for use at CMAM sites?		See WV essential medicine list.
CMAM 3	Is WV providing education in food-distribution points and in CMAM on the importance of EBF, continued BF, complementary foods and priority diseases?		Ensure that education programmes are implemented. Consider rapid training for key staff on IYCF.
CMAM 4	Are households with children under 24 months and breast-feeding mothers, pregnant women registered and linked to food assistance programmes?	Ensure that supplemental feeding rations, along with breast-feeding and nutritional counselling, are available for acutely malnourished mothers.	Ensure that referrals to appropriate services are in place.
CMAM 5	Are moms of malnourished infants under 6 months receiving a supplementary ration, regardless of their nutritional status?		Advocate with food-distribution planners.
CMAM 6	Do pregnant and lactating women have access to appropriate iron, folic acid, micronutrient supplementation?		Ensure that pregnant and breast-feeding women receive daily supplements (multiple micronutrients) to protect maternal stores and breast-milk content, regardless of whether they are receiving fortified rations. Iron and folic acid supplements should be continued, if provided prior to emergency.
CMAM 7	Do all nutrition and food-aid supplies meet with WV policies, including milk policy?		Discuss issues with food security and nutrition cluster.

Table 14. Programming checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response ?			
	Question	**If YES…**	**If NO…**
Nutrition further references	IASC/IFE/ENN (2009). *Integration of IYCF Support into CMAM Facilitator's Guide*. IFE Core Group (2007). *Infant and Young Child Feeding in Emergencies: Operational Guidance for Emergency Relief Staff and Program Managers*. ENN/IFE Core Group (2007). *Infant Feeding in Emergencies, Module 2, Version 1.1 for H/N workers in emergency situations, for training, practice and reference.* WHO/UNICEF (2009). *Acceptable Medical Reasons for Use of Breast-Milk Substitutes.* WHO (1981). *International Code of Marketing of Breast-Milk Substitutes* and relevant World Health Assembly Resolutions. http://apps.who.int/gb/e/e_wha63.html *Guiding Principles for Complementary Feeding of the Breastfed Child* (2001) ENN/IFE Core Group (2009). IFE Module 1, v 2.0, 2009: IFE orientation package. This is a package of resources to help in orientation on infant and young child feeding in emergencies. These resources are targeted at emergency relief staff, programme managers, and technical staff involved in planning and responding to emergencies, at national and international levels. http://www.ennonline.net/ife/orientation. *Nutrition in Emergencies*. Free web course on nutrition essentials in emergencies. www.unicef.org/nutrition/training/. WHO (1998). *Relactation: Review Of Experience And Recommendations For Practice.*		
	Child health		
CH 1	Is health education on priority disease prevention, early care seeking and treatment being shared at all contact points (CMAM, WAIFS, distributions)?		Get moving! Mobilise MNCH & WASH expertise and hygiene-promotion tools. Consider using mobile technology for health education.
CH 2	Are you communicating with shelter team with regard to adequate ventilation, structures and space to prevent common illnesses?		Work with shelter/NFI team on adequate shelter items.
CH 3	Are staff and volunteers familiar with community case management of pneumonia and referrals of severe cases using WHO and MoH protocols?	Ensure that standardised case-management protocols are used in clinical settings, and that children have access to first-line antibiotics (amoxicillin) within 24 to 48 hours of symptoms.	Access MoH/WHO protocols and update all health staff.
CH 4	Does population have adequate hygiene materials?	Encourage hand washing and sanitation practices.	Distribute hygiene kits and information materials.
CH 5	For children under 5 with diarrhoea, is ORS available at home level along with zinc supplementation?		Establish WHO support model to provide ORS corners at community level (health facilities and WAIFS). Use volunteers to provide ORS upon identification.
CH 6	Is measles vaccination programme being carried out?	Work with partners to mobilise community for vaccination campaign.	

