

DRAFT

[27 June 08]

Managing WHO Humanitarian Response in the Field

ANNEXES

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Annex series A
**Materials on the Effects and Priorities in Different Types of
Emergency**

Response priorities in particular kinds of disasters

[Extract from *Health effects of hazards*, http://www.who.int/hac/techguidance/tools/WHO_strategy_hazards.pdf]

Hazard	Impact on Public Health	Health Priorities for Response	Recovery and Rehabilitation
epidemics; environmental pollution	immediate increased risk of death, illness and disability; risk of infection or contamination for relief personnel; (long term) exposure of public to toxic substances; overload of facilities and services; rumours; diversion of resources	confirm the problem; identify and confirm the cause; issue guidelines, educate staff and mobilise resources; case diagnosis, case confirmation, patient care, case treatment and referral; activation of surveillance and monitoring systems to monitor caseload, case fatality rates, morbidity and mortality; prevent spread; protect staff and facilities; care of the dead; public information, dealing with the media and international aid	health education, public awareness, public information and community involvement; documentation and analysis of the incident; social services for the affected groups
storm; earthquake; volcano; flood; landslide; tsunami; fire; explosion; accidents	immediate increased risk of death, illness and disability; possible environmental pollution; (long term) exposure of public to toxic substances; damage to or loss of essential life support services - water, food, shelter; displacement of population; breakdown in security; breakdown in communications networks and information flows; damage to and loss of facilities, services and staff; high levels of psychosocial stress	search and rescue, triage, first aid, medical evacuation, hospital emergency care; protect staff and facilities; activate mass casualty management plans; activation of surveillance and monitoring systems for injury, disease, nutritional status, water quality and disability; special services for the homeless and displaced - water, food, shelter, health, security; stress management; care of the dead; public information, dealing with the media and international aid	health education, public awareness, public information and community involvement; documentation and analysis of the incident; social and counselling services for the affected groups - disabled, displaced; infrastructure demolition, repair and replacement; economic regeneration

ANNEX A – MATERIALS ON EFFECTS & PRIORITIES IN DIFFERENT TYPES OF EMERGENCY

Hazard	Impact on Public Health	Health Priorities for Response	Recovery and Rehabilitation
drought; famine; pests; plagues; infestations	long term risk of increased morbidity and mortality; breakdown in food security; population displacement; high levels of psychosocial stress; exposure to toxic substances (chemical sprays)	reinforcement of essential services; activation of surveillance and monitoring systems for disease, nutritional status and water quality; special services for the homeless and displaced - water, food, shelter, health, security; stress management; care of the dead; public information, dealing with the media and international aid	health education, public awareness, public information and community involvement; documentation and analysis of the incident; social and counselling services for the affected groups - disabled, displaced; economic regeneration
war; civil strife; economic crisis	immediate increased risk of violent death and disability; possible environmental pollution; damage to or loss of essential life support services - water, food, shelter; displacement of population; breakdown in security; breakdown in communications networks and information flows; damage to and loss of facilities services and staff; high levels of psychosocial stress	immediate provision of essential services - shelter, water, food, etc.; activation of surveillance and monitoring systems for injury, disease, nutritional status, water quality and disability; special services for the homeless and displaced - water, food, shelter, health, security; stress management; care of the dead; protect staff and facilities; public information, dealing with the media and international aid	health education, public awareness, public information and community involvement; document and analyse the incident; recruitment and training of new staff; social and counselling services for the affected groups - disabled, displaced, demobilised; infrastructure demolition, repair and replacement; dealing with special hazards such as landmines and military ordinance; economic regeneration



Demands on the health sector of different types of hazard/emergency

Type of Emergency	Primary Hazard	Primary Causes of Death & Illness	Main responsibility of the Health Sector	Level of risk for the health network	Capacities needed	
					Technical	Support
Epidemics of Infectious Origin	Known Disease	Agent-specific	Alert and Assessment Case Management Outbreak Control	+	Epidemiology & DC Medical/Nursing care Environmental Health	Communications, Laboratory, Facilities & Supplies, Funds Inter-sectoral collaboration
	New Emerging Diseases	Agent-specific	Alert & Assessment IDENTIFICATION OF AGENT Case Management Outbreak Control	+++	As above, plus field research, crash training of personnel, new, specific health education possibly Cordon Sanitaire	As above, plus access to more sophisticated Reference Centres, greater capacity for isolation, special drugs or vaccines
Emergencies by Other Natural causes	Mass Food Poisoning by Natural Causes	Agent-specific	Assessment Identification of Cause Case Management Information and education	-	Epidemiology Medical/Nursing care Education	Communications, Laboratory Facilities & Supplies Inter-sectoral collaboration
	Drought	Diarrhoea, Malnutrition, Any other cause, by decreased access to Health services and higher vulnerability	Need assessment Disease Control Nutritional Surveillance Therap./Supplem.feeding	+	Epidemiology Disease control Nutrition	Communications. Logistics & Funds for Outreach. Supplies Inter-sectoral collaboration and coordination of relief
	Floods	Drowning, Trauma, Diarrhoea, ARI, vector-borne diseases	Search & Rescue/triage Need assessment Disease control Assistance in temporary shelters	+	Mass casualty Management Env. Health/Vector Control Health care in temporary shelters	Special Training for staff and volunteers Inter-sectoral collaboration and coordination of relief
	Cyclone	Trauma, Drowning, Diarrhoea, ARI, Vector-borne diseases	Same as above	++	Same as above	Same as above
	Tidal surge & Tsunami	Drowning, Trauma, Diarrhoea, ARI, vector-borne diseases	Same as above	+	Same as above	Same as above

ANNEX A – MATERIALS ON EFFECTS & PRIORITIES IN DIFFERENT TYPES OF EMERGENCY

Type of Emergency	Primary Hazard	Primary Causes of Death & Illness	Main responsibility of the Health Sector	Level of risk for the health network	Capacities needed	
					Technical	Support
	Earthquake	Trauma, suffocation, Burns	Search & Rescue/triage Need assessment Casualty Management Assistance in temporary shelters	+++	Mass Casualty Management Health Care in Temporary shelters	Intensive care facilities Hospital vulnerability Assessment and reduction
	Landslide	Trauma, Suffocation	Same as above	+	Same as above	Same as above
	Volcanic eruption	Trauma, suffocation, burns, Acute Respiratory distress	Need assessment Casualty management Assistance in temporary shelters	+	Mass Casualty Management Health Care in Temporary shelters	Intensive Respiratory Care Unit
	Bush Fire	Burns, Trauma, suffocation	Same as above	-	Same as above	Burn care facilities
Emergencies from Technological Causes	Transport Incident (road, railways, air, sea etc.)	Trauma, Drowning, Burns, suffocation	Search & Rescue/Triage Casualty Management	+	Mass Casualty Management	Intensive care facilities
	Fire in Human Settlement	Burns, Trauma, suffocation	Search & Rescue/Triage Casualty Management	+++	Mass Casualty Management Intensive care unit	Burn care facilities Hospital vulnerability assessment and reduction
	Industrial explosion, fire, spill, radiation	Blast, Trauma, Burns, Acute respiratory distress, suffocation, Agent-specific	Search & Rescue/Triage Casualty Management	+	Mass Casualty Management Specific Medical/Nursing care	Intensive care facilities Hospital vulnerability assessment and reduction
	Collapse of man-made structure	Trauma, suffocation, drowning, other according to type of structure	Search & Rescue/Triage Casualty Management Assistance in temporary shelters	+++	Mass Casualty Management	Intensive care facilities Hospital vulnerability assessment and reduction
	Failure of lifeline systems	Any cause, by lack of critical support care Trauma by crowd panic	Prompt back-up Casualty Management	+++	Mass Casualty Management	Hospital vulnerability assessment and reduction Back-up systems

ANNEX A – MATERIALS ON EFFECTS & PRIORITIES IN DIFFERENT TYPES OF EMERGENCY

Type of Emergency	Primary Hazard	Primary Causes of Death & Illness	Main responsibility of the Health Sector	Level of risk for the health network	Capacities needed	
					Technical	Support
	Mass Food poisoning by Human causes	Agent-specific	Alert and assessment Identification of Agent Case Management	+	Epidemiology Specific Medical/Nursing care Environmental health	Toxicology Special Decontamination facilities Access to special Reference Centres
Complex Emergencies	Armed Conflict	Trauma, malnutrition, ARI, Diarrhoea, Measles, Meningitis, Vector-borne diseases	Need assessment and Advocacy Disease Control Nut. Surveillance & Select. Feeding Injury Management	+++	Epidemiology & Disease Control Nutrition War Surgery Health Care in temporary shelters	Special Agreements & Procedures War Surgery facilities/capacities Safe Transfusion facilities Coordination of International Aid
	Mass Labour Unrest	Trauma, any cause by lack of critical support care	Mass Casualty Management	+	Mass Casualty Management	Special Agreements & procedures
	Terrorist Attack	Blast, trauma, fire, suffocation, acute. respiratory distress, other specific (e.g. toxic gas)	Mass Casualty Management	-	Mass Casualty Management	Intensive care facilities
	Refugee/ Displaced Influx	Diarrhoea, ARI, Malnutrition, Measles, Meningitis, vector borne diseases	Disease Control Nut. Surveillance & Select. Feeding Assistance in Camps/Transit points	-	Epidemiology & Disease Control Nutrition Health Care in temporary shelters	Recruitment of volunteers Outreach and supervision Coordination
Major Public Functions	State Visit	Any: illness of state guests Illness among spectators Crowd incidents (stampede etc.)	Back-up for possible special, high-profile medical emergency Readiness for crowd incidents	-	Medical/Nursing care Mass Casualty Management	Intensive care facilities
	Pilgrimage	Epidemic diseases Illness among spectators Crowd incidents (stampede etc.)	Disease Control Readiness for crowd incidents Back-up for increased demand	-	Epidemiology & Disease control Environmental Health Mass Casualty Management	Intensive Care facilities Temporary outreach facilities
	Mass entertainment	Illness among spectators Crowd incidents (stampede etc.)	Back-up for increased demand Readiness for crowd incidents	-	Mass Casualty Management	Intensive Care facilities

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Some “areas of work” in relation to health services in disasters

[Extracts from *Template for planning WHO action in disasters*, version 1.5, WPRO February 2007]

PURPOSE	COMPONENTS	EXPECTED RESULTS
<p>To ensure international relief and recovery operations in health are comprehensive, adequate, appropriate, effective, timely and ethical</p>	<p><u>Organise and chair</u> regular meetings of health cluster member agencies to:</p> <p><i>Specifically:</i></p> <p><u>Develop and maintain</u> a database of contact information, location of operations and services provided by all member agencies.</p> <p><u>Plan and conduct</u> initial and follow-up assessment exercises.</p> <p><u>Prepare and disseminate</u> joint sitreps, press releases and operations reports.</p> <p><u>Reach consensus</u> on areas of responsibility and areas of operation for each member agency.</p> <p><u>Identify and resolve</u> gaps, overlaps, duplications or conflicts in resources, services, access or coverage.</p> <p><u>Facilitate</u> the development of common standards for reporting and for systems / mechanisms which collate, store, map and disseminate health data and health information.</p> <p><u>Facilitate</u> the preparation, publication and dissemination of operation-specific technical guidelines and public information / health education material.</p> <p><u>Facilitate</u> dialogue, consensus building and problem solving between member agencies and between the international community and government.</p> <p><i>Generally:</i></p> <p><u>Promote</u> the adoption of national policies and practices as the basis for planning projects and implementing operations.</p> <p><u>Promote</u> the adoption of internationally accepted benchmarks, standards and protocols such as on breast feeding, essential drugs, drug donations, DOTS, HIV/AIDS etc.</p> <p><u>Facilitate</u> the development of common approaches and strategies for operational planning and resource mobilisation.</p> <p><u>Facilitate</u> the setting of common goals, standards and benchmarks for projects and programmes.</p> <p><u>Promote</u> the adoption of common standards and specifications for the purchase of equipment and supplies.</p> <p><u>Identify</u> the need for and <u>facilitate</u> the planning of non-routine information gathering exercises, such as operational research, surveys and studies.</p>	<p>There are no <u>gaps, overlaps, duplications or conflicts</u> of resources, services access, or coverage;</p> <p>Reliable and appropriate <u>information</u> is available and accessible;</p> <p>Effective and appropriate <u>health services</u> are available and accessible to a high proportion of the affected population;</p>

ANNEX A – MATERIALS ON EFFECTS & PRIORITIES IN DIFFERENT TYPES OF EMERGENCY

<p>Organisation and Delivery of Essential Health Services</p>	<p>To ensure quality of, coverage of, and access to, effective and appropriate essential health services</p>	<p><u>Support</u> government and the international community to undertake an early Damage and Needs Assessment, focussing on health sector structural damage, equipment losses, personnel needs, access and communications issues and setting priorities for meeting urgent medical and public health needs;</p> <p><u>Support</u> for national and local authorities to work with and through national and local non-governmental groups to ensure that essential health care services are appropriate, adequate and sufficient in terms of quality, access and coverage; including availability of essential drugs; direct and referral services for life threatening non-communicable diseases, trauma care, emergency care and disability care; and critical diagnostic and support services such as laboratories and blood banks;</p> <p><u>Support</u> for health authorities to establish systems for the collection, analysis and dissemination of information on injuries, disabilities, mental health, nutrition status and water quality;</p> <p><u>Support</u> for agencies working in nutrition, mental health, reproductive health and child health to procure essential supplies</p> <p><u>Support</u> for agencies working in water, sanitation and waste disposal through strengthening laboratory for water quality testing, procuring essential supplies and promoting personal hygiene and food safety.</p> <p><u>Establish</u> mechanisms for:</p> <ul style="list-style-type: none"> • supporting the MOH to co-ordinate all providers of care • ensuring conformity with nationally agreed protocols • offering relevant technical advice and training. <p><u>Provide</u> analysis of health sector human resources needs and assist health authorities to devise appropriate strategies to recruit, train, retain, and motivate key health personnel, including re-starting training programmes disrupted by the disaster;</p>	<p>Reliable and appropriate <u>information</u> for all levels of decision making and service delivery is available;</p> <p>Minimum <u>resource</u> needs for essential health services are being met;</p> <p>Health services <u>support systems</u> such as IT, transport, communications and logistics are in place and functioning;</p> <p><u>Essential health services</u> are available and accessible to a high proportion of the population;</p>
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ANNEX A – MATERIALS ON EFFECTS & PRIORITIES IN DIFFERENT TYPES OF EMERGENCY

<p>Care of the dead, injured and disabled</p>	<p>To prevent excess disability, morbidity and mortality from injury and violence</p>	<p><u>Support</u> for health authorities in developing/enhancing and maintaining injury and disability surveillance/registry/tracking systems through technical advice, training and provision of supplies.</p> <p><u>Support</u> for the national authorities in developing/enhancing to retrieve, store and identify the dead, determine cause of death and return the dead, with appropriate counselling, to family members.</p> <p><u>Support</u> for health and related authorities in developing/enhancing systems to retrieve and transport the injured, provide onsite first aid and primary care, register the injured and track their outcomes, provide emergency wound care and emergency surgery, and follow up cases after discharge.</p> <p><u>Support</u> for hospitals in developing/enhancing systems for providing support services such as blood banks, orthotics; prosthetics; dental care; spinal, burns, head injury and amputee care and disability care;</p>	<p><u>Mortality rates</u> in the pre-hospital chain are low;</p> <p><u>Incidence</u> of wound infections, including tetanus, is low;</p> <p><u>Case complication rates</u> are low;</p> <p><u>Public satisfaction</u> with services for the care of the dead is high;</p>
<p>Communicable Disease Surveillance and Control</p>	<p>To prevent excess morbidity and mortality from diseases of epidemic potential (DEP), vaccine preventable disease (VPD), vector born diseases (VBD) and diseases of public health significance (DPHS)</p>	<p><u>Support</u> for health authorities to sustain a communicable disease surveillance, alert and investigation system through technical advice, training and provision of supplies.</p> <p><u>Support</u> for the national EPI programme to re-establish surveillance and control activities, and to implement an emergency vaccination programme against measles.</p> <p><u>Support</u> for the national TB Control and HIV-AIDS programme to re-establish surveillance, prevention and control activities;</p> <p><u>Support</u> for the Vector Born Diseases Control programmes to re-establish surveillance, prevention and control activities, particularly for malaria and dengue;</p>	<p><u>Cases</u> of Diseases Of Epidemic Potential are identified and outbreaks controlled;</p> <p><u>Incidence</u> of Vaccine Preventable Diseases is low;</p> <p><u>Detection</u> of TB, dengue and malaria cases is effective and mortality is low;</p> <p><u>Public</u> awareness on issues related to disease prevention and control is high;</p>
<p>Health Policy, Planning and Coordination</p>	<p>To facilitate effective and efficient identification, acquisition, use of and accounting for resources for health sector service delivery, in recovery and reconstruction</p>	<p><u>Build</u> capacity of provincial and district health authorities to:</p> <ul style="list-style-type: none"> o monitor and report on the health status of populations; o maintain an overview of national and external service providers and resources planned and available through provision of technical advice, training, repair and refurbishment of premises, equipment, supplies, transport, and operating costs. <p><u>Work</u> with UN joint planning mechanisms to ensure sufficient, adequate and appropriate inputs are being made to shelter, water and sanitation, livelihoods, food and nutrition.</p> <p><u>Ensure</u> that the activities of WHO are planned, executed and coordinated with district and sub-district health care systems.</p> <p><u>Work</u> with Government, UN agencies, multilateral and bilateral donors to agree a common approach to rehabilitation and reconstruction, which includes identifying and addressing future disaster risk reduction opportunities.</p>	<p>Provincial and district health offices are <u>staffed, organised and resourced</u>, and their services are functioning adequately;</p> <p>Systems and tools for providing the <u>evidence base</u> for developing policies and strategies for rehabilitation and reconstruction are in place and functioning;</p> <p><u>Coordination systems</u> at national, provincial, and district levels are established and functioning;</p> <p>Local multi sectoral disaster <u>risk reduction policies and plans</u> are in place;</p>