Table 14. Programming checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response ?			
	Question	**IfYES…**	**If NO…**
CH 7	In situations of outbreaks, are staff aware of mechanism for case identification and reporting?		Mobilise community volunteers to undertake home visits for case identification and referral.
CH 8	Does community have access to basic primary health care?	Ensure that standardised case-management protocols for diagnosis and treatment of common infectious diseases are readily available and used by clinical staff.	Consider WV temporary mobile clinic.
CH 9	In malaria-endemic areas, are people sleeping under nets?	Estimate coverage and use by age.	WV to provide LLINs, give demonstration on use and home follow-up, and promote care-seeking behaviour. Ensure that effective antimalarial treatment is available for children and pregnant women (artemisinin-based combination therapy).
CH 10	Is vitamin A supplementation available for all children under the age of 5 (along with other micronutrient supplementation where required)?		Advocate as part of the package of services. (Needs to be done in a planned way in consultation with H/N staff.) Are food rations fortified?
CH 11	Do families have adequate clothing for cold climates?		Distribute clothing and hats to children.
Child health further references	WHO (2005). *Malaria Control in Complex Emergencies: An inter-agency field handbook*. WHO/UNICEF (2004). *Clinical Management of Acute Diarrhoea*. WHO (2003). *Provision of Health Care to Children in Complex Emergencies*, version 4.0. WHO (2005). *Communicable Disease Control in Emergencies – A Field Guide.* WHO (1999). *Guidelines for Epidemic Preparedness and Response to Measles Outbreaks.* WHO (2008). *Communicable Disease Alert and Response for Mass Gatherings: Key Considerations.*		

Table 14. Programming checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response ?			
	Question	**IfYES…**	**If NO…**
Integrated issues: Child protection and MHPSS			
ChProt 1	Are sex-specific hygiene facilities available at health facilities, schools and child-friendly spaces, WAIFS?		Work with WASH team to have them installed.
ChProt 2	Are there opportunities for children to play, make friends and build social support networks?	Link health messaging into programme (child-to-child approach).	Work with child protection or education team to include some social programmes as part of response.
ChProt 3	Are routes to/from child-friendly spaces or schools well-lit and patrolled for safety?		Work with community and protection team to develop strategies to protect children.
ChProt 4	Is there a birth registration process for deliveries during the disaster?	Ensure that health workers know the process and provide referral/ forms.	Advocate with government body to have mobile registration in affected area
ChProt 5	Are children's corners or child-friendly spaces available?	Ensure some of the staff have training in psychological first aid	
MH 1	Are there opportunities for peer groups (i.e. mothers, adolescents and children) to share and support each other?	Ensure that there is a safe space available at times suitable for the group.	
MH 2	Are health personnel or WAIFS facilitators trained in psychological first aid on how to reduce stress?		Access the PFA guide , included as part of orientation to new staff.
MH 3	Are positive coping strategies promoted (sleeping well, rest, nutrition, talking with trusted friends, etc.)?		Access the PFA guide.

Table 14. Programming checklist (continued)

Is the WV programme planning and implementing an appropriate MNCH and nutrition response?			
	Question	**If YES…**	**If NO…**
MH 4	Is there evidence that parent-child stimulation is being promoted in the clinics/ WAIFS/nutrition programmes (Encouraging or showing mothers how to interact with their children – making eye contact, talking with them, playing with them, etc. – has good mental health outcomes for mothers as well as positive development outcomes for the infants/children.)		Consider a WAIFS or similar programme.
MH 5	Is there culturally and contextually relevant referral mechanism for individuals needing further mental-health support?	Check if services are accessible (cost, distance, etc.) for affected population. Vouchers or additional support may be needed.	Advocate for MoH to include mhGAP training for health staff once situation has stabilised.
Child Protection and MHPSS further references	Child Protection important further references: World Vision *Children in Emergencies Manual* World Vision Children in Emergencies Interest Group World Vision Draft: Child Protection Strategy World Vision Child Protection Standards Inter-Agency Guidelines for Child-friendly Spaces Child Protection in Emergencies Response One-Pagers UNICEF Introduction to Child Protection in Emergencies MHPSS important further references: World Vision Communication Guide on MHPSS World Vision MHPSS DADDs (forthcoming) World Vision Interest Group on Mental Health Psychosocial Support Inter-agency Standing Committee (2007). *Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* Geneva: IASC Inter-agency Standing Committee (2011). *Psychological first aid: Guide for field workers.* Geneva: IASC World Health Organization. WHO Mental Health GAP Action Programme (mhGAP). http://www.who.int/mental_health/mhgap/en. REPSSI (2009). *Mainstreaming Psychosocial Care and Support within Early Childhood Development* Part of the Psychosocial Wellbeing series.		

TOOL 7. MONITORING INDICATOR LIST

Table 15. Indicator List for 'DOs'

	Key WV 'DO' activity definitions	Indicator	Threshold	Frequency	Source of data	Remarks
Staff competencies	H/N staff has been trained in psychological first aid	# staff who have been oriented to psychological first aid	50% field-facing staff have been trained	Prior to response and after recruitment	HR recruitment and capacity building	Ongoing as part of staff orientation for all new staff
	Staff understand the importance of accountability within an emergency response	# staff who can articulate who they are accountable to	100% staff oriented to The Code of Conduct and accountability	Prior to response and at orientation and staff training	Accountability staff and staff training records	
	Health promotion, seeking and reducing risk-taking behaviour	# staff demonstrate good hygiene and health practices	100%	Prior to response and ongoing staff training	Direct observation and training records	
	Staff aware of referral mechanism for appropriate services	# staff can identify location of referral services or information sheets	100% field-facing clinical staff	At orientation to location, staff training and when referral locations change	Information sheets available at all locations WV is offering services and all outreach staff have copies in their files	Clinical management of rape, who offers contraception, who can provide ART, etc.
	Timing of PEP	# of eligible staff who receive PEP within 72 hours of an incident/total number of incidents reported x 100	100% of eligible staff Individuals potentially exposed to HIV (occupational and non-occupational exposure) have received PEP within 72 hours of an incident	Mid and end of emergency response	Procurement records, PEP consent documents	WV collects for monitoring purposes, to assess implementation of workplace policy
Reproductive health	(# or coverage of) supplies for standard precautions	# health delivery (service) points with adequate supplies to carry out standard precautions Coverage: #/ number of health-service delivery points X 100	100% of health facilities (including nutrition centres and WAIFS) have adequate supplies to carry out standard precautions	Daily for observation supervisory check; weekly for coverage statistic	Clinical equipment and supply list; case load; observation supervisory checks	Observational on daily basis for WV quality-control monitoring

Table 15. Indicator List for 'DOs' (continued)

	Key WV 'DO' activity definitions	Indicator	Threshold	Frequency	Source of data	Remarks
Pregnancy	Timing of PEP	# of eligible beneficiaries receive PEP within 72 hours of an incident	Individuals potentially exposed to HIV (occupational and non-occupational exposure) have received PEP within 72 hours of an incident		Procurement records, PEP consent documents	
	(# or coverage of) Clean delivery kits	# clean delivery kits distributed Coverage: # / per estimated no. of pregnant women X 100/ month	100%: All pregnant women in third trimester have received clean delivery kits	Monthly, as health team does distributions	Procurement records, distribution reports	
	Pregnant women aware of where to go for labour and delivery	# pregnant women who have received counselling on the need for SBA for delivery and know where to go	100% women who receive birth kits	Monthly, as health team does distributions	SBA/CHW reports	
	Coverage of LLIN	# pregnant and lactating women and children under 5 sleeping nightly under net	Universal coverage	Baseline and endline	Distribution records, home visits and hygiene-promotion session records	Priority distribution to severely malnourished enrolled in CMAM, members of their households, pregnant women and children under 2
Childbirth, maternal & newborn	(# or coverage of) Newborn assessment	# newborns visited with 24 to 72 hours for assessment Coverage: #/ estimated no. of newborns	100%	Monthly	CHW/midwife reports	Thermal regulation, skin-to-skin, respiration, early initiation of BF

Table 15. Indicator List for 'DOs' (continued)