Annex series B
**Materials for Directing and Coordinating the WHO
Response**
(ref. chapter 3)

Possible WCO structures (organigrams) for humanitarian response

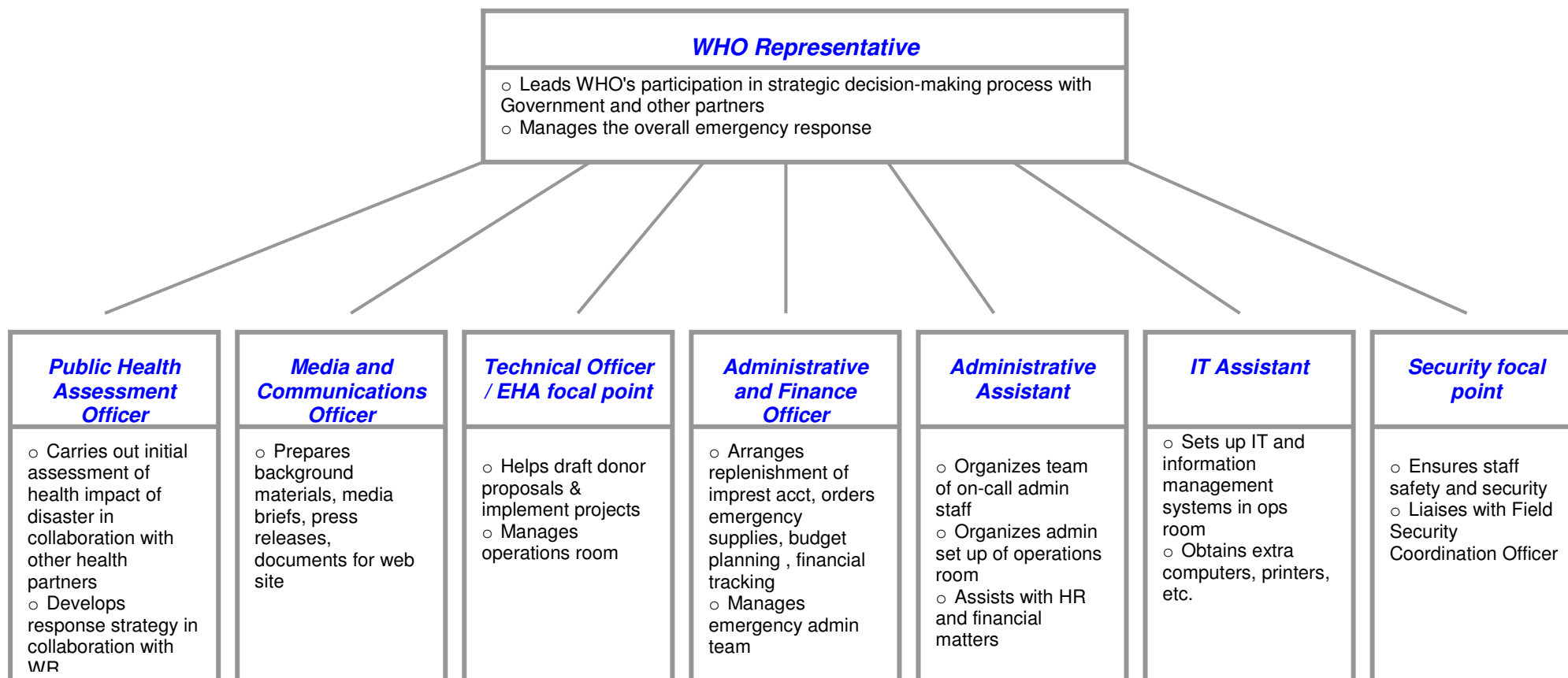
This annex presents three possible structures/organigrams:

- Possible structure for a small-scale emergency (reproduced from SOP 2.2, 2007)
- Possible structure for a large-scale humanitarian crisis (reproduced from SOP 2.4, 2007)
- The structure adopted by the WCO Bangladesh for response to the cyclone in 2007

One or other of these possible structures/organigrams may be taken as a starting point and adapted to the needs of the particular situation and context.

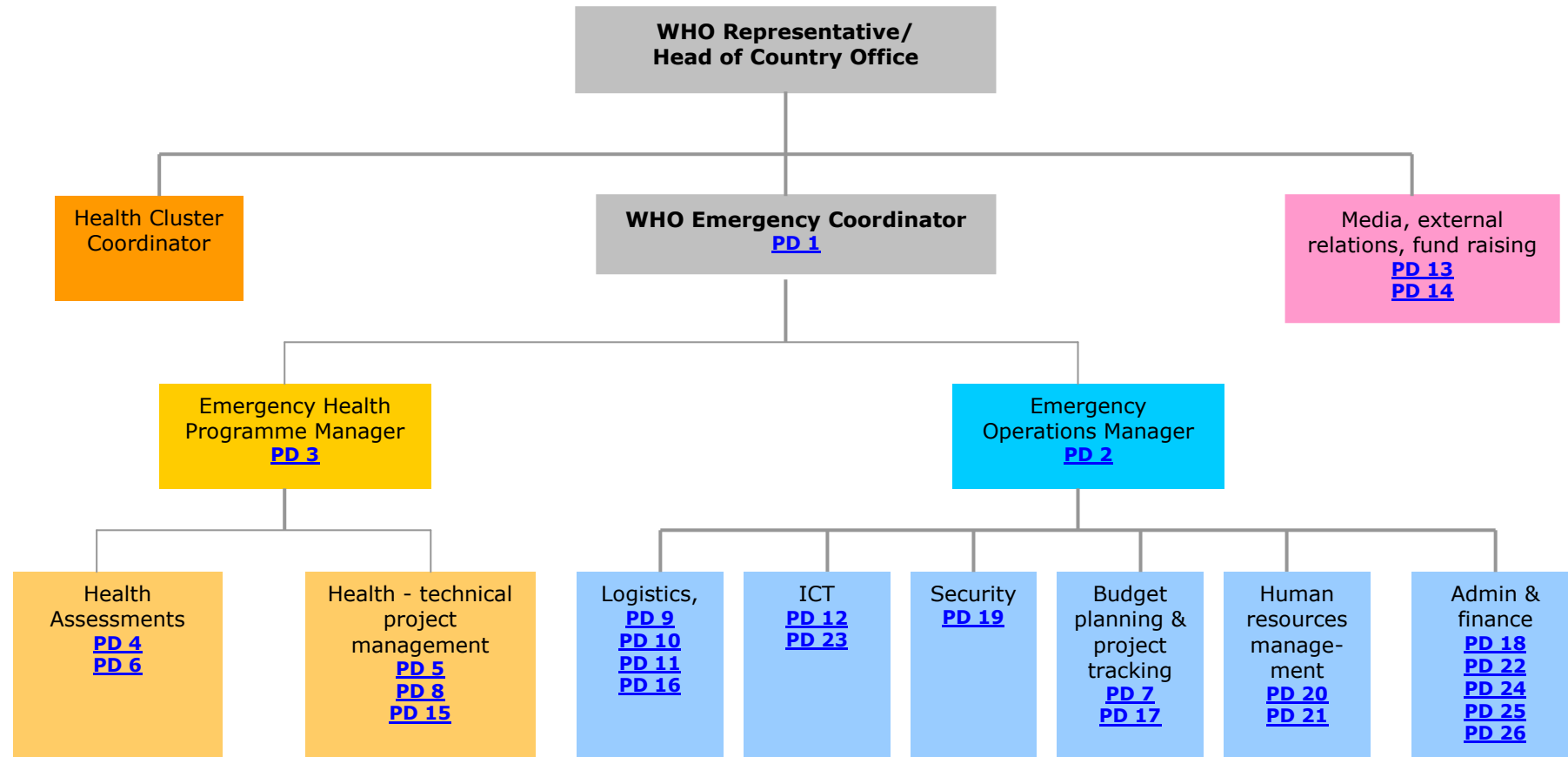
Possible WCO structure (organigram) for a small-scale emergency

One person may be responsible for several of the functions shown, depending on staffing levels in WHO country office.
More details of each function are provided under “Key Tasks” in SOP 2.2.

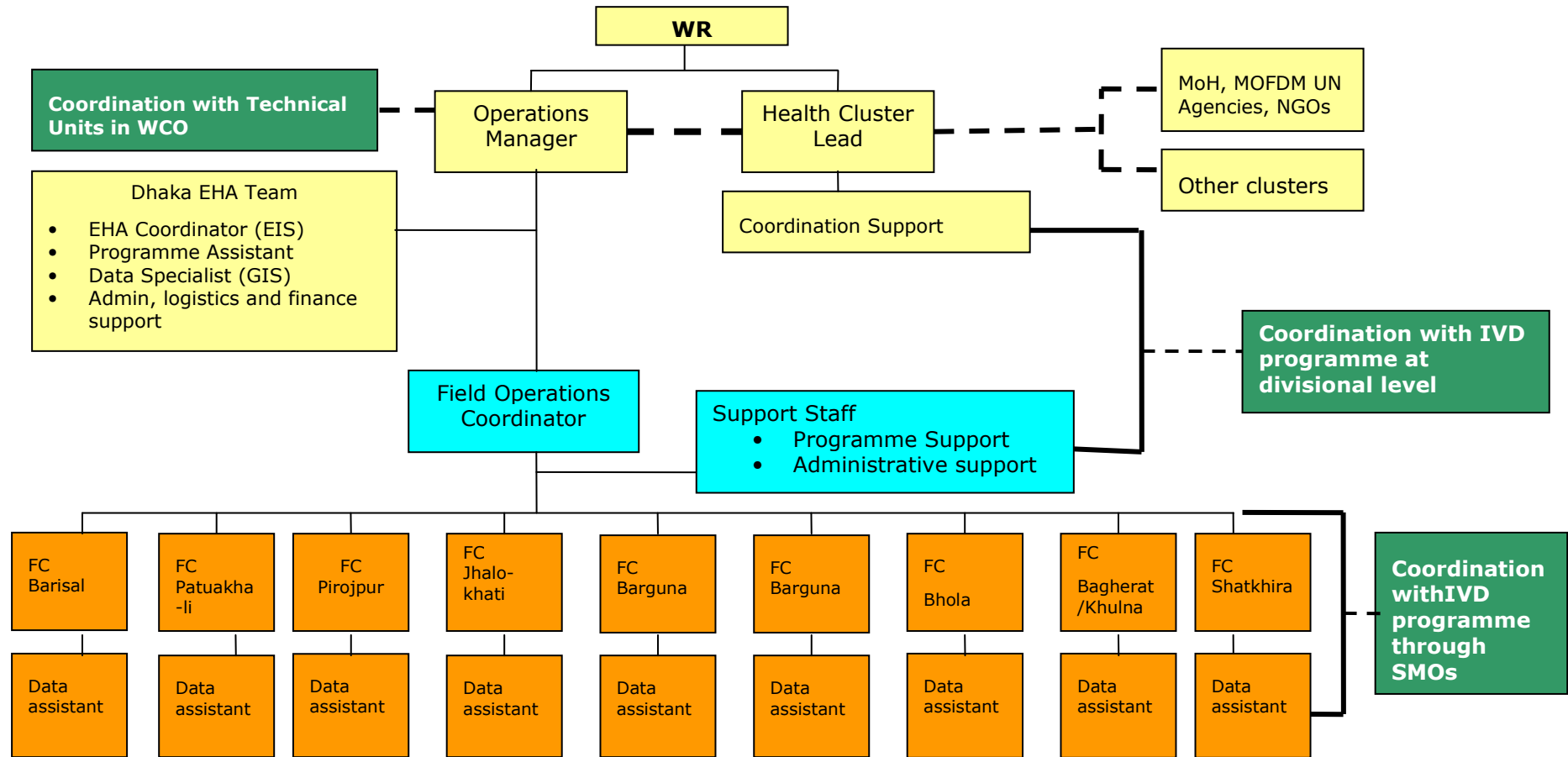


Possible WCO structure (organigram) for a major humanitarian crisis

PD# = generic emergency post description in SOP 8.1



Structure/organigram adopted by WCO Bangladesh for response to the cyclone in 2007



- WR oversees the operations
- The Field Operations Coordinator is based in Barisal with support staff and reports directly to the Operations Manager twice a week
- Field Coordinators (FCs) are based in identified districts and report directly to the Field Operations Coordinator twice a week
- All field coordinators have, or share, a data management assistant and secretary
- The health cluster coordinator works with partners in close liaison with the operations manager

ANNEX B – MATERIALS FOR DIRECTING AND COORDINATING THE WHO RESPONSE

Operational Tasks and Duties (defined for WCO Bangladesh response to the cyclone)

<p>Health Cluster Lead</p> <p>Under the guidance and supervision of the WR:</p> <ol style="list-style-type: none"> 1. Lead in the coordination of the activities of the health cluster 2. Supervise coordination support staff 3. Coordination support staff to report daily on activities of the health cluster and sub-groups 4. Liaise regularly with partners and central team of cluster heads 5. Organizes the documents, information of the health cluster for easy retrieval and archiving 6. Liaise with Operations Manager on a daily basis 7. Facilitate information sharing with partners 8. Coordinate the maintenance of a health cluster website, UN DER website and other information products 9. Other duties that may arise as per WRs instructions 	<p>Operations Manager</p> <p>Under the guidance and supervision of the WR:</p> <ol style="list-style-type: none"> 1. Liaise with Health Cluster Lead daily 2. Plan and lead in the implementation for the operations in consultation with the rest of the cyclone SIDR team 3. Supervise Divisional Field Operations Coordinator, EHA Coordinator, Information Management Coordinator 4. Provides back stop support to field operations coordinator 5. Provides information management support to the operations <ol style="list-style-type: none"> a. Consolidation of WHO situation report b. Provision of information to UN Agencies situation reports c. Provision of maps for the health cluster and the field operations d. Maintain the WHO BAN EHA website and 6. Looks after administrative matters for the operations 7. Liaise with the relevant technical officers in WHO through the WHO CMT (eg EPI, Reproductive health, nutrition) 8. Other duties which may arise out of the operations as per WR instructions or needs
<p>Field Operations Coordinator</p> <p>Under the guidance of the Operations Manager:</p> <ol style="list-style-type: none"> 1. Liaise and meet with partners in Barisal and affected districts 2. Plan for the field activities in coordination with field coordinators and the in consultation with the operations manager 3. Supervise the work of the field coordinators 4. Report regularly to the Operations manager through <ol style="list-style-type: none"> a. Internal Operations reporting b. Health situation reporting c. Collation and analysis of data from the field 5. Coordinate the production and dissemination of a weekly health bulletin 6. Coordinate information flow amongst the field coordinators and partners 7. Liaise with EPI coordinators 8. Manage the activities of the office including administrative and financial supervision for field operations including regular weekly reporting to the operations manager including coordination of arrival of supplies and equipment that may be needed for the different districts 9. Other duties which may arise out of the operations as per Operations Manager instructions or needs 	<p>Field Coordinator</p> <p>Under the guidance of the Field Operations Coordinator:</p> <ol style="list-style-type: none"> 1. Liaise and meet with partners in the districts in which they are based 2. Report regularly to the Field Operations coordinator through <ol style="list-style-type: none"> a. Regular weekly reporting as per format b. Collate information and data from partners c. Minutes of meetings that were conducted d. Provide inputs to a weekly health bulletin 3. Organize meetings, workshops and trainings at the district/upazila for assessments, surveillance, 4. Support MoH staff at district level in public health investigations/assessments, interventions 5. Provide logistics support for supplies and equipment that need to be in place in the districts 6. Coordinate information flow amongst partners 7. Supervise data management assistants 8. Liaise and coordinate with SMOs for EPI 9. Other duties assigned by the field operations coordinator

Roles and responsibilities in management and coordination – draft for refinement

FUNCTION		Representation	Programme Management	Health cluster(or sector) ¹ Coordination
PURPOSE		<i>There is accountability for country health cluster and WHO`s programmes and activities</i>	<i>WHO programs are managed in a coordinated way, in the emergency response as well as in the recovery</i>	<i>Country health cluster (or health sector) is coordinated, both in emergency response as well as in recovery</i>
Objective	Standards of performance			
Critical information made available	Assessment conducted; information shared	Reports to the Humanitarian Coordinator as Head of Health Cluster Lead Agency	<ul style="list-style-type: none"> Supervises and consolidates WHO contribution to joint assessments Uses and promotes the use of multi-cluster assessment tools 	<ul style="list-style-type: none"> Compiles stakeholder analysis (and 3W) Takes the lead in organizing assessments together with partners Promotes use of multi-cluster assessment tools Coordinates with RC/HC to ensure the Health sector's contribution to assessments within the framework of agreed guidelines Disseminates joint assessment reports
	Surveillance in place; information disseminated regularly	Ensures that critical health information is collected, validated, disseminated and utilized for appropriate decision making.	<ul style="list-style-type: none"> Support partners with advice, tools and guidelines; promotes cluster endorsed products De-conflicts between international best practice and national guidelines Ensures epidemiological quality control 	<ul style="list-style-type: none"> Ensures that all health partners contribute to, and receive information from common health surveillance system Promote standardized methods and tools Oversees the regular production of a health cluster bulletin Promote common system of reviews and evaluations using common benchmarks/indicators
Coordination in place	Health Partners coordinated	<p>Is the Head of the Cluster Lead Agency, and represents the Health Cluster vis-à-vis the Humanitarian Coordinator</p> <p>Ensures that the national/local health authority is fully involved in the work of the Health Cluster and jointly leads the cluster</p> <p>Ensures that public health priorities are given</p>	<ul style="list-style-type: none"> Represents WHO in Health Cluster meetings Has other WHO programmes coordinate with health partners Supports MOH input into Health Cluster or other health coordination forum 	<ul style="list-style-type: none"> Ensures that national authorities co-chair the Cluster, that all partners can participate Orchestrate decisions on the basis of the best public health evidence available Ensures that decisions are recorded, responsibilities attributed and action monitored Manages the Cluster secretariat