	Key WV 'DO' activity definitions	Indicator	Threshold	Frequency	Source of data	Remarks
Nutrition: PLW, IYCF, CMAM	(# or coverage of) Breast-feeding support	# women receiving BF advice Coverage: #/ per estimated no. of lactating women X100/ month	100%: All breast-feeding mothers have access to skilled breast-feeding support	Monthly	WAIFS reports or CHW reports	Skilled support (i.e. trained BF peer support counsellor, nurse, midwife or lactation specialist)
	Exclusive breast-feeding rate under 6 months; continued BF rate at 1 and 2 years	Proxy: % of infants aged 0 to 6 months who were fed exclusively with breast milk during the entire day prior to interview. % of children aged 6 to 24 months still breast-fed and % of children under 2 breast-fed	WHO aims for 100% exclusive BF to 6 months	Baseline and endline	Survey Secondary data from health programmes (mobile clinics, MNCH activities, etc.)	Exclusive breast-feeding means the baby has not received any other fluids (not even water) or foods, with the exception of ORS, drops and syrups (vitamins, minerals, medicines).
	Coverage of appropriate BMS for targeted mothers, using replacement feeding prior to emergency	#/per estimated no. of BMS-fed infants X100/ month	100%	Monthly	Procurement records, distribution reports (Survey)	There is access to Code-compliant supplies of appropriate BMS and associated support for infants who require artificial feeding.
	Parent-child stimulation promoted in WV nutrition programmes (WAIFS, CMAM, others)	% of programmes with well-established stimulation activities	100%	Monthly	Observation report	Stimulation activities or programmes are formal, established and run on regular basis (baby-friendly spaces or any others).
	Complementary food access	Caregivers have access to timely, appropriate, nutritionally adequate and safe complementary foods for children 6 to under 24 months	100%	Baseline and endline	Survey	

Table 15. Indicator List for 'DOs' (continued)

	Key WV 'DO' activity definitions	Indicator	Threshold	Frequency	Source of data	Remarks
Child health	Proportion children receiving Vitamin A	# children under 5 with one vitamin A dose/estimate no. of children under 5	100%	Baseline and endline	Survey, mass campaign results, verifiable with health card	WV child well-being outcome indicator
	Coverage of ORS and zinc supplementation	# ORS kits distributed per estimated no. of children under 5 years with diarrhoea X 100/month	100% presenting in facilities	Monthly, more frequently if outbreak	mobile clinics, facilities, household outreach	
	Coverage of LLIN, in malaria-endemic area	# nets distributed per estimated # of priority beneficiaries X100/month	Universal coverage		Procurement records, distribution reports	Priority distribution to severely malnourished enrolled in CMAM, members of their households, pregnant women and children under 2.
	Incidents of major communicable diseases relevant to the context are stable (not increasing)	# patients treated for recorded diseases	No increase in number of cases in endemic areas; case fatality rate of 1–2%	Weekly	Surveillance report and MoH reports	Depending on the disease, as to whether walk in or active case finding.
	Standardised case-management protocols for diagnosis and treatment are readily available and consistently used	# patients treated according to standardised case-management protocols	100% of consultations	Weekly	Medical registers	Based on approved MoH or WHO and/or national guidelines.

The following indicators may be valuable to WV work, but are not necessarily going to be collected by our health teams.

Table 16. Indicator list for 'Assure' (continued)

WV 'ASSURE' activities definition	Indicator or formula	Standard	Source of indicator	Remarks
Coverage primary health care	% population with access to PHC		Secondary sources prior to emergency; health cluster survey	
EmONC services availability	# EmONC facility per population	At least four BEmONC facilities/ 500,000 population, and at least one CEmOC/500,000	UN process indicator 1, MISP, Sphere	
Percentage of births assisted by SBA	# deliveries attended by a trained health worker/# of deliveries X100	Over 90%	IASC HC	
Coverage of HIV rapid tests for safe blood transfusion	# facilities with sufficient HIV rapid tests to screen blood for transfusion/ number of health service delivery points X 100	100% of health facilities have adequate supplies to carry out standard screening; 100% of transfused blood is screened for transfusion-transmissible infections including HIV	MISP, Sphere	
STI case management	# of patients with STI assessed, treated and counselled according to protocol/total number of patients with STI accessing services X 100	All primary health-care facilities have antimicrobials to provide syndromic management to patients presenting with symptoms of an STI (MISP)	MISP, comprehensive services – IAFM RH, Sphere	Disaggregate data by age and sex. Measured in STI clinics and facilities integrating STI management (antenatal, PNC).
Condom distribution rate	# male condoms distributed/total population/month	0.5 condoms/ person/month	MISP	
Coverage of ARV in MNCH	# of mother-newborn pairs who swallow ARV according to protocol/ total number HIV-positive deliveries X 100	100% Pregnant women known to be HIV-positive have received ARV drugs for PMTCT (MISP)	MISP, comprehensive services – IAFM RH, Sphere	
Clinical management of rape victims	% of health facilities with availability of clinical management of rape victims (EC and PEP)	100% of health facilities have trained staff, sufficient supplies and equipment for clinical management	Sphere, IASC HC	based on national or WHO protocols

Table 16. Indicator list for 'Assure' (continued)

WV 'ASSURE' activities definition	Indicator or formula	Standard	Source of indicator	Remarks
HIV prevention programming	# MARPs reached	100% of MARPs	Sphere	(comprehensive response)
Malaria treatment	# children under 5 receiving treatment/ estimated total number children under 5 with malaria symptoms	100%; All children under 5 years old presenting with malaria have received effective antimalarial treatment within 24 hours of onset of their symptoms	Sphere	
Pneumonia treatment	# children under 5 receiving treatment/ estimated total number children under 5 with pneumonia symptoms	100%; All children under 5 years old presenting with pneumonia have received appropriate antibiotics	Sphere	
Measles vaccination	#/% children age 6 months to 15 years received measles vaccination	Over 95% coverage among children 6 to 59 months	IASC HC	
Mental health	# health facilities with trained staff and systems for the management of mental-health problems			Assumes health staff had training opportunity in ways to help management MH at primary health care level (e.g. mhGAP intervention training)
	A referral system for specialised mental-health services documented and functioning			

Annex

SUGGESTED EMERGENCY STAFF FOR MNCH AND NUTRITION RESPONSE

For large CAT III responses, there may be the need for international staff to manage the different components, but in a smaller-scale response, the local health manager may be able to support a local response manager.

Table 17. Suggested emergency staff for MNCH and nutrition response

National office	Field positions/ local staff	Field positions/ local staff	Field positions/ local staff
International staff • Medical Advisor (to start programme) • Health, nutrition and HIV manager for response • Disability advisor (if disability programme) • Nutrition advisor (if nutrition programme) • HIV in emergencies advisor • GBV advisor (if not done by protection or HIV advisor) • MHPSS advisor (if not in protection) • Health and hygiene trainer **National staff** • Health, nutrition, HIV manager (local counterpart) • Administrator • Translator (for expatriates) • Drivers	**Mobile clinics** • Mobile clinic manager • MNCH manager • Pharmacist/medical supplies • Nurse/midwife • Doctor (where countries require an MD to run clinic) • Dispenser/medical technician/vaccinator • Warehouse assistant for medical supplies • Health outreach volunteers • HMIS officer for reporting • Warehouse labour	**Nutrition/CMAM programme** • Nutrition manager • Mobilisation manager • HMIS/database officer • Stablisation centre (SC) supervisor • SC nutrition nurse • SC measurers • SC support staff (distributer, cleaner, etc.) • Outpatient therapeutic programme (OTP) supervisor • Nutrition nurse • OTP measurers • OTP support (distribution staff etc • Nutrition mobilisers • Food distributor • Warehouse supervisor for CMAM products • Warehouse labour	**Women and baby-friendly spaces** • Baby-friendly area/women's space manager • Nutritionist • MNCH facilitator • IYCF facilitator • Nutrition mobilisers • Local support officers
	Health, HIV and hygiene promotion • Health, HIV and Hygiene promotion manager • HIV in emergencies manager (in areas of high prevalence) • Health/HIV promoters • Trainer for health/HIV promotion messages	**Disability support** • Disabilities manager • Disabilities facilitators/ case workers • Rehabilitation specialist	**MHPSS** • Psychosocial manager • MHPSS interagency online networker • MHPSS facilitators/case workers • Translator