Title depends on whether cluster approach has been implemented, role should be similar

ANNEX B – MATERIALS FOR DIRECTING AND COORDINATING THE WHO RESPONSE

FUNCTION		Representation	Programme Management	Health cluster(or sector) ¹ Coordination
	Other Sectors/Clusters coordinating with Health Cluster for optimal health outcomes	due consideration by , and that public health programmes are coordinated with other humanitarian, transitional and developmental strategies and programmes Serves as Health Cluster Lead at all HC and Cluster Lead meetings and other high level meetings	<ul style="list-style-type: none"> • Ensure that MOH and WHO are active in other sectors/clusters, as relevant • Ensures WHO technical inputs at least to NUT and to WASH Clusters 	<ul style="list-style-type: none"> • Participates in HC-chaired meetings of Cluster Leads • Promotes and leads inter-cluster action for public health, by tasks forces, etc Promotes coverage of cross-cutting issues in overall health response
Critical gaps filled	Life-threatening conditions promptly addressed	Ensures that a) the WHO Emergency programme and b) the plan of work of the Health Cluster reflect the country's public health priorities, at immediate and medium term	<ul style="list-style-type: none"> • Identifies priority threats to human life • Identifies the determinants of these threats • Identifies the most appropriate measures at immediate and medium-term • mobilizes WHO expertise and resources accordingly • produces evidence to mobilize partners 	<ul style="list-style-type: none"> • Mobilizes Health Cluster on common priorities, • Ensures that priorities are translated into programmes and projects • Orchestrates the preparation of a common plan of action, • Coordinates attribution of tasks and allocation of resources with partners
	Equitable access to health care ensured	Ensures that all WHO country programmes a) coordinate with WHO/EHA and b) contribute to the humanitarian agenda Ensures that all possible measures have been taken to fill gaps and priority needs in the health sector (as provider of last resort)	<ul style="list-style-type: none"> • Identifies priority obstacles to equitable access to and delivery of health care • Identifies the determinants of these obstacles • mobilizes WHO expertise and resources accordingly • produces evidence to mobilize partners 	<ul style="list-style-type: none"> • Seeks alliances with other clusters/sectors • Supports implementation, monitors progress and reports to WR as Head of Lead Agency • Ensures partners are aware of norms and technical standards • Continually briefs WR on unfilled gaps as trigger for provider of last resort
Local systems preserved and reactivated	National partners fully integrated in relief	Advises MOH on how to accommodate humanitarian priorities in national long-term health strategies	<ul style="list-style-type: none"> • Facilitates national authorities acquaintance with international public health standards for humanitarian action • Provides list of national public health experts as resources for international partners 	<ul style="list-style-type: none"> • Facilitates technical collaboration between partners and national health research institutions, medical schools, etc • Supports de-centralized coordination and the involvement of sub-national health authorities and partners
	International partners complement national efforts and help to (re) build national capacity	Certifies the international public health value of national policies, strategies and standards	<ul style="list-style-type: none"> • Facilitates collaboration between national health programmes and international partners, according to respective capacities and objectives • Ensure that international health partners are acquainted with national strategies, policies, guidelines and protocols 	<ul style="list-style-type: none"> • Maintains liaisons between Health partners and the Early Recovery network • Ensures involvement of Health partners in recovery assessments, planning and negotiation processes, Donors' Round Tables, etc

ANNEX B – MATERIALS FOR DIRECTING AND COORDINATING THE WHO RESPONSE

FUNCTION		Representation	Programme Management	Health cluster(or sector) ¹ Coordination
Safe and strong WHO systems	Administration/operational support: <ul style="list-style-type: none"> ▪ Staff and assets safe ▪ Real time exchange of information ▪ Staff and assets administered and accounted for 	Delegates authority for, and supervises the deployment and use of WHO staff and assets (this includes the resources needed for the secretariat of the Health Cluster)	Plans and supervises the security, communications, logistics and all the administrative aspects of WHO emergency programme	
	Planning, Funding & Management: <ul style="list-style-type: none"> ▪ Overall direction in place ▪ Global back-stopping in place: <ul style="list-style-type: none"> - technical & programmatic - political and financial ▪ All stakeholders informed on progress 	Has the ultimate responsibility for the effectiveness and efficiency of a) the WHO emergency programme and b) of the overall health response Advocates and mobilizes resources at country and global levels; works with HC and donors to promote both WHO and health sector needs Ensures the continued functioning of other WHO programmes	<ul style="list-style-type: none"> • Assists WR in providing direction to WHO emergency programme • Ensures that the WHO emergency programme has the necessary resources and technical backstopping • Manages the WHO emergency programme: <ul style="list-style-type: none"> ○ prepares plans of work, ○ identifies projects, ○ mobilizes resources ○ ensures that resources are applied ○ monitors, evaluates and reports 	Actively advocates and mobilizes resources at country and global levels; works with WR and HC to promote health sector needs , flash appeal, CAP on behalf of all health partners

What is expected of a team leader in a humanitarian response

(Based, in part, on *Emergency Team Leadership Competences*, IASC Task Force on Training, 2004)

Leadership is concerned with overall vision, broad-based strategy, advocacy and ensuring that principles are promoted and maintained.

Management focuses on the implementation of agreed strategies and ensuring that result-based objectives are achieved.

Assuming a leading role for health means making sure that decisions for health action are taken in an integrated strategic framework and on the basis of a focused view of the real determinants of survival and health (not just on the basis of the capacities and interests of the different stakeholders).

Emergencies are characterised by fluid information, shifting operational priorities, often precarious management structures and high turn over of staff. In such circumstances, one key requirement for leadership is to formulate a **vision** that is wide enough and a **strategy** that is articulate and flexible, as well as easy to understand, so to accommodate frequent and rapid changes in situations, priorities, mechanisms and people.

Have and communicate a strategic vision

- Maintain a broad perspective of the situation
- Ensure all staff members understand the humanitarian needs and priorities, and the objectives and strategies being pursued.
- Understand the motivations of other actors (including political, military and other non-humanitarian actors)
- Ensure that longer-term goals are reflected in current activities, as much as feasible
- Consider the medium- and long-term implications of decisions (not short-term expediency)
- Avoid getting lost in the detail ... but be ready to go into detail when it is clear there is a problem that is affecting the overall success of the operation
- Carefully monitor the situation and all aspects of WHO's response, systematically review and analyse all new information and, when necessary, adjust priorities and WHO's approach according to changes in the situation.

Prioritize and delegate

- Focus on objectives and results at all times, and how to achieve them.
- Distinguish what is important, what is urgent, and what is not.
- Set clear targets so that team members feel responsible and accountable for their work.
- Delegate tasks to staff within their limits (so that tasks are completed and moral is maintained).
- Refrain from intervention where none is required.

Motivate; encourage team work

- Be positive. Focus on solutions rather than problems.
- Be practical and pragmatic. Remain in close contact with field realities through frequent field visits
- Draw on the knowledge and experience of all team members for benefit of the programme.
- Listen. Provide opportunities for issues to be debated within the team. Let staff know that their inputs are listened to and welcomed.

ANNEX C – MATERIALS FOR PLANNING AND MANAGING THE WHO PROGRAMME

- Encourage staff to “think outside the box”, propose ideas and, within the limits of their specific responsibilities, to take initiatives.
 - Provide structure: establish a clear plan of action but allow – and encourage – flexibility to adapt to changes in the environment during implementation
 - Define responsibilities clearly including an organigram and reporting lines. Respect those reporting lines yourself!
 - Emphasize the importance of sharing information among staff and with partners. Establish and get agreement on procedures for sharing information, and express appreciation for such sharing.
 - Review objectives and progress regularly with team members, sometimes individually sometimes collectively. When course corrections are needed, help the concerned team members to recognize the need and decide on corrective action
 - Give credit for work well done. Give credit/visibility to the efforts all individuals.
 - Understand and respect the diversity and skills of team members – their individual strengths, weaknesses, motivations, characteristics, management needs and expectations.
 - Help individuals to use and develop their skills and capacities, and to overcome their weaknesses. Provide opportunities for coaching and mentoring.
 - Look for and encourage opportunities to develop networking within team and externally at all levels.
 - Give close attention to managing staff turnover and integrating new team members. Ensure the preparation of good hand-over notes by staff preparing to leave, and arrange overlaps with successors whenever possible.
 - Ensure that short-term emergency response personnel from HQ and RO are incorporated into, and work efficiently and sensitively with, the existing WCO team.
 - Deal fairly with all staff.
 - Demonstrate personal commitment, calmness and provide direction.
 - Quickly tackle any conflict that arises between staff members; address the problem and its causes sensitively.
-

Take responsibility

- Be willing to take calculated risks and sometimes unpopular decisions, and take responsibility – be accountable – for the consequences.
 - Be decisive, when necessary, but also persuasive – explain your reasons.
 - Be ready to defend staff/team members who may face difficulties and criticism when they are doing what is asked of them to the best of their abilities.
 - Maintain security awareness and take responsibility for the safety and security of team members.
-

Support staff

- Acknowledge stress among team members and ensure (directly or through delegation) that opportunities are provided for staff to deal with stress constructively. Be aware of your own stress and reactions!
 - Look after the welfare of all team members, and encourage everyone to do likewise.
 - Support and encourages opportunities for relaxation for team members.
 - Recognize that different individuals have differing need: some need 8 hours sleep per night, while others can manage on 4!
-

Be self-aware

- Be aware of your own strengths and weaknesses. Build on the skills of other team members to establish and maintain team cohesion and identity (e.g. delegate another staff member to organise social events if that does not come naturally to you).
- Be open and honest, not defensive, about the limits of your own knowledge. Seek advice when you need to.
- Be aware of, understand and appreciate cultural differences. Be aware of your own prejudices.



Establishing an Operations Room ²

The following are indicative of what might be needed for an operations room for a major emergency operation. It must be adapted to the particular needs and possibilities of the local situation.

Premises

- a room large enough to hold meetings and give briefings
- space in the same room or an adjacent room for office equipment (see below), files and reference material
- good lighting, sufficient electric wall sockets, telephone line(s)
- access to nearby toilets and refreshment facilities (e.g. kettle, coffee machine, cups, etc.)

Equipment

- desks, chairs, filing cabinets, pigeon holes, bookshelves (including lockable drawers or cabinets)
- telephones (including one with teleconferencing facility, if possible), fax machine,
- computer workstations with internet connections, printer(s), scanner
- multimedia projector, overhead projector, screen
- photocopier
- wall clock
- maps (see notes below)
- flip charts, felt-tip pens
- white boards, non-permanent markers
- stationery including files, pens, pencils, paper, staplers, hole punch, masking tape (to fix maps and charts on the wall), trays for incoming/outgoing documents, etc.
- calculator(s), blank CD-ROMs, computer disks
- television and video cassette recorder (VCR) for presentations and briefings
- reference materials: baseline (pre-disaster) details on demography, epidemiology, health service capacities and usage, water supplies, sanitation, climate, the economy, etc.

Maps

A large-scale map of the country and bordering countries showing the main towns, transportation routes (airports, highways, railways and shipping ports), national and provincial/district boundaries.

Smaller scale maps of each affected area showing settlements, main routes, health facilities and water sources.

Use colour-coded pins or markers to show:

- where organizations are working.
- problem areas - direction of spread of diseases, etc.
- insecure areas or routes

² Adapted from WPRO *Emergency Response Manual* 9.11 and SOP 2.4 *Standard Equipment for meeting room/operations room*

Maps can help to:

- breakdown the affected area into manageable sections
- plan the deployment of resources and delineate areas of responsibilities
- identify movements of people and disease, and thus predict future trends and problems
- brief the partners on the overall situation

Maps may be obtained from government departments, the national survey office, other UN agencies or the military (which often has the best maps).

Tourist maps from hotels and service stations are sometimes useful (more detailed than might be thought) and readily available.

If possible, laminate copies of key maps and mount them on the wall.

Other information displays

Use wallboards or flip-chart sheets pinned to the walls to display key information such as; management structures (organigrams); where different teams and organizations are working; the locations of health facilities, transport and other assets; stocks of critical items in different locations; surveillance data and trends, etc.

Tables and graphs can display information on demography, climate, disease prevalence, service provision, etc. in a useful and easily interpreted manner. They can help track the progress of the operations and identify gaps and changes. They can thus help in determining present and future resource requirements and in predicting future difficulties.

Charts on the wall can be linked to maps by lines of coloured thread to show the areas to which they pertain.

Some sample charts are shown below.³

Population affected							Correct as at: .. / .. / ..
Location	Total	Dead	Injured	Missing	Homeless	Disease	...

Contacts				Correct as at: .. / .. / ..
Organization	Name(s)	Tel numbers etc	Notes	

Deadlines/Targets					Correct as at: .. / .. / ..
Date & time	Event/Action	Responsibility	Completed	Notes	

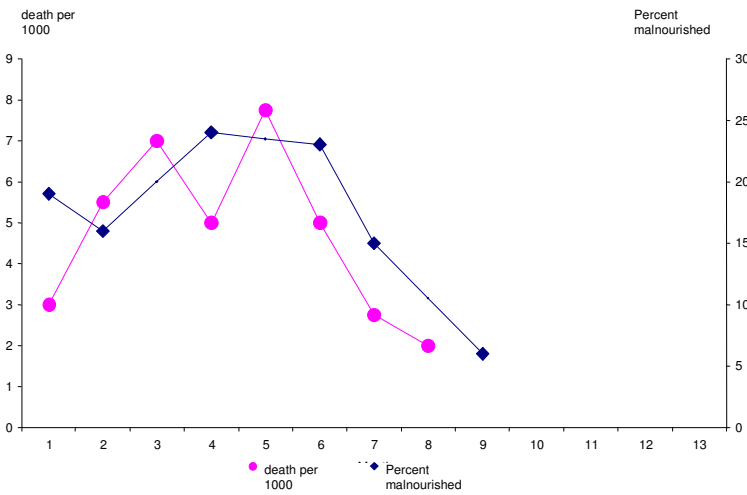
³ Mortality/malnutrition graph from *Emergency Field Operations*, EHA/FIELD/99.1; other charts from *Standard Operation Procedures for SEARO in Emergencies*, draft, 2001, reproduced from WPRO *Emergency Response Manual*, 2003.

ANNEX C – MATERIALS FOR PLANNING AND MANAGING THE WHO PROGRAMME

Resources			Correct as at: .. / .. / ..
Items	Quantity	Current location	Notes

Travel				Correct as at: .. / .. / ..
Name	Departure date & time	Arrival date & time	Travel details	Purpose

Reported mortality and malnutrition rates



Establishing a new field sub-office

In a major emergency, and especially when the MoH and health system are weak and in need of substantial technical or material support, WHO should establish a presence as close as reasonably possible to the affected area and populations while respecting the basic agreement with the government.

The guidance provided here may also be applied to the establishment of a WHO guesthouse.

Guiding principles

The WR can establish one or more field sub-offices for an emergency operation if the emergency delegation of authority has been granted by the RD (see annex B4 and SOP 6.1) and if the following criteria are met:

- a full-time WHO presence is needed in order to ensure the effective management and monitoring of WHO assistance in an area that cannot adequately be served from the country office or any existing sub-office;
- the emergency-affected area and population are large;
- the Designated Official (DO) for UN security approves;
- the national and local governments agree/have no objection; *and*
- funds are available for at least 6 months operation of the office.

WHO should consider establishing a field sub-office in – or at least out-posting a staff member to – any location where other UN and IASC agencies are establishing sub-offices and that is therefore becoming a *humanitarian hub*. Only through such a presence will WHO be able to provide technical leadership, try to ensure appropriate standards, and facilitate coordination in the field.

The RO and HQ-HAC should be informed.

Field sub-offices, where needed, should be established in locations with good road and/or air communications and reliable services (water, electricity), and where the MoH and other UN agencies have operational bases.

Adequate living quarters must be assured for staff at the sub-office location(s) including the minimum facilities necessary for hygiene, comfort and mental health.

What to do – key management actions

- Determine whether a field sub-office is necessary and justified and, if so, decide on the location.
- Prepare a proposal/plan and budget covering all the elements listed in the first panel below. For further details, see SOP 10.10 which also provides a large number of forms and guidelines for use in a sub-office.
- Choose premises using the criteria in the second panel below.
- Define procedures for recruitment and procurement. The following may be considered:
 - Recruitment: normally, vacancies are announced locally and candidates are screened and interviewed jointly by the sub-office and county office. Decisions are made and letters of appointment issued by the WCO.
 - Salaries for sub-office staff are paid from the WCO by bank transfers, wherever possible.
 - Local procurements: normally, the head-of-sub-office is delegated authority up to an amount determined by the WR. For larger amounts, the sub-office would undertake market research and obtain quotations, but decisions be made and contracts awarded by the WCO.