DECISION TREE FOR MANAGEMENT OF ACUTE MALNUTRITION

Table 18. Decision tree: Interventions and appropriate products for MAM prevention and treatment (continued)

	Context	Programme intervention	Purpose	Target group	Product	Recommended use
Prevention	• **High prevalence of global acute malnutrition (GAM Over 15%)**[81] • **High incidence (caseload) of MAM and/or SAM**[82]	**Blanket supplementary feeding** • Supplementary feeding for ALL children aged 6 to 24 months irrespective of nutritional status • During lean season for three to four months or during an nutritional emergency for three to six months	• Reduce prevalence of acute malnutrition to less than 15%. Prevent morbidity and morality • Reduce incidence (number of cases) of MAM and/or SAM	ALL children aged 6 to 24 months	**Ready-to-use supplementary food (RUSF)**	• Where there is food at household level and/or a general ration is in place • Used as a snack between meals • Can also be used as part of the general ration
					Corn Soya Blend (fortified) for children 6 to 24 months CSB ++ 200 g/day	• Where food insecurity is a significant problem and/or there is no general ration in place • Used as a partial replacement for local diet twice/day
	• **High prevalence of acute malnutrition** • **High rates of stunting and/or LBW**	**Blanket supplementary feeding** • ALL pregnant women from second trimester up to six months after delivery	• Protect nutritional status of mother and prevent under-nutrition in infants	ALL PLW with infants aged less than 6 months	**Corn Soya Blend (fortified) for children <2 yrs and adults CSB + 200 g/day**	• In emergency situations where food insecurity is a significant problem and/or there is no general ration in place • In non- emergency situations as part of MCH programming

81 Prevalence of acute malnutrition among children 6 to 59 months at population level is defined as weight for height less than -2 Z and/or oedema. This is the global acute malnutrition (GAM) rate. GAM rate of greater than 15% is considered an emergency and reason for intervention. This is context specific. Aggravating factors include CMR greater than 1/10,000/day; epidemic of measles or whooping cough; high prevalence of ARI or diarrhoeal diseases.

82 Moderate acute malnutrition (MAM) is defined for entry to treatment as mid-upper arm circumference (MUAC) less than 125 mm. Severe acute malnutrition is defined for entry to treatment as MUAC less than 115 mm and/or oedema. Incidence is the number of cases meeting the criteria for MAM and/or SAM.

Table 18. Decision tree: Interventions and appropriate products for MAM prevention and treatment (continued)

	Context	Programme intervention	Purpose	Target group	Product	Recommended use
Prevention	• **Population difficult to reach due to logistical or security problems**	**Blanket supplementary feeding** **OR part of the general ration** • ALL children aged 6 to 24 months for three months • Whole population for limited period during first month of emergency	• Prevent decline in nutritional status • Stop-gap measure until programming and pipeline are established	ALL children aged 6 to 24 months Whole population	**RUSF**	• Initial phase of an emergency • No cooking facilities • Limited food available/ pipeline not established
	• **High prevalence of stunting greater than 30% or underweight greater than 20%** • **Low GAM** • **High risk of growth faltering**	**Blanket supplementation approach** • Supplement to ALL children aged 6 to 24 [83] months for six months	• To reduce prevalence and incidence of stunting	ALL children aged 6 to 24 months	**Lipid-based nutrient supplements sachet**	• As a supplement to the local diet • Where there is food at household level • Given twice a day
					CSB++ **200 g/day**	• As supplement to local diet • Where food insecurity is a significant problem
		• Supplement to ALL pregnant women from second trimester until infant is 6 months	• To protect the nutritional status of the infant, promote growth	ALL PLW with infants aged less than 6 months	**LNS sachet**	• As a supplement to local diet • Taken twice a day
	• **High prevalence of micronutrient deficiencies** • **Prevalence of anaemia is greater than 40%** • **Low GAM and stunting levels**	• Minimum of 60 sachets every six months for each child. One sachet per day. • Dosage is context specific	• To prevent micronutrient deficiency, particularly iron deficiency anaemia	ALL children aged 6 to 24 months	**Micronutrient powder (MNP)**	• Diet monotonous, lacks animal source and/or fortified food • MNP added to local food after cooking • MNP should not be added to CSB or any RUF