Planning for and establishing a new (emergency) field sub-office		
	What to include in the plan/proposal	What must be done to implement
Purpose/role of the office	Specify the functions and responsibilities of the office in relation to project design and implementation, the procurement, transportation and storage of supplies, etc.	Specify the levels (if any) of delegated authority to allocate/commit WHO commodities, establish partnership agreements, and issue purchase or service contracts.
Staffing structure and reporting responsibilities	Prepare a staffing plan and job descriptions including both national and international staff. These should match the proposed functions and responsibilities of the office and the magnitude of the operation. It may include some or all of: programme, logistics (transport and warehousing), administration and finance, ICT/telecommunications and communications/public information.	Define reporting responsibilities to WCO, and supervision responsibilities within WCO. Recruit local staff (see section 5.4)
Office requirements	Specify space requirements based on staffing plan plus requirements for meeting rooms, radio/ telecommunications facilities, storage, parking space, etc.	Choose premises – see Panel 5-5. Explore possibilities for sharing facilities and capacities with other organizations (e.g. WFP, UNICEF). Negotiate and sign a lease/rental agreement (where relevant). Obtain telephone lines.
Security	Specify the security measures likely to be needed and the level of expenditure involved, depending on the UN security phase and local conditions.	Order and install security equipment, where needed; ensure MOSS compliance. Establish internal security procedures. Establish a security (and evacuation) plan with DO, FSCO and other agencies.
Office furniture and equipment	Specify requirements, which might include: desks cupboards, water filter, refrigerator, stove or water heater, air-conditioners, photocopier, desk/pocket calculators. Specify any purchase or standard rapid response kit requirements.	Borrow, or seek premises that have, as many of these items as possible. Borrow, rent, purchase or order through the WCO all required office furniture and equipment. (Consider purchasing second-hand furniture, recognizing that the office is only temporary, but ensure that drawers and cabinets are equipped with locks and keys for security.) Order office supplies.
ICT equipment and energy	Specify requirements for ICT equipment and connectivity, generators, voltage regulators, etc. on the basis of the guidance in ... Determine whether the capacity exists locally to install and maintain ICT equipment. For a major operation, requirements should be determined and installation arranged by an ICT Team.	Arrange the provision and installation of energy and ICT equipment, and train local staff. Obtain permission (and frequencies) from the relevant authorities to operate radio equipment, if needed.
Transport	Specify the types and numbers of vehicles/motorcycles required. Determine the possibility and cost of borrowing or renting locally.	Borrow, rent, purchase or order through the WCO required vehicles. Arrange driver selection, training and performance monitoring. Establish a discipline of using log sheets.
Costs	Prepare budget estimates for: <ul style="list-style-type: none"> • setting up costs • recurrent operating costs 	Monitor initial expenditures and, if necessary, revise the budget estimates.

Planning for and establishing a new (emergency) field sub-office		
	What to include in the plan/proposal	What must be done to implement
Administration & finance		<p>Open a bank account and designate signatories.</p> <p>Establish per diem rate (if not already).</p> <p>Establish an imprest account, petty cash accounts, financial control procedures, and procedures for safeguarding cash.</p> <p>Establish procedures for the control and use of vehicles, telecommunications facilities, etc.</p> <p><i>If a new duty station, complete the Duty Station Classification form and send to HQ.</i></p>
HR management		<p>Set up attendance records; establish working hours; train new staff in WHO procedures.</p>

Criteria for choosing field sub-office premises [Adapted from <i>Emergency Field Operations Pocketbook</i> , WFP 2003]
<p>Choose premises on the basis of the following criteria:</p> <ul style="list-style-type: none"> • security: controlled access to the office and/or compound (locks may be changed); • suitability: appropriate total floor space, number of separate rooms; • condition: sound or repairable roof, walls, doors, etc., and the local availability of materials and skilled labour for repair work; • utilities: sanitary facilities, water and electricity supplies, parking facilities; • location: proximity to residences, warehouses, government offices, other organizations; • cost of repairs and rent. <p>Options for premises are (in order of preference): provided rent-free by the government; shared with UN partners; rented independently by WHO; a rapid-response emergency office package (from UNHRD) set up in a government or rented compound.</p>

Tools and other guidance

SOP 10.10 and attached documents for establishing a field sub-office.

SOP 10.12 concerning the establishment of a guest house.

Workshop on Decentralization of WHO Technical Cooperation in Countries, Final Report, WHO-AFRO 2003 (provides useful perspectives on the establishment and use of sub-offices for development programmes).

Working with UN and other partners ⁴

The country office should work with other UN entities and other organizations as below:

Working with OCHA

In case of a major emergency, the UN Office for the Coordination of Humanitarian Affairs (OCHA) may assign a staff member, consultant or an UNDAC team (see [SOP 1.3](#)) to assist the UNRC and the country team in mobilizing and coordinating international humanitarian assistance.

In some cases, an OCHA field coordination unit may be able to assist in collecting/compiling health-related information as well as in logistics, communications with field outposts, and press releases.

WHO remains responsible for coordinating international health assistance but the country office should collaborate with the OCHA staff/unit to ensure appropriate inter-sectoral coordination.

Working with UNICEF

WHO and UNICEF share a commitment to improving the health situation in emergency-affected countries.

In general, UNICEF focuses on and is able to mobilize resources for: primary health care services; safe motherhood and women's reproductive health; nutritional surveillance and special feeding for malnourished children; the care of unaccompanied children and psychosocial needs of children and women; and community-level water supplies, sanitation and health promotion. UNICEF often provides vaccines, cold chain equipment, other supplies and equipment, therapeutic foods, and funds for local operating costs and the training of health personnel in the field.

In each situation, the WHO and UNICEF representatives should collaborate in assessing the situation and in providing assistance to the MoH, and health-related assistance more generally, capitalizing on their respective strengths, areas of expertise and operational capacities in the country. Joint projects and appeals should be considered for specific activities.

WHO would normally focus on providing technical expertise to add value to UNICEF inputs (e.g. for immunization) and providing assistance to surveillance, disease control and other priority areas beyond UNICEF's mandate.

Working with WFP

WFP assesses the food security situation and any need for international emergency food aid and, when required, mobilizes and delivers food for general distributions and supplementary feeding operations for refugees and other emergency-affected populations, especially in least-developed countries (LDCs). WFP conducts assessments and ongoing monitoring of the food and nutrition situation in collaboration with relevant government entities, FAO, UNICEF, NGOs and bilateral donors, when appropriate, and with UNHCR for refugees.

WHO may advise on and collaborate in assessment and monitoring of the nutritional situation (in liaison with UNICEF) in assuring food safety and hygiene in feeding operations, and in identifying micronutrient deficiencies and advising on ways to address them.

In some situations, WFP may provide assistance to WHO (and other organizations) in logistics and telecommunications on a cost-sharing or reimbursable basis. See the WFP-WHO Technical Agreement for Cooperation in Logistics.

Working with UNDP

UNDP focuses on economics, governance, capacity building and long-term development. In relation to disasters, its focus is on disaster prevention, mitigation and preparedness, and post-disaster recovery including the resettlement/reintegration of returnees and people who have to be permanently relocated following a disaster. UNDP can also provide some funds for initial relief and to support the management and coordination of relief operations.

⁴ Adapted from WPRO *Emergency Response Manual* 2003, 1.5

WHO may propose ways in which UNDP funds could be used (directly or in support of WHO project activities) to: improve the public health situation of a disaster-affected population through limited, focused relief provisions; support relief management and coordination systems; assure services for returnees and in resettlement areas; and enhance national preparedness for future events.

Working with UNHCR

UNHCR is responsible for the protection of and international assistance to refugees. UNHCR also provides assistance, when needed, to facilitate voluntary repatriation and the re-installation of returnees. Exceptionally, UNHCR provides protection and assistance to some IDP populations.

WHO should be ready to assist UNHCR and the MoH in (i) assessing the health situation of refugees and planning the provision of appropriate health services for them, and (ii) planning to strengthen public health services in areas to which refugees are returning.

For key points of the WHO/UNHCR MOU (1997), see Annex F8. For the full text, see CD-ROM.

Working with the Red Cross/Red Crescent

The national Red Cross/Red Crescent (RC) society often plays a central role in: a) promoting disaster mitigation and preparedness at community level, and providing first aid and disaster management training for RC volunteers and local officials; and b) providing first aid, relief and support to health services during and after a disaster.

In case of a major disaster/emergency, and in disaster mitigation and preparedness activities, the society may be supported by the International Federation of Red Cross and Red Crescent Societies (IFRC)⁵, which may launch an international appeal for resources and provide technical assistance.

WHO and IFRC have signed a joint “letter of collaboration” recognizing, amongst other things, the need for strengthening collaboration on early warning/early action, forgotten emergencies, information management and information sharing mechanisms and tools, for attention to mental health in emergencies and prioritizing public health, water hygiene and sanitation. The letter also recognizes the value of joint advocacy in areas of common interest especially in collaboration with the national society. For details, see <http://www.who.int/hac/network/interagency/en/>

WHO should maintain close working relationships with the national RC society, and with IFRC when present, and collaborate in relation to preparedness, assessment and response in the health sector.

Working with NGOs

National and international NGOs provide considerable assistance at times of disaster and also in relation to disaster mitigation and preparedness at community level in the (sometimes limited) geographic areas where they work. Some receive large amounts of funding directly from donors, who sometimes rely on the assessments and operational capacities of NGOs rather than the government/MoH or the UN system. NGOs sometimes meet urgent needs that the health services are unable to meet. Their contribution is essential but should be coordinated with/by the health authorities, with the support of WHO when needed.

WHO should maintain close working relationships with the NGOs that are active in the health sector and collaborate with them in relation to health sector preparedness, assessment and response, while seeking to ensure that there is effective overall coordination of health-related activities.

For summary information on a number of major international NGOs and NGO coordinating bodies (as well as international and inter-governmental organizations), see *Natural Disasters - protecting the public's health*, PAHO 2000, Annex IV [in EHLK and HeLiD].

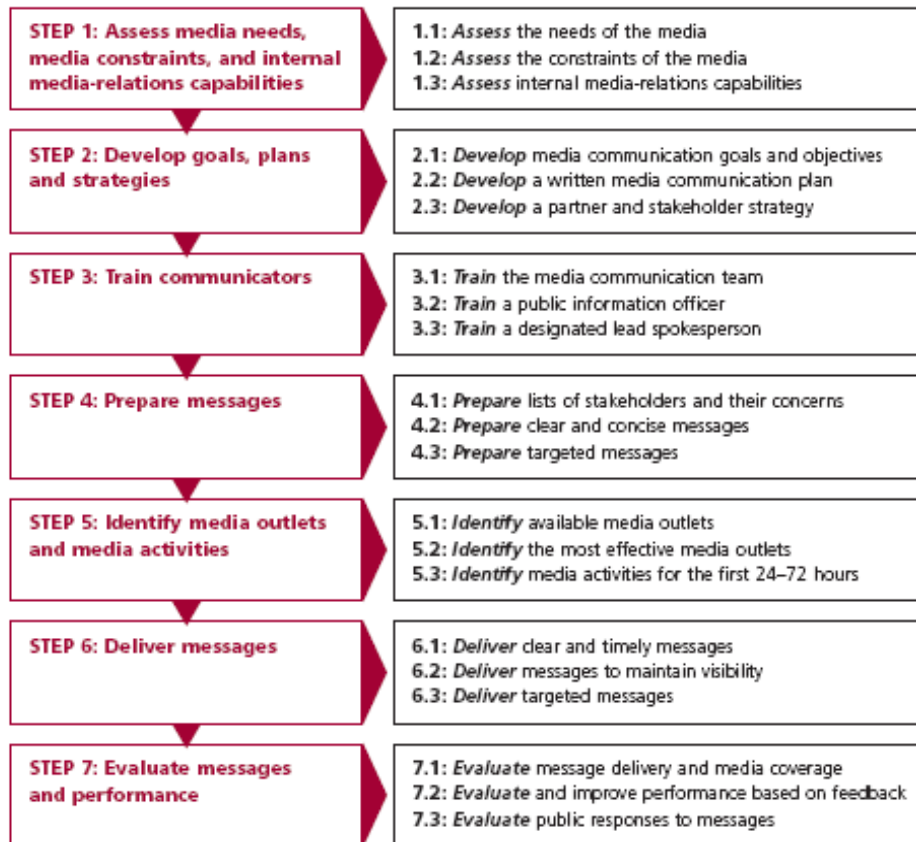
WHO policy on relations with non-governmental organizations can be found in EB111/22 of 25 Nov. 2002 (<http://www.who.int/gb/EB.WHA/PDF/EB111/eeb11122.pdf>)

The standard format for a country-level project agreement with an NGO is in Annex C11.

Some considerations related to the selection of NGO partners are in Annex C12.

⁵ The IFRC must not be confused with the ICRC (International Committee of the Red Cross) which is a private Swiss organization that acts at times of conflict to uphold the Geneva Conventions and provide assistance to civilian victims of conflict as well as wounded combatants and prisoners of war.

7 STEPS TO EFFECTIVE MEDIA COMMUNICATION DURING PUBLIC HEALTH EMERGENCIES



Taken from:
Effective Media Communication during Public Health Emergencies: A WHO Handbook.
Hyer RN and Covello VT. Geneva, World Health Organization (WHO/CDS/2005.31) 2005; July.

When talking with the media, questions often asked include:

- Who is affected?
- Who is at fault?
- Who is responsible?
- What has happened?
- What is the cost?
- Where has it happened?
- What is being done?
- When did it happen?
- Why did it happen?
- Why wasn't it prevented?
- Will it happen again?

See WHO Handbook for a fuller list of 77 frequently asked questions.

When wanting to return to key points or redirect the communication, examples of "bridging" statements include:

- *And what's most important to know is...*
- *However, what is more important to look at is..."*
- *However, the real issue here is..."*
- *And what this all means is..."*
- *And what's most important to remember is..."*
- *With this in mind, if we look at the bigger picture..."*
- *With this in mind, if we take a look back..."*
- *If we take a broader perspective,..."*
- *If we look at the big picture..."*
- *Let me put all this in perspective by saying..."*
- *What all this information tells me is..."*
- *Before we continue, let me take a step back and repeat that...*
- *Before we continue, let me emphasize that..."*
- *This is an important point because..."*
- *"What this all boils down to is..."*
- *"The heart of the matter is..."*

See WHO Handbook for a fuller list of 33 bridging statements.



World Health Organization

Points to remember when Preparing and Delivering Messages

When preparing messages

- ✓ prepare three key points that communicate your core messages;
- ✓ prepare supporting message points;
- ✓ develop supporting material such as visuals, examples, quotes, personal stories, analogies, and endorsements by credible third parties;
- ✓ keep messages simple and short; *and*
- ✓ practise delivery.

To communicate voluntariness – prepare messages that:

- ✓ make the risk more voluntary by providing options and choices;
- ✓ encourage public dialogue and debate;
- ✓ ask permission; *and*
- ✓ ask for informed consent.

To communicate controllability – prepare messages that:

- ✓ identify things for people to do (for example, precautions and preventive actions);
- ✓ indicate a willingness to cooperate and share authority and responsibility with others;
- ✓ provide important roles and responsibilities for others;
- ✓ tell people how to recognize problems or symptoms; *and*
- ✓ tell people how and where to go to get further information.

To communicate familiarity – prepare messages that:

- ✓ use analogies to make the unfamiliar familiar;
- ✓ encourage experiential learning;
- ✓ have high visual content; *and*
- ✓ describe means for exploring issues in greater depth.

To communicate fairness – prepare messages that:

- ✓ acknowledge possible inequities;
- ✓ address inequities; *and*
- ✓ discuss options and trade-offs.

When delivering messages during an emergency

- ✓ recognize and acknowledge anger, frustration, fear, outrage or concern;
- ✓ provide three or more positive points to counter negative information or bad news;
- ✓ accept and involve the public and the media as legitimate partners;
- ✓ indicate through actions, words and gestures that you share their concerns;
- ✓ listen carefully to what people are concerned about;
- ✓ convey compassion, conviction and optimism through actions, gestures and words;
- ✓ speak clearly, simply and calmly – avoid technical terms and long words or phrases; *and*
- ✓ gain trust by admitting that there are things you do not know.

When conducting a news conference or other formal media event:

- ✓ make your formal statement as brief as possible;
- ✓ include all pertinent information in your statement and allow time for questions;
- ✓ limit the number of speakers to no more than three and limit each to 3–5 minutes;
- ✓ remember that it is primarily held to allow the media to ask questions, not to attend a lecture; *and*
- ✓ start on time – journalists have deadlines and need enough time to file your story.

When addressing affected populations:

- ✓ identify the information they most need to protect themselves;
- ✓ use very clear means and formats to communicate the information to them; *and*
- ✓ use diverse formal and informal channels, such as community meetings, open houses, stand-up presentations where people congregate, radio broadcasts and posters.

ANNEX C – MATERIALS FOR PLANNING AND MANAGING THE WHO PROGRAMME

<p><i>To communicate trust – prepare messages that:</i></p> <ul style="list-style-type: none">✓ cite credible third parties;✓ cite credible sources for further information;✓ acknowledge that there are other points of view;✓ indicate a willingness to be held accountable;✓ describe achievements;✓ indicate conformity with the highest professional, scientific and ethical standards;✓ cite scientific research;✓ identify the partners working with you; <i>and</i>✓ indicate a willingness to share the risk.	<p><i>When communicating through the media during an emergency:</i></p> <ul style="list-style-type: none">✓ brief the media promptly following an incident;✓ fill information vacuums;✓ state, if appropriate, that the information is preliminary;✓ state that the media will be updated as additional information becomes available;✓ state what is factual and known – avoid speculating on the unknown;✓ hold regular briefings (for example, every 2 hours) even if nothing has changed;✓ state when you expect new information to become available;✓ provide dedicated hotlines and telephone information services for all important stakeholders;✓ provide a media communications centre that is staffed 24 hours a day;✓ plan how often information updates will be provided, who will do it, and how; <i>and</i>✓ use news conferences, briefings and one-on-one interviews.
---	--

Sample format for a health cluster bulletin

Bulletin # 1

Date

Highlights

- *Example of text*
- *Major points of interest*
- ...
- ...
- ...
- ...
- ...
- ...
- ...
- ...
- ...
- ...
- ...
- ...
- ...
- ...
- ...
- ...
- ...
- ...

Place a photo here if you want - quote the source venue and date

Assessment

- Quote here **major outcomes** of health related assessments performed during the week quoting date, location, major outcomes and agency that performed the assessment. Encourage agencies in using same assessment formats.
- Quote here epidemiological abstracts from the surveillance system
- Quote here summary of priority needs/gaps

Coordination

- Quote here coordination meetings quoting: dates, venue and **major outcomes**
- ...
- ...

Filling Gaps

- Quote here activities conducted by various agencies to fill existing gaps such as: immunization; drug and medical supplies; rehabilitation of health infrastructures; mobile medical teams, field hospitals, Water and sanitation, Mental health, etc. Each activity should be described in one bullet point and should include information on location, date and name of implementing agency.
- ...

Capacity Building

- Quote here actions implemented to strengthen the local capacity in dealing with health emergencies such as: training (quote number of trainees and duration); specific support provided to MoH Crisis Cells, development and dissemination of guidelines; etc.
- ...
- ...

Summary of Resources Available

- Insert here an update table on funds requested and received by the various health agencies (source: OCHA Financial Tracking System)

Agency	Funds Requested	Funds Received (US\$)	Shortcoming %

Contacts

- Insert here a table as follows:

Agency	Field of activity (mobile teams; drug supply, reconstruction, training, etc.)	Location	Contacts

Planning an evaluation or lessons-learning exercise⁶

Defining the purpose and selecting the appropriate approach

The panels below indicate the different possible purposes of evaluation or lessons-learning exercises and suggest the approaches that may be most appropriate for different purposes.

A national workshop with nationals and international health partners to identify lessons-to-be-learned from successes and shortcomings, and the publication of the experience, is probably the best means to ensure learning and institutional memory.

Possible purposes of evaluation/lessons-learning
<p>Evaluating WHO's own performance</p> <p>This is a programme management function, analysing WHO's performance based on our own policies and plans. The purpose is:</p> <ul style="list-style-type: none"> to be transparent and accountable to our partners to provide feedback for internal management and decision making processes to learn and improve the performance of our (current and future) programme activities <p>Evaluating the overall response by its health outcomes</p> <p>This will always be done jointly/in close collaboration with all WHO's relevant partners. The purpose is:</p> <ul style="list-style-type: none"> to provide insight into how people's own efforts and national and international assistance affected the general health and nutritional status of the affected population to guide continuing health sector programmes and related inter-sectoral coordination to inform health system preparedness for future crises

What approach might be appropriate?	
For internal learning related to WHO's performance	Options may be: <ul style="list-style-type: none"> an internal evaluation/review using a WHO staff member and/or an external evaluator with good knowledge of WHO; <i>and/or</i> a lessons-learning workshop within the in-country WHO team, facilitated by a staff member not involved in the operation, an external person or independent consultant.
For accountability to WHO's member States or donor(s)	An external evaluator with good understanding of WHO and the UN system is required, possibly in combination with evaluator(s) proposed by main donor(s).
For learning and accountability of the health sector response	A joint exercise involving several or all actors is essential. The options may be: <ul style="list-style-type: none"> a joint 'ex-post' evaluation, with MoH, local health authorities, other UN agencies, the Red Cross/Crescent, NGOs, and donors; <i>and/or</i> a joint/international lessons-learned workshop with the national health authorities and main humanitarian actors, possibly externally facilitated.
For improving an ongoing operation	A 'real-time'/performance evaluation process is required using staff not involved in the operation and/or external evaluators. Ideally, this should be initiated during the early stages of an intervention and provide regular updates on performance.

⁶ Adapted from WPRO *Emergency Response Manual*, 2003, section 3.5

Learning versus accountability

If **accountability** is the primary objective, plan and manage the evaluation to ensure that:

- the evaluation process is transparent
- the evaluators are clearly impartial and free to state their conclusions
- all stakeholders have an opportunity to comment on the evaluators' conclusions and such comments are given due weight. Seek to resolve differences before the report is finalized, otherwise ensure that the differences are reflected

If **lesson-learning** is the major objective, ensure:

- that those involved in implementation have the maximum opportunity to learn the lessons emerging
- ownership of the evaluation process by implementers before the evaluation starts, hence their greater involvement during implementation and a greater planned investment in dissemination

[Adapted from *Evaluation Guidelines*, DFID: <http://www.dfid.gov.uk>]

Defining criteria and key questions

Activities and performance should be compared against international standards for good practice guidance and the benchmarks indicated in section 1.4. The WHO/PAHO health library for disasters (HeLiD) including the Sphere handbook can be referred to.

The following are examples of some possible sets of criteria against which the programme/activities can be evaluated and/or lessons be drawn:

- Main criteria: efficiency, effectiveness, impact, relevance/ appropriateness, and sustainability (or connectedness for short-term project impact on long term processes). Sub-criteria: coverage, coherence, co-ordination and protection [OECD/DAC evaluation criteria for humanitarian assistance]
- What is going/went well? What could go better/went wrong, and why? What needs to be done now/learned for the future?
- What was planned – what were the targets, the planned outputs and outcomes? What are the actual results? What are the weaknesses and reasons for deviation/positive experiences and unplanned results? What recommendations?

A sector-wide evaluation should look at the effectiveness of overall health/humanitarian response and try to explain changes in certain health outcome/impact indicators like CMR, U5 mortality rates, malnutrition rates, etc.). It should cover broad strategic issues – collaboration, decision-making, linkages, beneficiary satisfaction, cost-effectiveness, etc. – in addition to the technical aspects of health and nutrition service provision.

Drawing up the terms of reference (TOR) and composing the team

The panels below suggest a framework for drawing up the TOR for an evaluation and proposing team composition.

Framework for evaluation TOR

Detailed terms of reference generally include:

1. The reasons for the evaluation and its objectives (why evaluate).
2. A statement of the scope and specific issues to be addressed (what to evaluate – policy, programme, operation, issue).
3. Objectives – the extent to which the evaluation is expected to provide accurate measures of impact and contribute to accountability should be carefully considered.
4. The questions to be answered (criteria or focus) and tasks to be carried out, including, if possible, what information is to be collected and how.
5. The locations to be visited (where); access to information and people.

6. Which people are responsible for which tasks (who) – to what extent is the evaluation independent?
7. A statement of the expected output & style of the report.
8. A timetable (when to evaluate) indicating when various tasks will be completed as well as the due dates and recipients of any periodic reports or outlines. The TOR should specify that an initial report will be submitted in draft and provide time for corrections or changes to the draft once it has been reviewed.
9. A budget indicating the costs associated with the evaluation.
10. What happens after the evaluation (follow up, ownership).

[Adapted from: *Planning and Organising Useful Evaluations*, UNHCR Inspection and Evaluation Service, 1998]

Composition of an evaluation team

An evaluation team should contain a mix of relevant skills and experience including the following characteristics:

- ✓ Professional expertise relating to the issues being evaluated
- ✓ Knowledge of the country/region
- ✓ Cross-disciplinary skills (social economic and institutional)
- ✓ Gender balance
- ✓ Representation from the main partners and stakeholders (This improves the quality and the local credibility of the evaluation findings as well as building local capacity, although representatives can find themselves in difficult positions if the evaluation findings reflect negatively on their organisation or colleagues.)
- ✓ A quality team leader

All team members should be available for the whole time of the evaluation.

Appointing and evaluation manager and establishing a budget

Evaluations (and the preparation of lessons exercises) need to be well managed. In each case, an evaluation manager must be appointed. S/he will be part of the evaluation team albeit with a special role and perspective. S/he must, amongst other things:

- ☑ *Ensure financial and logistical preparation*: careful budgeting and thorough logistics preparations are essential – don't under-estimate the cost, time and resources required, especially the field work component of an evaluation
- ☑ *Devote adequate time to the process*, be systematic (in planning and supervising), sensitive (to the needs of the team and others involved), and solutions-oriented (anticipate and respond promptly to the problems that will inevitably arise)
- ☑ *Ensure that sufficient time is given* to building the appropriate level of interaction and ongoing reporting back between the evaluation team, the evaluation manager, operational personnel and other stakeholders
- ☑ *Ensure follow-up* – that the report/findings and recommendations are promptly disseminated to all concerned and brought to the attention of the managers who need to know and take action.

An adequate **budget** must be provided. Possible budget items for an evaluation include:

- | | |
|---|-------------------------------------|
| 1. Staff salary and benefits | 6. Communications |
| 2. Consultants | 7. Support staff |
| 3. Travel | 8. Printed materials |
| 4. Costs of surveys and data processing | 9. Supplies and equipment |
| 5. Printing and duplication | 10. Non-financial or indirect costs |

Annex series C
Materials for Planning and Managing the WHO Programme
(ref. chapter 7)

Core-functions analytical framework

The format below suggests how the *core functions* listed in section 1.2 may be used as a framework for analysis when developing objectives and strategies.

Function	Benchmarks (desired situation)	Situation	Remarks	Strategy options	Lessons from other countries
Information analysis & understanding	<input checked="" type="checkbox"/> Health needs, system delivery capacity and operational constraints known; information consolidated & displayed in a manner that facilitates consensus and decisions <input checked="" type="checkbox"/> Priority health threats and system's critical capacities monitored regularly with possibility of early warning				
Facilitating Coordination	<input checked="" type="checkbox"/> Organized space and time for all health partners to discuss issues, decide actions to take and assign responsibilities; mechanisms for follow up, evaluation <input checked="" type="checkbox"/> Work in all other sectors geared to the survival, health and sustainable livelihoods of the population				
Filling gaps (in health service provision)	<input checked="" type="checkbox"/> Life-threatening conditions prevented or promptly addressed, with CFR maintained within international <input checked="" type="checkbox"/> Appropriate means applied to improve equitable access to health care in a sustainable way and according to international standards				
(Re-)Building Systems & capacity	<input checked="" type="checkbox"/> National health partners fully integrated in, and supportive of, the delivery of humanitarian assistance <input checked="" type="checkbox"/> International health partners effectively complementing national efforts				

Cross-cutting function	Benchmarks (desired situation)	Situation	Remarks	Strategy options	Lessons from other countries
Standards & strategies	<input checked="" type="checkbox"/> All health actors are aware of relevant international standards and best practices in emergency health <input checked="" type="checkbox"/> Strategies adopted to address current needs and risks are appropriate				

The table below illustrates how this approach was used by WHO to analyse options for supporting the recovery of the health sector in Somalia in 2005 (a country with no functioning government and in which the health sector had totally collapsed). The full table is available on the CD-ROM. Other aspects covered in the analysis of that "transition" situation were: policy formulation, financing, infrastructures, human resources, pharmaceuticals, management systems, and equity in access to services.

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Area / Issue	Situation	Remarks	Policy options (not always mutually exclusive)	Relevant experiences from other countries in transition
<p>Filling gaps in Health service provision</p>	<ul style="list-style-type: none"> Health service coverages are low. Access to a comprehensive package of basic services is the exception, rather than the rule. Access to some basic services, like TB control, is severely inadequate. Quality of care is poor, with negative effects on service uptake. Private operators deliver most health services. Curative care, mainly delivered by private providers, has thrived, whereas public health has lagged behind. 	<ul style="list-style-type: none"> Functioning health facilities are not part of a coherent and organized health system. Some public health services are left to the responsibility of aid agencies and NGOs. Hospital-centred approaches exert a strong appeal on Somali health professionals. Private health providers account for most health service delivery. Any delivery model to be introduced must explicitly encompass them. Health service design must address the variety of settlement patterns and lifestyles of target populations. Nomadic communities (representing perhaps half the population) present particular challenges. 	<ul style="list-style-type: none"> Carry out a comprehensive assessment of private health care providers. Opt for affordable service delivery approaches (given foreseeable resource constraints). Encourage the merging of selected functions (like supply) of special programmes, as first step towards their progressive integration into general health services. Identify concrete measures aimed at improving quality of care. Start designing a long-term, comprehensive programme, targeting both private and public service providers. Introduce appropriate incentives (positive and negative) for private and public service providers. 	<ul style="list-style-type: none"> Cost figures computed during a transition (when they are abnormally high) become quickly outdated. Donor-supported areas may thrive at the expenses of general services. A review of 'priority' areas and of their relative strength is needed to identify few true general priorities, where efforts must be concentrated. Realistic, adapted, quality guidelines and manuals, provided they are widely disseminated, may contribute to reduce fragmentation and give coherence to a pluralist health sector. No recognized good-practice approach to health care provision to nomadic populations is on offer. To develop a satisfactory one entails patient experimentation.

CERF PROJECT SUMMARY (2 pages)

Requesting Agency:	
Project Title:	
CAP/Flash Appeal Project Code	<i>(Mandatory to provide where an appeal exists. If not, CERF will return the application to agency with no further action)</i>
Sector:	
Targeted Beneficiaries:	<i>(total disaggregated by sex/age)</i>
Implementing Partners:	<i>(List only those partners that will benefit from CERF funding, including the activities planned and grant amount per implementing partner)</i>
Total Project Budget:	
Amount Requested from CERF:	

Project Summary

Briefly describe how CERF funding will be used to support life-saving/core humanitarian activities. Include any relevant assessment data to support the submission. [1-2 paragraphs]

Description of the CERF Component of the Project**(a) Objective**

The objective should be specific, measurable, achievable, relevant and time-bound.

(b) Proposed Activities

List the project's main activities.

(c) Expected Outcomes

Explain the results you expect to have at the end of the CERF grant period, and no more than five indicators you will use to measure the extent to which those results have been achieved

(d) Implementation Plan

Explain planned mechanisms for implementation. Specifically, report planned grants to implementing partners, including NGOs, government actors, etc.

Budget (CERF component only)

Cost breakdown	Amount (USD)
A. Staff costs <i>(salaries and other entitlements)</i>	-
B. Travel	-
C. Contractual Services <i>(please itemize below; add rows if necessary)</i>	-
D. Operations <i>(please itemize below; add rows if necessary)</i>	-
	-
E. Acquisitions <i>(please itemize below; add rows if necessary)</i>	-
F. Other	-
Subtotal project requirements	-
G. Indirect programme support costs <i>(not to exceed 7% of subtotal project costs)</i>	
PSC amount	-
Total cost	-

Life-saving activities in health and related sectors for CERF

The table below is reproduced from *CERF Life-saving Criteria and Sectoral Activities*, OCHA August 2007. For any up-date, check: <http://ochaonline.un.org/FundingFinance/CERF/tabid/1109/Default.aspx>

Activities	Conditions
Health	
<i>Criteria: Activities that have an immediate impact on the health of population affected by an emergency.</i>	
Coordination of health aspects in the context of natural disasters and complex emergencies.	As part of a wider initiative (it may be included in overall inter-sectoral coordination).
Disease surveillance and dissemination of critical health information and laboratory reagents for early diagnosis.	Case detection action and epidemiological surveillance through existing Early Warning Systems.
Ensuring equitable and timely access to Emergency Primary Health Care, including: establishment of facilities and support systems, core health staff, complementary pharmaceuticals, basic equipment, waiving user-fees and individual referral to secondary health care. Provision, distribution and replenishment of quick-turnover emergency stockpiles.	All of these in the context of specific emergency response.
SGBV medical and psycho-social support to survivors of rape. Including PEP kits.	
Mass casualty management	
Addressing life-threatening conditions related to communicable diseases (immunizations, outbreak control).	
Maternal and neo-natal risk, reproductive health emergency interventions (including provision of emergency reproductive health kits based on the Minimum Service Package MISP);	
Secondary Level Health Care (only as follow up to natural disasters)	Case-by-case basis
Psycho-social support for survivors of emergencies	Case-by-case basis
HIV/AIDS emergency awareness and provision of education material/condoms. HIV counselling, testing and treatment for vulnerable groups.	Case by case basis and only in the context of natural disasters or complex emergencies.
Nutrition	
Infant Feeding in Emergencies	In refugee/IDP situations ensure secluded areas for breast feeding; supplementary feeding when required; targeted distributions of formula and education on preparation and use of formula.
Management of severe and moderate acute malnutrition	Requires community involvement and establishment of feeding centers.
Micronutrient supplementation - Vitamins supplementation	
Shelter and Non-Food Items	
<i>Criteria: Immediate provision of temporary/semi-temporary shelter and basic utensils for victims of disaster.</i>	
Provision and distribution of shelter materials	Only for temporary emergency shelter
Construction/repair of temporary emergency shelter	
Basic provision of Non-Food items for affected populations and	

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Activities	Conditions
hosting families.	
Cash Grants and Cash for Work	Cash can replace handouts after impact assessments are undertaken.
Water and Sanitation <i>Criteria: Provision of minimum requirements of water, sanitation and hygiene standards in emergency situations.</i>	
Provision of drinking water and emergency repair (wells, boreholes, pumps, small pipeline systems, trucking)	
Water purification systems/vector control.	
Sanitation systems in emergency situations.	
Water management.	
Hygiene and sanitation supplies (including for women and girls) and awareness-raising.	



CAP Project Summary Sheet (1 page)

Appealing Agency(ies):	<i>Name(s) of appealing organisation(s) in bold and capital letters, followed by acronym in parenthesis () e.g. WORLD HEALTH ORGANIZATION (WHO)</i>
Project Title:	<i>Be concise. Capture the essence of the project</i>
Project Code:	<i>[Leave blank – code number is assigned by OCHA's FTS]</i>
Sector:	<i>Health</i>
Objective:	<i>What does the project aim to achieve? This should relate directly to one of the sector objectives.</i>
Beneficiaries:	TOTAL: Children: Women: Other group (specify): <i>Disaggregate TOTAL as much as possible.</i>
Implementing Partner(s):	<i>List partners, only in the sense of those whom you will subcontract – not those with whom you will coordinate e.g. Ministry of Health, Oxfam</i>
Project Duration:	<i>From when to when does the project run? Note that a project's duration can exceed one year. In that case, total project budget covers the whole project, while funds requested should be the portion needed for 2007 only. e.g. January – December 2007</i>
Total Project Budget:	<i>\$ Optional if different from Funds Requested.</i>
Funds Requested:	<i>\$ Bottom-line amount appealed for in the CA for [2007] only.</i>

Needs

(What is the evidence for the needs that this project addresses? How does the project support overall strategic priorities and sector objectives?)

Activities

(What are the project's main activities?)

Outcomes

(What are the expected outcomes?)

FINANCIAL SUMMARY	
Budget Items	\$
Cost A e.g. staff	
Cost B e.g. inputs	
Cost C e.g. administration	
Sub-total	
Minus available resources	
TOTAL	

Key health services & functions

The table below lists the key health service areas and functions prepared by the Global Health Cluster (draft, Dec. 2007). It can be used to record “Who is doing What, Where” (3W) and identify gaps and, thus, areas on which WHO assistance may need to focus.