83 Promotion of linear growth has proven effective in infants 6 to 12 months. This is the preferred target group.

Table 19. Decision tree: Interventions and appropriate products

	Context	Programme intervention	Purpose	Target group	Product	Recommended use
Treatment	**High prevalence of GAM greater than 15%** **High incidence of MAM (caseload exceeds seasonal levels)**	**Targeted supplementary feeding programme (SFP)** Take home ration[84] 6 to 12 months emergency intervention and/or Ongoing programme according to national CMAM guidelines	• Treat MAM • Prevent deterioration to SAM • Treat MAM and protect nutritional status of infant	Children aged 6 to 59 months MUAC under 125 mm PLW MUAC under 210 mm or with infant aged under 6 months	**RUSF or RUTF[85]**	• Situations where access and logistics are difficult • Situations where fuel and water are issues • Provided through existing OTP or by voucher at pickup point every two weeks or monthly
					CSB++ 200g/day	• Situations where logistics/ storage is not a problem • Fuel and water are available for cooking • When RUF is not feasible • Provided through exiting OTP or by voucher at pickup point every two weeks or monthly
	High HIV prevalence and associated MAM	**HIV+ adults with MAM on ART** Ongoing programme according to national CMAM guidelines and/ or guidelines for nutrition and HIV	• Treat MAM • Prevent deterioration to SAM • Increase adherence to ART	HIV+ older children (MUAC under 145–180 mm) HIV+ adults MUAC under 210 mm	**RUSF or RUTF**	• Provided by prescription at pharmacy every month • Situations where sharing, logistics and stigma are issues
					CSB++ 300g/day	• Provided by prescription through pharmacy or by voucher at pickup point • Situations where storage, logistics, sharing and stigma are not issues and/ or RUF is not feasible
	High prevalence of micronutrient deficiencies known or suspected	One sachet per day for 60, 90 or 120 days, or 60 sachets over a period of 90 to 120 days – no more than one sachet per day. Dosage is context specific	• Treat micronutrient deficiency, particularly iron deficiency anaemia	Children aged 6 to 59 months PLW	**MNP**	• MNP added to local food at home after cooking • MNP should not be added to CSB or any RUF

84 The majority of supplementary feeding programmes include a take-home ration every two weeks or monthly. On-site feeding programmes are implemented in exceptional situations where security is a concern, food preparation is imposs ble at home and the ration provided needs to be cooked, or there are large numbers of unaccompanied children/OVC.

85 RUTF (one sachet /day or two for adults) can be used instead of RUSF for the treatment of MAM. It is effective. The primary concern is reduction of cost. An RUSF (or RUTF) that does not contain milk is cheaper. In HIV and nutrition programs RUF and CSB ++ rations are sometimes both provided (combined ration).

GLOSSARY OF KEY TERMS AND CONCEPTS

Complex emergencies

A combination of internal conflict (produced by warfare, civil disturbance) with large-scale displacements of people, mass famine or food shortage and fragile or failing economic, political and social institutions. Often complex emergencies are also exacerbated by natural disasters.

Dual protection

Protection against both unintended pregnancy and STIs, including HIV.

Emergency

A situation that threatens the lives and well-being of large portion of the population, needing extraordinary action to ensure the survival, care and protection of those affected. Emergencies may occur suddenly in time (quick onset), or they may develop over a period of time (slow onset). In this guide we use the term 'emergency' to refer to natural disasters, conflict or complex situations that can affect the well-being and survival of populations.

Emergency obstetric care[86]

Life-saving emergency interventions performed by skilled providers to manage the majority of maternal complications in pregnancy, childbirth and postpartum period, including basic neonatal resuscitation to treat asphyxia.

Emergency obstetric and newborn care (EmONC)

Emergency obstetric and newborn care (EmONC) ensures not only that obstetric functions are performed, but also that essential newborn care interventions are carried out, such as resuscitation, thermal protection, promoting early and exclusive breast-feeding, treatment of neonatal sepsis, and care of preterm and LBW babies. In this guide, EmONC is used to stress the importance of linking newborn care with maternal health interventions.