Level of Care	Areas of Service / sub-sectors		Health Services (in bold the RH MISP Services)		Yes/No		
A	Community Care	A1	Collection of Vital Statistics	A11	Deaths & births		
					A12	Others: eg.: population movements; registry of pregnant women and new-born	
		A2	Child Health		A21	IMCI community component: IEC of child care taker+active case findings	
					A22	Home based treatment of: fever/malaria, ARI/pneumonia, dehydration due to acute diarrhoea	
					A23	Community mobilization for and support to mass vaccination campaigns and/or mass drug administration/treatments	
		A3	Nutrition		A31	Screening of acute malnutrition (MUAC)	
					A32	Follow up of children enrolled in supplementary/therapeutic feeding (trace defaulters)	
					A33	Community Therapeutic Care of Severe Acute Malnutrition	
	A4	Communicable Diseases		A41	Vector control (IEC+impregnated bed nets+in/out door insecticide spraying)		
				A42	Community mobilization for and support to mass vaccinations and/or drug administration/treatments		
				A43	IEC on TB self referral		
	A5	STI & HIV/AIDS		A51	Community leaders advocacy on STI/ HIV		
				A52	IEC on prevention of STI/HIV infections and behavioural change communication		
				A53	ensure access to free condoms		
	A6	Maternal & newborn health	A61	Clean home delivery , including distribution of Clean Delivery (CD) kit to visible pregnant women, IEC & behaviour change communication, knowledge of danger signs & where/when to go for help			
	A7	Non-Communicable Diseases	A71	Psyco-social support for: mental health disorders, terminal patients including AIDS patients, rape survivors, orphan & unaccompanied children, unaccompanied elders			
A8	Environmental Health	A81	IEC on hygiene promotion & on water and sanitation, community mobilization for clean up campaigns and/or other sanitation activities				
B	Primary Care	B1	General Clinical Services	B11	Outpatient Services		
				B12	Basic Laboratory		
				B13	Short hospitalization capacity (5-10 beds)		
				B14	Referral capacity 3 Transportation, 2 means of communication 4 referral procedure		
	B2	Child Health	B21	EPI : Routine Immunization against all national target diseases & adequate cold chain in place			
			B22	Under 5 Clinic conducted by IMCI trained health staff			
	B3	Nutrition	B31	Management of Moderate Acute Malnutrition			
			B32	Management of Severe Acute Malnutrition			

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		B4	Communicable Diseases	B41	Sentinel site of Early Warning System of epidemic prone diseases, outbreak response	
				B42	Diagnosis & treatment of Malaria	
				B43	Diagnosis & treatment of TB	
				B44	Other local relevant communicable diseases (eg: sleeping sickness)	
		SEXUAL REPRODUCTIVE HEALTH	B5 STI & HIV/AIDS	B51	Syndromic Management of Sexual Transmitted Infections	
				B52	Standard Precautions	
				B53	Availability of free condoms	
				B54	Prophylaxis & Treatment of Opportunistic Infections	
				B55	VCT	
				B56	PMTCT	
				B57	ART	
			B6 Maternal & Newborn Health	B61	Family Planning	
				B62	Antenatal Care, 1) assess pregnant, pregnancy stools, birth & emergency plan2) respond to observed signs3)family planning 4) Advise/counsel on nutrition & self care	
				B63	Post Care 1) Postpartum examination of of mother (up to 6 weeks) 2)respond to observed signs 3) Family planning	
				B64	Clean & Safe Normal Delivery	
				B65	Basic Essential Obstetric Care (BEOC) : Parenteral antibiotics, oxytocic & anticonvulsivant drugs + manual removal of placenta + removal of retained products + assisted vaginal delivery 24/24 7/7	
				B66	Essential Newborn Care : Basic newborn resuscitation + warmth + eye prophylaxis + clean cord care + early & exclusive breast feeding	
			B7 Sexual Violence	B71	Clinical Management of Rape Survivors (including psychological support)	
				B72	Emergency contraception	
				B73	Post Exposure Prophylaxis for STI&HIV infections	
			B8	Non Communicable Diseases	B81	Injury Care & Mass Casualty Management
		B82			Hypertension Treatment	
		B83			Diabetes Treatment	
		B84			Mental Health Care	
B9	Environmental Health	B91	Health Facility Waste Disposal & Management			
C Secondary and Tertiary Care	C1	General Clinical Services	C11	Inpatients Services (Medical, Pediatrics & Ob-Gyn wards)		
			C12	Emergency & Elective Surgery		
			C13	Laboratory Services (including Public Health Laboratory)		
			C14	Safe blood transfusion / Blood Bank Service		
			C15	X-Ray Services		

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	C2	Child Health	C21	Mangement of children classified with severe or very sever diseases (parenteral fluids and drugs, O2)	
	C6	Maternal & Newborn Health	C31	Comprehensive Essential Obstetric Care: basic essential obsetric care + cesarean section + blood transfusion	
	C8	Non Communicable Diseases	C41	Outpatient psychiatric care	
			C42	Acute psychiatric inpatient unit	
			C43	Disabilities & Injuries Rehabilitation	

Possible input requirements for projects in key functional areas

Key function areas	STAFF		EQUIPMENT		FUNDS		GUIDELINES & TOOLS	
	Not less than	with at least these characteristics	Not less than	with at least these characteristics	Not less than	with at least these characteristics	Not less than	with at least these characteristics
1. Assessment	3 Expatriate 3 Nationals	1 Health Assessor/ Assessment Team Leader 1 Nutritionist 1 Watsan expert 3 Drivers/Translators	3 2 1 6 3	Off-road cars Portable water testing kits Nutritional survey kit VHF radios PC sets	USD 330,000	Driver salaries 9,000 Cars 60,000 Cars maintenance/fuel 18,000 Water testing 10,000 Nutritional survey 5,000 Share office bills 9,000 Field workshops 20,000 Publications 10,000 Radio hand sets 3,000 PC sets 15,000 Contingency 9,000	10 10 10	Initial Rapid Assessment Protocols Guidelines on assessment of nutritional status in emergency-affected populations Environmental health in emergencies and disasters: a practical guide
2. Surveillance	1 Expatriate 1 Nationals	1 Epidemiologist 1 Driver/Translator	1 2 1	Off-road car VHF radios PC set	USD 55,000	Driver salary 3,000 Car 20,000 Car maintenance/fuel 6,000 Surveillance forms and other publications 3,000 Field workshop 5,000 Radio hand sets 1,000 PC set 5,000 Share of office bills 3,000 Contingency 3,000	10	WHO Communicable diseases control in emergency situations: a field manual
3. Public Information	1 Expatriate 1/2 National	1 Public Information Officer 1/2 Driver/Translator	1/2 1 1	Off-road car Professional PC set Radio set	USD 41,000	Share of driver salary 1,500 Shared car 10,000 Share of car maintenance/fuel 3,000 Publications: fact sheets, newsletters, etc 10,000 Radio hand set 500 PC set 10,000 Share of office bills 3,000 Contingency 3,000	1	OCHA good practices: information sharing in complex emergencies.

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Key function areas	STAFF		EQUIPMENT		FUNDS		GUIDELINES & TOOLS	
	Not less than	with at least these characteristics	Not less than	with at least these characteristics	Not less than	with at least these characteristics	Not less than	with at least these characteristics
4. Coordination	1 Expatriate 1/2 National	1 Coordinator 1/2 Driver/Translator	1/2 1 1	Off-road car PC set Radio set	USD 34,000	Share of driver salary 1,500 Shared car 10,000 Share of car maintenance/fuel 3,000 Meetings 5,000 Publications: minutes and other 3,000 Radio hand set 500 PC set 5,000 Share of office bills 3,000 Contingency 3,000	10	Strengthening the coordination in emergency humanitarian assistance of the United Nations: report of the Secretary-General
5. Leadership	1 Expatriate 1 and 1/2 Nationals	1 Team Leader 1 Personal Assistant 1/2 Driver	1/2 2 2 1	Off-road car PC sets Radio set Office kit	USD 53, 500	Share of driver salary 1,500 Shared car 10,000 Share of car maintenance/fuel 3,000 Publications: sitreps, advocacy papers and others 10,000 Office kit 5,000 (?) Radio hand sets 1,000 PC sets 10,000 Share of office bills 3,000 Contingency 10,000	5	Emergency library kits
6. Logistics & Security	1 Expatriate 1/2 National	1 Logistic/Security Officer 1/2 Driver/Translator	1/2 1 1	Off-road car PC set Radio set	USD 30,000	Share of driver salary 1,500 Shared car 10,000 Share of car fuel & maintenance 3,000 Publications: security briefings and other 3,000 Radio hand set 500 Radio base station 1000 PC set 5,000 Share of office bills 3,000 Contingency 3,000		UNJLC documents

ANNEX C – MATERIALS FOR PLANNING AND MANAGING THE WHO PROGRAMME

Key function areas	STAFF		EQUIPMENT		FUNDS		GUIDELINES & TOOLS	
	Not less than	with at least these characteristics	Not less than	with at least these characteristics	Not less than	with at least these characteristics	Not less than	with at least these characteristics
TOTALS	8 expatriates 7 Nationals	3 Assessors 1 Epidemiologist 1 Coordinator 1 Logistic/ Security Officer 1 Public Information Officer 1 Team Leader	6 7 1 15 1 2 1 1	Off-road cars PC sets Professional PC set Radio hand sets Base station Portable water testing Nutritional survey kit Office kit	USD 543,500			

Project budget items and sample budget

A budget for HAC operations typically includes items such as:

- Recruitment of international and national staff
- Emergency kits and medical supplies
- Communications
- IT equipment
- Meetings and workshops
- International airfares and per diem
- In-country travel
- Establishment of a sub-office (see Annex B6)
- Purchase of vehicles

Make sure that cost estimates are realistic. Include justification for each budget line. Use standard costs for staff, not just estimates of salaries, and include installation allowances where relevant.

Include provision for a local finance and administrative staff member to track expenditures and prepare spreadsheets, monitoring tables and reports.

Include realistic provision of **local operating/recurrent costs** such as:

- Running costs of a sub-office (rent, rates, electricity, phone bills, water, cleaning, maintenance);
- Maintenance/repair of office equipment;
- Office stationery and supplies;
- Car maintenance and spare parts;
- Fuel for generator and vehicles;
- Mobile and satellite phone bills;
- Computer and Internet connections;
- Miscellaneous contracts for the provision of local services;
- Security expenses (local guards and watchmen);
- In-country travel.

Use \$20,000 per month as a very rough estimate, pending detailed information on local costs.

Include project monitoring and reporting (PMR) costs in the RO and HQ at a standard rate of 10% on the total cost of the activities, except in proposals for ECHO consideration.

Include programme support costs (PSC): consult HAC/HQ on the appropriate PSC rate to be used – contact <crises@who.int>. (7% is applied for a country covered by a UN CAP or Flash Appeal, a country in crisis for which WHO's Financial Comptroller has approved a 7% rate, and on ECHO grants. The rate is 13 % for other countries.)

For more guidance and standard budget formats, see [SOP 14.2](#) which also includes a pre-formatted table to calculate PMR and PSC costs and a sample completed budget.

ANNEX F – MATERIALS RELATING TO COORDINATION

Sample project budget

[Reproduced from SOP 14.2]


	Activity ref.	Cost \$/month or cost per unit	Number of staff/items	Number of months	Total USD
International Staff					
Health Systems and Finances Specialist	All		1	3	Covered by other sources
Task Force Team Leader (STC-P5)	All	14,500	1	3	43,500
District Health Coordinator (STC-P4)	All	13,300	1	3	39,900
Technical Officer (STC-P4)	All	13,300	1	3	39,900
Logistics Officer (STC-P3)	All	14,400	1	1	14,400
Communication Officer (STC-P2)	All	11,500	1	3	34,500
Local staff					
Logistician	3.1		1	2	Covered by other sources
Information Assistant	3.2		1	3	Covered by other sources
Equipment & other activities					
Communication (mobile phones and radios)	3.2	34,000			34,000
8 cholera kits (incl. transportation)	2.1	105,000			Covered by other sources
Assessment missions	All	10,000			10,000
Establishment of antennas, including operational settings	All	20,000			20,000
Printing and distribution of weekly epidemiological bulletin and surveillance form	2.1	5,000			5,000
Rapid training on case definitions	1.2	5,000			5,000
Project monitoring and reporting costs	All	24,620			24,620
SUB-TOTAL					270,820
Programme support costs (7%)					18,957
<i>...need to add PMR...?</i>					
GRAND TOTAL					289,777

Budget notes

- 1 Taskforce Team Leader: manage the programme to ensure that all components are effective in delivering results, build a strong team culture and resolve any working problems.
- 1 Health Systems and Finances Specialist: based within the MoH, provide advisory support to national and local authorities as they work with health partners to ensure that essential health care services are accessible for all those in need, whilst safeguarding the medium and longer term policy objectives in relation to cost recovery.
- 1 District Health Coordinator/Epidemiologist: work closely with local health authorities and maintain good contact with all stake holders supporting the epidemiological surveillance in the affected regions; monitor health trends, support possible epidemic response, identify gaps and

ANNEX F – MATERIALS RELATING TO COORDINATION

overlaps and work with NGOs and other service providers accordingly, and play an active role in local coordination arrangements.

- 1 Technical Specialist: work closely with local health authorities and maintain good contact with all stake holders. This includes offering evidence-based advice, supporting active surveillance activities, data collection and rapid dissemination, case management protocols and the training of key health workers.
 - 1 Communication Officer: ensure that weekly and other periodic situation and technical reports are prepared and disseminated widely on time; supply to and gather information from health partners, liaising closely with other reporting officers in the UN system, particularly OCHA and UNICEF.
 - 1 Logistics Officer: ensure that transport, supplies and procurement, welfare, IT, communication, and other key operational support elements are linked together effectively, deployed efficiently where-ever needed, and operational problems resolved speedily for maximum functionality of the programme.
- 

Standard format for a country-level project agreement with an NGO

**GRANT PROJECT AGREEMENT BETWEEN
THE WORLD HEALTH ORGANIZATION (WHO)
AND
FOR IMPLEMENTATION OF A PROJECT FUNDED BY THE UN CENTRAL EMERGENCY
RESPONSE FUND (CERF)
UNDER THE 200# UN WORKPLAN /**

A. PROJECT SUMMARY

1. **Project Title:** ..
2. **Time frame:** .
3. **Grant amount:** .
4. **Project activities:** As described under the UN Workplan/CAP 2006found on page of the UN CAP/Workplan. Full details are provided in Annex 1 hereto, which forms an integral part of this Agreement.
5. **Accountability:** ENTITY/NGO(hereinafter referred to as the "Grantee") shall ensure that the grant shall not be used for purposes other than those described in Annex I to this Agreement.

B. FINANCIAL PROVISIONS

6. The Grantee shall establish a separate ledger account under its financial regulations and rules for the grant receipt and administration of the funds disbursed to it from WHO for the above project. The Grantee assumes full programmatic and financial accountability for the funds disbursed to it. The separate ledger account shall be administered by the Grantee in accordance with its own regulations, rules, directives and procedures, including those related to interest.
7. The Grantee, if so required, shall facilitate the financial and operational audit of the project by persons so designated by WHO. The Grantee shall make available without restriction all relevant financial and operational information, as well as certified statements of account, relating to the project to persons so designated by WHO and provide satisfactory explanations to all queries arising in connection therewith.
8. The project funds shall be disbursed in total by WHO in United States dollars, within one month after the signature of the Agreement, when the period of execution is three months or less. In projects spanning between three months and one year, the project funds will be disbursed in two instalments to the following the Grantee's account:
.....
.....
9. The project funds shall not be used to meet the cost of import or customs duties (or any similar fees) imposed by any government on any goods imported or services provided.

C. REPORTING

Substantive Reporting

10. The following reports shall be submitted for this project: (1) Substantive report covering activities from 1 January to 31 December to be submitted by 15 March of the following year and (2) a progress report covering activities from 1 January to 30 June to be submitted by 15 July of the same year.

ANNEX F – MATERIALS RELATING TO COORDINATION

The Grantee shall in addition submit to WHO any other reports necessary to address the UN-CERF reporting requirements, as per the attached Letter of Understanding between WHO and the UN Central Emergency Response Fund (CERF).

11. The WHO country office, as the leading party of the health cluster in the Country, will liaise with Save The Children UK for monitoring the implementation of the agreement, for gathering from the recipient the financial and technical reports indicated in this instrument and for ensuring a coordinated approach in the implementation of the different initiatives funded under the CERF framework.

Financial Reporting

12. Financial reports shall reflect the amount received in relation to expenditure from the contribution. The following reports shall be submitted to WHO for this project: (1) the final financial report certified by the Comptroller of the Grantee no later than one month after end of project agreement. (2) an interim certified financial report by 30 January 2007.
13. Financial reports shall provide information according to the Statement on Income and Expenditure's template attached.(ANNEX 2)
14. At the termination of the project, any unexpended or uncommitted part of the contribution shall be returned to WHO, unless otherwise agreed in writing by the parties.

D. CORRESPONDENCE

15. All correspondence regarding the implementation of this Agreement, other than this signed Agreement, shall be addressed to:

<i>World Health Organization</i>	<i>Entity</i>
Dr Ala'din Alwan
Representative of the Director-General
for Health Action in Crises
World Health Organization
20 Avenue Appia
CH.1211 Geneve 27
Tel:+41 22 791 14.72
Fax:+41 22 791 48.44
e-mail: alwana@who.int	

E. LIABILITY

16. The Grantee shall be solely responsible for the manner in which project activities are carried out. Thus, WHO shall not be responsible for any loss, accident, damage or injury suffered by the Grantee or any person claiming under it arising during or as a result of the implementation of the activities funded from the grant or in any manner whatsoever.
17. The Grantee shall be solely responsible for complying with applicable national laws and for dealing with claims by third parties arising from its implementation of the activities funded from the grant.
18. The Grantee's personnel performing services related to this Agreement shall in no way be considered employees of WHO, which assumes no responsibility in respect of life, health, accident, travel or any other insurance coverage and any security clearance which may be necessary.

F. TERMINATION

19. This Agreement, may, at any time, be terminated by either party by written notice to the other, if, in its opinion, an event beyond its reasonable control occurs which makes it impossible to carry out its obligations under this Agreement. Termination shall be effective thirty days after receipt of the notice as set forth in D.14 above.

ANNEX F – MATERIALS RELATING TO COORDINATION

20. The obligations assumed by the parties under this Agreement shall survive the termination of the Agreement to the extent necessary to permit the orderly conclusion of activities, the withdrawal of personnel, funds and property, the settlement of accounts between the parties hereto and the settlement of contractual liabilities that are required in respect of personnel, contractors, consultants or suppliers.

G. DISPUTES SETTLEMENT

21. Any dispute relating to the interpretation or application of this Agreement shall, unless amicably settled, be subject to conciliation. In the event of failure of the latter, the dispute shall be settled by arbitration. The arbitration shall be conducted in accordance with the modalities to be agreed upon by the parties or, in the absence of agreement, in accordance with the NCITRAL Arbitration Rules. The parties shall accept the arbitral award as final.

H. PRIVILEGES AND IMMUNITIES

22. Nothing in or relating to this Agreement shall be deemed a waiver of any of the privileges and immunities of WHO in conformity with the Convention on the Privileges and Immunities of the Specialized Agencies approved by the General Assembly of the United Nations on November 21, 1947 or otherwise under any national or international law, convention or agreement.

I. AGREEMENT BY THE GRANTEE

23. The Grantee certifies that the statement herein under the heading "Project Activities" is an accurate description of the project and that the duly authorized signature below indicates agreement and acceptance of this Agreement.

Signed: _____

On behalf of WHO

Dr A. Alwan
Representative of the Director-General
For Health Action in Crises
World Health Organization

Date: _____

Signed: _____

On behalf of ENTITY/NGO

ENTITY /NGO Representative
.....
.....

Date: _____



Considerations related to the selection of NGO partners

In the absence of any official WHO guidance on selecting NGO partners, the guidance below that is provided by WFP to their country offices may be of interest to WRs.

Key factors to consider in selecting partners, and especially NGO partners, are:

- i. their experience and reputation (locally and internationally) in the management of [relevant] programmes;
- ii. their ability to provide the necessary complementary inputs, especially technical supervision and support for [relevant] activities; and
- iii. their capacities in terms of:
 - administrative procedures and management systems;
 - financial management, including budgeting, accounting and fund raising;
 - human resources management, including recruitment, placement, training and support; *and*
 - management of other resources, including information, equipment and infrastructure.

To be in accordance with WFP's aims and principles, the NGO needs to have the following institutional profile, financial capacity and willingness to collaborate with other institutions:

NGO profile: The NGO needs to:

- be vetted against the [UN 1267 List of individuals and entities belonging to or associated with the Taliban and Al-Qaida organizations as established and maintained by the 1267 committee](#);
- be accepted by the Government. The NGO must be recognized by the national authority governing a specific area of operation, permitting it to carry out humanitarian relief and development activities in the country or area. It is expected to have a physical office and therefore a contact address;
- have extensive experience in humanitarian and relief operations;
- have sound, specific programmes for [relevant] assistance [activities], advocacy and development which correspond to WFP's general priorities and target groups;
- have adequate personnel and in-country organizational structures, including staff, field offices, vehicles and access to communications. The staff must be reliable, qualified and suitably experienced, with reasonable continuity in assignments;
- have a transparent institutional framework, active grass root participation, information systems and documentation, technical knowledge and geographical presence;
- be willing and able to work with communities and community-based organizations.

Financial and complementary inputs: The NGO should:

- be able to cover part or all of non-food items, staffing and equipment. While WFP may reimburse operational costs relating to [the food aid distribution], the NGO should be able to cover part or all complementary inputs;
- have staff with basic skills in project and financial management, analytical skills and capacity in areas of commodity tracking, food distribution and beneficiary participation. An NGO will need to provide detailed plans for [distributing food] to the intended beneficiaries;
- be able comply with WFP's monitoring and reporting requirements and have sound, reliable financial and accounting systems.

Relationship with other groups: The NGO needs to:

- collaborate with Government infrastructure: the NGO should have demonstrated willingness and ability to work with the responsible Government authorities at all levels;
- coordinate with others: the NGO should ideally be an active participant in any established coordination mechanism for an operation (and any separate NGO coordinating body).

Annex series D
Materials for Planning and Managing WHO programme support
(ref. chapter 10)

Responsibilities of staff members for imprest accounts and petty cash

Responsibilities of a staff member managing an imprest account

A staff member who is entrusted with the management of an imprest account must:

- ☑ Keep a separate imprest for each currency unit that you use (e.g. USD & local currency) with a separate bank account for each.
- ☑ Obtain receipts for all expenditures, no matter how small.
- ☑ Use vouchers with every payment: number and date them chronologically and mention the appropriate sticker number for each expenditure.
- ☑ Record all disbursements in the Imprest Account Cash Book.
- ☑ Update the imprest book daily.
- ☑ Never issue a cash cheque.
- ☑ Never sign a blank cheque.
- ☑ Never mix funds from different accounts.
- ☑ Never accept funds from an outside source (non-WHO) without first clearing it with the WR and RO-DAF.
- ☑ Never make loans from the imprest account. (Exceptionally, salary advances may be given, with the approval of the WR/RO-DAF, up to a maximum of 25% of the monthly wage of the employee.)
- ☑ Submit accounts at the end of each month, within 7 days of the end of the month (funds will be replenished only after the monthly imprest has been submitted).
- ☑ Submit a final detailed accounting report at the end of the assignment and transfer any unused balance to the WCO.

Responsibilities of staff members who receive petty cash advances

A staff member who receives a petty cash advance is personally responsible for its proper disbursement and accounting and must:

- ✓ obtain receipts for all cash that is disbursed;
- ✓ keep a careful tally of all expenditures using the petty cash reporting template (with entries numbered and the same numbers written on the corresponding receipts);
- ✓ reconcile the petty cash balance at the end of each working day;
- ✓ submit detailed accounts together with original receipts at the end of each month; *and*
- ✓ submit a final detailed accounting report at the end of the assignment and return any unused funds.

Any amounts not properly accounted will be recovered from future salary payments.

No further advances will be made until previous advances have been properly accounted for.

Staff who are given petty cash advances should *not*:


- ✓ carry cash advances for other people;
- ✓ lend money from their cash advance to other people, including other WHO or UN staff;
- ✓ confuse/mix petty cash and per diem advances.

Staff carrying cash should:

ANNEX F – MATERIALS RELATING TO COORDINATION

- ✓ limit the awareness of others of the presence of cash (not publicize the fact);
- ✓ limit the amount of cash on their person at any time;
- ✓ deposit the cash in an office or hotel safe as soon as possible; *and*
- ✓ keep a minimum amount in a petty cash box for incidental expenditures.
- ✓ *If the cash is being used to open a field office:* purchase and install a reliable safe as soon as possible. Ideally, the safe should be cemented into an inside wall of the office have dual access facilities, i.e. a combination (known by person A) and key (held by person B) or two keys (one for person A and one for person B). Until you have access to a safe, keep the money on your person or split it among the team members and document the distribution.

A staff member confronted with *armed robbers* should surrender the money without resistance. Under no circumstances should staff endanger their lives in order to protect any goods or property, including money. Any such event must be substantiated by a police report and a Security Incident Form completed and submitted to the WR and HQ.



Local Procurement – competitive bidding requirements

This annex provides a summary of the competitive bidding requirements for local procurements. For details of local procurement procedures, see SOP 10.5.

WHO follows standard procedures intended to promote competitiveness and transparency in the procurement process.

Competitive bidding requirements

For procurements below *US\$500* there is no need for quotes or pro forma invoices.

For procurements of *US\$500 to 10,000*, local procurement generally is by *Request for Quotation* (RFQ). A minimum of three quotations is required. This method is for procuring readily available, off-the-shelf goods or standard specification commodities of small value, or simple civil works of small value.

For procurements of *US\$10,000* and above an *Invitation to Bid* (ITB) is sent to potential suppliers. A minimum of three valid and technically acceptable bids is required.

For procurement of services or issues that require a complex solution or when procuring unusual/non-standard items regardless of value, an *Request for Proposals* (RFP) is sent to a number of suppliers seeking to obtain at least three valid and acceptable proposals. Proposals are assessed for "best value for money" judged against the requirements established in the RFP and not only on compliance and cost factors.

Exemption from competitive bidding

An exemption from competitive bidding processes may be given under the following conditions:

- an order of USD500 or less. Written quotations should be obtained from qualified vendors with a history of good performance;
- during an emergency that does not permit the delays that accrue from the full procurement process;
- When a Request for Quotation is issued to three or more suppliers and fewer than three bidders respond;
- the solicited goods, services or other item are subject to fixed prices or rates by the national government or its regulatory entities;
- there is only a single source of supply available or it is a proprietary item;
- the Contracts Review Committee has deemed that it is in the interests of WHO to standardize the item (generally equipment and/or spare parts or technical supplies);
- a decision is taken that competitive bidding will not achieve a result that is in the best interests of WHO; *or*
- when the procurement/contract is for services of a professional nature.

In all exemptions to the competitive bidding requirement the decision to proceed must be documented and all appropriate documents placed in the relevant procurement file.

The RFQ format in SOP 10.5 should be used even for purchases for which competitive bidding is waived as suppliers still need to know all the information included in a standard RFQ if they are to provide a serious price quotation.

Ethical Standards

Suppliers to WHO must have: no direct or indirect connection with the sale or manufacture of anti-personnel mines or the components thereof; and no direct or indirect connection with child labour.

Standard WHO kits

Drug and medical supply kits available from HQ: The standard kits provided by WHO globally are described in SOP 10.2. In general, these kits are ordered through the RO in the same manner as other international procurements. Allotment and sticker numbers are provided by the country office (unless funding is from the RO). HQ then procures and arranges direct shipments from the suppliers in northern Europe.

Sometimes, Inter-Agency Emergency Health Kits (IEHKs), Italian trauma kits (A & B), and diarrhoea disease kits (DDK) can be obtained as donations from the Government of Italy (GOI) from the stocks held in UNHRD Brindisi as a bilateral contribution or as part of a joint WHO-GOI operation. Requests for funded kits should be addressed to HQ-HAC.

WHO Emergency Health Library kit: Stocks are held by HQ-HAC and dispatched from Geneva. It constitutes a comprehensive collection of basic health reference texts (published by WHO and others) and is useful when a WHO or field health office is being established for a major operation that is expected to be of fairly long duration. Most of the WHO-published documents that are available electronically are included on the Health Library for Disasters (HeLiD) CD-ROM.

UNFPA reproductive health kits: These kits are not normally provided by WHO. When needed, UNFPA usually supplies, and funds, them. The WR/CLO should discuss any requirement with the UNFPA representative.

Guidelines for drug donations

Policy guidelines agreed among WHO, UNICEF and a number of other organizations are provided in *Guidelines for Drug Donations*, WHO 1999. This annex presents a summary of the key points. It is reproduced with minor editing from PAHO [http://www.paho.org/english/PDE/te_ddon.htm].

Core principles for drug donations:

- ✓ All donations should benefit the recipient.
- ✓ Respect the wishes and authority of the recipient.
- ✓ There should not be a double standard in quality.
- ✓ Effective communication between the donor and the recipient.

Guidelines for drug donations:

- ✓ All drug donations should be based on an expressed need and be relevant to the disease pattern in the recipient country.
- ✓ All drugs should be approved for use in the recipient country.
- ✓ The presentation, strength and formulation of donated drug should, as much as possible, be similar to those commonly used in the recipient country.
- ✓ All donated drugs should be obtained from a reliable source and comply with quality standards in both donor and recipient countries.
- ✓ No drug should be donated that have been issued to patients and then returned to a pharmacy or elsewhere.
- ✓ After arrival in the recipient country all donated drugs should have a remaining shelf-life of at least one year.
- ✓ All drugs should be labelled in a language that is easily understood by health professionals in the recipient country.
- ✓ Donated drugs should be presented in larger quantity units and hospital packs.
- ✓ All drug donations should be packed in accordance with international shipping regulations (named by INN, dosage form, quantity, batch number, expiry date, volume, weight and any special storage conditions).
- ✓ Recipients should be informed of all drug donations that are being considered, prepared or actually underway.
- ✓ In the recipient country the declared value of a drug donation should be based upon the wholesale price of its generic equivalent in the recipient country (except for patented drug for which there is no generic equivalent).
- ✓ Cost of international and local transport, warehousing, port clearance and appropriate storage and handling should be paid by the donor agency, unless specifically agreed otherwise with the recipient in advance.


Recommendations for the recipient country:

- ✓ In emergency situations, it is common to have many organizations involved in receiving and distributing international donations (mainly NGOs). It is wise to have an official unit to coordinate them or at least to have access to information on what drugs are being received and the areas/institutions to which they are being sent.
- ✓ Provide international donors with a list of needed drugs and inform them whenever the list is updated.
- ✓ Include in the list of needed drugs all necessary devices for administering them, such as syringes and needles.

ANNEX F – MATERIALS RELATING TO COORDINATION

- ✓ In making the list of needed drugs, make a specific provision for controlled medicines, following WHO guidelines (WHO/PSA/96.16).
- ✓ Although it is hoped that most donors will follow the drug donations guidelines, some drugs that are unnecessary, expired or near the expiration date are likely to arrive. Have a special team to deal with those cases.

In principle, drugs close to or past their stated **expiration dates** should not be accepted. However, such drugs will often be offered or sent, and the MoH must be prepared to deal with such offers and arrivals. Expiration dates are very conservatively set for some drugs and, with suitable storage, the drugs remain safe and potent for much longer. When such drugs are of particular value, health authorities should decide whether reference laboratory testing and re-certification should be arranged. There may be a negative public reaction nationally or internationally if this course is pursued.



Delivering and managing supplies ⁷

The delivery of health and medical supplies to the affected area is often a critical component of the humanitarian response. It required good management as well as resources.

Guiding principles

Effective use must be made of in-country stocks (held by the MoH, other government entities, the private sector, the Red Cross and NGOs).

Donations of medical and health supplies should be appropriate and in line with international guidelines (see Annex #), meet identified needs, and be delivered in a manner that facilitates their classification and use.

Potential donors (national and international) should be informed of what is needed and also what is *not* needed in order to avoid the arrival of large quantities of unsolicited donations that create unwanted logistic and management problems. Statements of what is and is not needed should be updated regularly.

The Government should restrict its requests – and WHO its recommendations – to items in the approved list of essential drugs and to quantities that are commensurate with the number of people affected by the disaster. The time required for shipment and distribution should be considered when requesting supplies.

Standard, pre-packed *kits* of drugs and essential supplies can be useful during the early stages of emergency response when there is limited capacity to sort and inventory incoming stocks, and to assemble and dispatch supplies in response to orders from individual facilities.

Bulk supplies may be more appropriate later and whenever the capacity and systems exist to manage bulk supplies and respond to specific requirements notified by field health facilities. When drugs are provided in bulk, donors should be encouraged to provide large quantities of a few items.

Perishable products and vaccines should not be requested unless refrigeration facilities are available and special handling arrangements can be made at the airport.

The existing health/medical supply management system should be used if it is up to the task. If existing systems are not adapted to the management of large numbers of donations and the rapid inclusion of additional items and users, the LSS/SUMA system may be used – see Panel #-#.

What to do – key management actions

First steps – during the first few days

- ☑ Assist the MoH, as needed, in preparing and disseminating a national policy and corresponding guidelines for the international community and potential local donors regarding donations and arrangements for the receipt of emergency supplies. This should:
 - identify the focal point – the MoH emergency health coordinator or another designated official – whom donors should consult before purchasing, collecting or shipping donations of health or medical supplies;
 - emphasize the value of – preference for – cash donations that enable a) resources to be directed to meeting the most urgent needs as they evolve, and b) appropriate supplies to be purchased locally, in neighbouring countries or from reliable international sources, as appropriate;
 - specify the types and quantities of supplies and equipment that are needed; *and*
 - list items that are *not* needed as donations.

⁷ This section is adapted from *Natural Disasters – protecting the public's health*, PAHO 2000, chapter 12 *Managing humanitarian relief supplies*, and *Emergency Response Manual*, WPRO 2003, section 5.7.

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- ☑ Help the MoH, as needed, to review requirements and available stocks, to arrange the rapid transfer of needed supplies from other parts of the country where they are in stock and, when needed, prepare appropriate requests for international assistance, and coordinate the delivery of international assistance. Ensure that:
 - requests clearly indicate the order of priority, amounts and formulation (e.g., tablets or syrup) – avoid vague requests for “anti-diarrhoeal drugs”, “antibiotics”, or “vaccines”; *and*
 - the amounts requested are compatible with the size of the affected population and the anticipated occurrence of trauma and disease.
- ☑ Actively encourage potential donors to contribute within the framework of those guidelines and to accept to provide supplies to replenish national stocks drawn down during the early days of the emergency, see Panel #-#.
- ☑ Provide advice to international agencies and donors concerning quality requirements, packaging and delivery arrangements, etc.
- ☑ Use funds available to WHO, and mobilize additional funds when needed, to procure and deliver urgently needed supplies and equipment that are not being provided by other agencies or donors. Coordinate supply actions closely with UNICEF and UNFPA.
- ☑ Ensure that an efficient supply management system is in place and, when needed, propose LSS/SUMA and help to install and operate that system.
- ☑ Work with the MoH, other concerned government entities, the UNRC and other agencies to ensure that appropriate priority is given to medical and public health supplies in plans for the use of available transport capacity.