Basic emergency obstetrics

Basic emergency obstetrics is performed by trained health professionals with competency to administer intravenous antibiotics, intravenous uterotonic drugs (such as pitocin), intravenous anticonvulsant drugs (magnesium sulphate), manual removal of placenta and retained products of conception using appropriate technology, assisted delivery (vacuum or forceps), maternal and newborn resuscitation.

There must be at least five EmONC facilities (including at least one comprehensive EmOC facility) for every 500,000 population. These facilities have to be accessible by road or waterway with affordable means of transport. The services should be free at point of delivery, culturally appropriate and respectful to women.

Comprehensive emergency obstetric care (CEmOC)

Comprehensive emergency obstetric care (CEmOC) at the hospital level includes all of the above interventions plus operating theatre and staff able to perform caesarean delivery/laparotomy, under general anaesthesia, and safe blood transfusion.

Fragile context

Often defined as states that lack the capacity and/or will to provide for the well-being and security of their citizens. Fragile contexts often have ongoing conflict and/or significant violations of civil and political rights, weak capacity among duty-bearers, lack of aid delivery from donors direct to national governments, or active isolation of national governments by donors.

Global acute malnutrition

Prevalence of acute malnutrition among children 6 to 59 months at population level is defined as weight for height less than -2 Z and/or oedema.

Health cluster

The cluster system may be activated during an emergency. The Global Health Cluster is led by the World Health Organization (WHO); however, the health cluster lead agency at the country level may be another humanitarian health organisation. A reproductive health (RH) coordinator or officer will be appointed by the health cluster lead agency to facilitate the RH emergency coordination and response.

86 Inter-agency Working Group on Reproductive Health in Crisis (2010). *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, revision for field review*.

Long-lasting insecticidal net (LLIN)

An insecticide-treated net that does not need to be retreated because the insecticide has been incorporated into the mosquito net fibres.

Mid-upper arm circumference (MUAC)

Measurement made with a tape at the mid upper left arm of a child <59 months or a pregnant or lactating woman to determine nutritional status.

Minimum initial service package (MISP)

Addresses reproductive health needs at the onset of an emergency and defines which RH services are most necessary in order to prevent morbidity and mortality, especially among girls and women. MISP is a Sphere standard and describes minimum requirements.

Moderate acute malnutrition (MAM)

Is defined as a MUAC reading less than 125 mm.

Optimal infant and young child feeding

Refers to initiating exclusive breast-feeding within one hour of birth, exclusive breast-feeding for the first six months of life, followed by nutritionally adequate and safe complementary foods, while breast-feeding continues until the child is 2 years or older.

Rapid onset disasters

Natural disasters that often occur unexpectedly with little warning, including earthquakes, tsunamis, volcanic eruptions, landslides, hurricanes, flash floods and wildfires, to name a few.

Reproductive health

'…a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes.' *ICPD Cairo 1994; Programme of Action, Para 7.2.*

Severe acute malnutrition (SAM)

Is defined as a MUAC reading less than 115 mm and/or oedema.

Skilled birth attendant

An accredited health professional such as midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.

Slow onset disasters

Those that gradually deteriorate a society's capacity to withstand the effects of the hazard or threat. Hazards causing these disaster conditions typically include cyclical droughts, famines, general food insecurity, environmental degradation, desertification, deforestation and some floods.

The Code

The International Code of Marketing of Breast-Milk Substitutes and additional WHA resolutions (the Code), adopted by the World Health Assembly, aims to protect and promote breast-feeding by ensuring the proper use of BMS when these are necessary, and the provision of adequate information and appropriate marketing and distribution.

Traditional birth attendant

Either trained or untrained community members who are tasked with overseeing childbirth. It is currently not recommended by WHO to train or equip TBAs to conduct deliveries. In humanitarian settings, it is important to integrate them into specific MNCH services, such as arranging referrals to facilities, promoting reproductive health, and organising community acceptance of facility services.

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