During the emergency phase/first month

- ☑ Continue to work with the MoH and other partners, especially through the health cluster/ sector group to coordinate efforts to mobilize and deliver needed supplies, including publishing regular updates of the lists of what is and is not needed.
- ☑ Consolidate management and distribution systems for emergency supplies. Provide technical and material support for the storage, management, distribution and tracking of supplies, if needed.
- ☑ Provide, and promote the provision of, drug and supply kits where this can facilitate handling and accelerate distribution.

Once the situation has stabilized/beyond the first month

- ☑ Phase out the provision of kits and focus on (re-)building the capacity and systems to manage bulk drugs and respond to the specific needs of field facilities.

Tools and other guidance

Guidelines for drug donations, WHO 1999

Annex #: a synthesis of some of the key elements of the above guidelines.

Annex #: details of the kits available through WHO. (The contents lists may also be taken as a basis for establishing lists of essential needs if the MoH does not already have its own list of basic medical supplies to be made available immediately after a disaster.)

<http://www.unfpa.org/>... for details of a comprehensive reproductive health kit is available through UNFPA.

Use of Essential Drugs: (Tenth Model List). Seventh Report of the WHO Expert Committee, Technical Report Series No. 882, WHO Geneva: 1997

Likely health supply needs

Following a sudden disaster:

The most critical health supplies in the first phase are generally those needed for:

- treating casualties – items such as x-ray film and developing chemicals, casting plaster, dressings, some equipment and supplies for blood banks; *and*
- preventing the spread of communicable diseases – including disinfectants, a few essential drugs, some vaccines (especially measles vaccine) and cold-chain items, equipment and supplies for laboratories, etc.).

Following the initial emergency phase, needed supplies may include sanitary engineering equipment, disability aids, supplies for basic health care including continuing treatment for chronic conditions, and construction materials.

Note that:

- Localized shortages of supplies in the emergency zone during an initial period may arise from disruptions in normal supply channels and difficulties in locating, accessing, sorting, classifying, inventorying, transporting and distributing supplies in a disaster zone, rather than from an absolute shortage in the country.
- The first international humanitarian assistance shipments may arrive at the country's airports, seaports or land border crossings within 24 to 72 hours of the event, but unloading, sorting, storage and distribution will take much longer. The majority of these supplies usually arrive in the affected area *after* the most urgent health needs have already been met through local means. The bulk of international donations, therefore, should be planned to *replenish* national stocks and sustain services during the *post-disaster* phase.
- Donations of *blood* from abroad are rarely needed. Equipment to collect blood, or a suitable supply of blood substitutes, may be more appropriate (if needed at all).

In a slow-onset crisis or complex emergency:

The focus is likely to be on preventing the spread of communicable diseases and sustaining (or restoring) essential health care services. Supply needs may include disinfectants, essential drugs, vaccines (especially measles vaccine) and cold-chain items, equipment and supplies for laboratories, sanitary engineering equipment, and supplies for basic health care including continuing treatment for chronic conditions. In case of conflict, supplies for casualty treatment, disability aids and construction materials may also be needed.

Key actions to ensure effective supply management: LSS/SUMA

All elements of the supply chain must be well coordinated – preferably by an integrated management system. This includes: acquisition (from in-country stocks, by local purchase, imports, donations or loans); transport to the area; storage and inventory management; distribution to users.

The keys to good supply management are:

- ✓ rapid, systematic and accurate entry into the inventory of details of receipts and dispatches at all locations;
- ✓ good communications; and
- ✓ the production of regular reports.

There is transparency and accountability: information circulates among agencies, records are kept, and reports issued to the government and donors.

Priorities should be assigned for each shipment to the affected area to meet the most urgent needs and make efficient use of transport capacity.

Supplies sent into the affected area must be packaged and labelled to facilitate sorting, storage and use, and to minimize the time health personnel have to spend in such tasks.

LSS/SUMA, created by PAHO, has been adopted by WHO as a standard for the general management of emergency supplies. The SUMA software and guidelines for its use are on the CD-ROM.

The main tasks of a supply management system (such as SUMA) include:

- Sorting and identifying/classifying humanitarian assistance supplies
- Rapidly identifying and establishing priorities for the distribution of supplies urgently needed by the disaster-affected population
- Maintaining inventory and distribution control in warehouses
- Entering all incoming supplies in a database (national authorities use reports generated from the database for decision-making)
- Registering consignments that are delivered to consignees
- Keeping disaster managers informed about items available for distribution
- Keeping national authorities and donors informed about items received

SUMA can be used for all kinds of relief items

Donor reluctance to replenish medical stocks

Some donor countries and agencies are reluctant to replace local medical stocks that have been used for emergency purposes and instead want to supply emergency needs directly.

This problem may be lessened if donors are informed that the depletion of local stocks because of the emergency will restrict rehabilitation of normal medical services. Donors should also realize that their consignments of supplies often cannot be received and distributed in time to be used in treating casualties.

Annex series E
Materials relating to Information and Analysis
(ref. chapter 5)

Principles of emergency assessments

Assessments and ongoing situation monitoring provide the basis for decisions on assistance strategies and the allocation of resources to particular activities by the government, donors and aid agencies. Assessments must provide information and recommendations in time to inform the planning of responses. Monitoring/surveillance must provide information to inform programme management – including programme adjustments when needed – and early warning of health threats to enable preventive action to be taken. All this requires good information management.

WHO has a responsibility to see that:

- the health-related aspects of emergency situations are adequately assessed and monitored;
- priority health-related needs and risks are identified; *and*
- information on the health situation is well managed, disseminated and used.

This requires that:

- a good health **baseline** is available including sub-national (e.g. district) level profiles;
- quality **assessments** are completed in a timely manner at the beginning of a crisis and whenever necessary during an ongoing crisis;
- an appropriate monitoring/**surveillance** system is in place and functions effectively providing information on mortality, morbidity, injury treatment and rehabilitation, potential health risks, health service coverage and performance, and changes in the overall situation/context that could affect health or health services;
- an appropriate **warning and response** system is in place, linked to the surveillance system;
- a good health **information management** system is in place and information is well **communicated**: this includes encouraging shared data bases and/or a website (including baselines and district profiles as well as current data linked with OCHA-HIC or equivalent), and ensuring the production/publishing of regular bulletins/newsletters (*what's going on, who's doing what where*) and, when appropriate, special reports.

These tasks should be accomplished jointly, collaboratively by the MoH with other main health actors whenever possible, through a Health “Cluster” or equivalent (see section 2.2). If this is not possible for any reason, WHO has a responsibility to provide the international community – and the government – with its own assessment and analysis while seeking to strengthen national capacity to take on and fulfil these functions. WHO should therefore take the lead in organizing or coordinating assessments, where necessary.

In situations of conflict, WHO should also use independent and validated health evidence to promote the overall **humanitarian agenda**.

Guiding principles

Assessments should be undertaken, surveillance assured, and information managed and disseminated by or in collaboration with – with the maximum possible involvement of – national and sub-national-level health authorities as well as other partners. All should use common or compatible standards, protocols and case definitions.

Assessments would be organized by WHO only if not already done by others or it is necessary to validate information.

Health-related **assessments** must:

- consider all the **vital needs** of the affected population and 'contextualize' the health situation in the global picture. These needs may include, in addition to health care: security, water, food, shelter, sanitation, clothes, blankets and essential domestic items, health care, and public health and hygiene promotion through public information and education.
- examine **resources, capacities and risks** as well as needs;

- be undertaken by experienced public health "**all-rounders**", to the extent possible (specialists almost inevitably focus their attention and recommendations on aspects relevant to their specialization and are not always able to take a broad overview and prioritize among the range of needs); *and*
- be well **planned and organized**: the ability of an assessment to provide useful information efficiently and in a timely manner to inform decision-making depends on systematic planning (which may be rapid), good management, and make maximum, effective use of available, **secondary data**.

An assessment should produce *at least*:

- information on health status, determinants, risks to health, performance of health system and which health aid organizations are doing what, where, including a clear map of conditions of accessibility, needs and the coverage and residual capacity of local systems;
- conclusions on the nature and scope of the crisis, and health and nutrition priorities;
- recommendations for immediate action with enough material for formulation of initial project(s) and information to stakeholders;
- identification of health care delivery units/partners upon which to build a surveillance system;
- stronger national *and* local capacities.

The report should:

- describe the method(s) used, any limitations on the data, and assumptions made;
- present the findings in a manner that is easy to incorporate in a common (shared) data base;
- be finalized and circulated to all stakeholders (government departments, donors, UN and NGO partners) within a few days of completion of the field visits.

Reports of assessments undertaken or coordinated by WHO should be cleared by the WR.

The different stages of information collection and analysis are summarized in the panel below.

Guidance on planning and managing assessments is provided in chapter 6.

SPHERE standards for (initial) assessments
<p>“Assessments provide an understanding of the disaster situation and a clear analysis of threats to life, dignity, health and livelihoods to determine, in consultation with the relevant authorities, whether an external response is required and, if so, the nature of the response.”</p> <p><i>Key indicators include:</i></p> <ul style="list-style-type: none"> • Information is gathered using standardised procedures and made available to allow for transparent decision-making. • Through consultation, the assessment takes into account the response of the local and national authorities and other actors and agencies. • Local capacities and strategies to cope with the disaster, both those of the affected population and the surrounding population, are identified. • The assessment takes into account the responsibility of relevant authorities to protect and assist the population on the territory over which they have control, and takes into account national law, standards and guidelines applicable where the affected population is found, as they conform with international law. • The assessment includes an analysis of the operating environment, including factors affecting the personal safety and security of the affected population and of humanitarian staff. • Estimates of population numbers are cross-checked and validated with as many sources as possible, and the basis of the estimate made known. • Assessment findings are made available to other sectors, national and local authorities and representatives of the affected population. Recommendations are made on the need

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for external assistance, and on appropriate response that should be linked with exit or transition strategies.

[SPHERE handbook, 2004, common standard 2]



The (3-Cluster) Initial Rapid Assessment

This annex provides an overview of the IRA process and what is expected in relation to health. It complements the IRA guidelines issued by the Global Health, Nutrition and WASH Clusters that provide guidance on the information an IRA should collect and how.

An IRA is a joint health-nutrition-WASH assessment undertaken in the early stages of a crisis to gain an understanding of the public health situation and establish priorities for action in the areas covered by the three Clusters. The panel below show what is expected in relation to “health”. It is a crucial stage in the process of information collection, analysis and decision-making in the early stages of a crisis as outlined in section 2.1.

What is expected of an IRA in relation to “health”

An IRA must enable decisions to be made on what, if any, action should be taken by the relevant authorities and assistance agencies to:

- organize/provide needed emergency medical care;
- assure shelter, water, food and other basic necessities for the survival of the affected people;¹
- advise the population and concerned agencies on measures to reduce health risks;
- intensify or institute appropriate environmental health and disease control measures;
- intensify or institute surveillance to monitor the evolving health (and, where necessary, nutritional) status of the population, and the performance of the health care system;
- coordinate the efforts of different entities in providing health and related services; *and*
- organize detailed follow-up assessments of particular aspects in specific localities.

It must provide the basis for developing a plan of action. To do this, it must determine; whether there is an emergency; how many people are affected; what the immediate needs are; what local resources are available; and what external resources are needed. It must assess and analyse:

- the health status of the population and how it compares with what would be normal for the season, trends in morbidity and mortality, and the (direct and underlying) causes of health problems;
- the state of the health system and the reasons for service delivery problems; *and*
- the risks to public health and the health system in the coming months.

The analysis must take account of:

- the political, economic, social and security context (including changes in the recent past);
- the pre-disaster/pre-crisis situation – epidemiology and the characteristics of, and constraints on, the health system; *and*
- *in case of displaced populations* (refugees or IDPs): their previous environment – the epidemiology of the areas from which they have come; their numbers and rates of arrival or departure; their relationships with the local, host population.

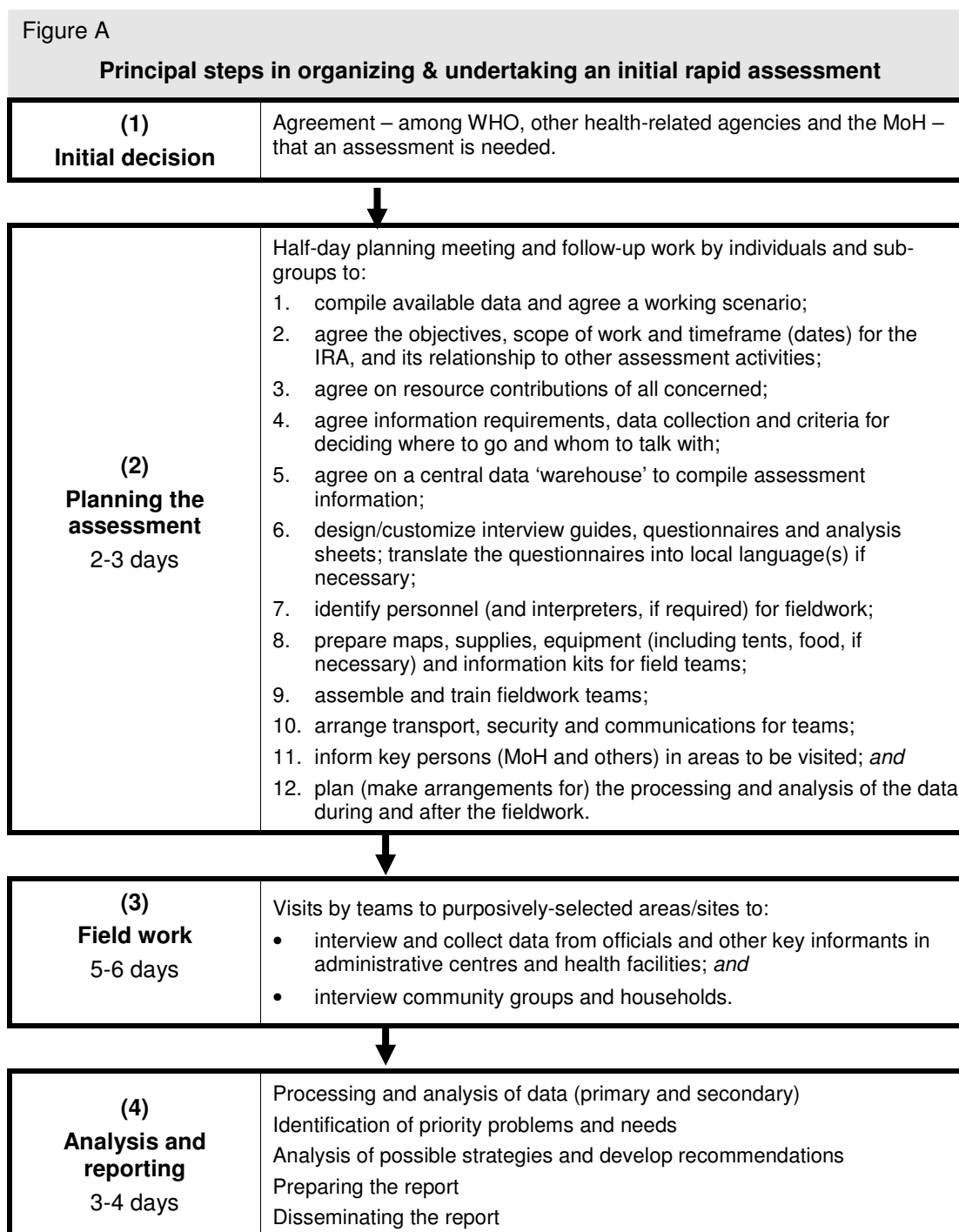
Detailed follow-on assessments may need to be undertaken in particular localities, depending on the findings of the initial assessment, in relation to some or all of the following:

- damage to health facilities – detailed surveys by competent technicians and engineers to prepare specific plans and cost estimates for repair/ reconstruction
- the human and other resources/capacity available to assure needed health services in the immediate future and the long term – requirements to re-establish the primary health care system
- the impact on people’s ability to access health services
- damage to water supply and sanitation structures and systems
- the impact on vectors and vector control programmes
- the psychological impact on the population and on relief workers
- the causes of death, injury and disease and their distribution among different population groups to inform planning for future, long-term prevention and preparedness measures

¹ Provision of assistance in these areas would normally be by ministries other than health, supported by agencies other than WHO, but the Ministry of Health and WHO should seek to ensure that adequate provision is made and they should advocate for additional action and resources if needed.

An IRA should normally be initiated within a maximum of 2 days of the onset of a crisis and produce a report and recommendations within a week. The time frame may be slightly longer in case of a slow-onset crisis. An IRA may also be undertaken when a previously inaccessible area becomes accessible or, as a re-assessment, following a significant change in the overall humanitarian context.

The key elements of planning, undertaking and reporting on an assessment are indicated in Figure A. Following a decision that an assessment is needed, there are three main stages – planning, field work, and analysis and reporting. The time required for each phase depends on the situation – the country and the availability and quality of existing data but are typically as shown. Good preparation is essential. The success of an assessment and the value of the report are heavily dependent on the quality of the planning – steps 1 to 10 – done *before* the field visits. In most cases, steps 3 to 10 will be undertaken more-or-less concurrently.



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The need is to assess:

- the health status of the population and how it compares with what would be normal for the season, trends in morbidity and mortality, and the (direct and underlying) causes of health problems;
- the state of the health system and the reasons for service delivery problems; *and*
- the risks to public health and the health system in the coming months.

The analysis must take account of:

- the political, economic, social and security context (including changes in the recent past);
- the pre-disaster/pre-crisis situation – epidemiology and the characteristics of, and constraints on, the health system; *and*
- *in case of displaced populations* (refugees or IDPs): their previous environment – the epidemiology of the areas from which they have come; their numbers and rates of arrival or departure; their relationships with the local, host population.



Assessment management and planning checklist

(Reproduced from WPRO Emergency Response Manual, section 9.3)

Preparing an assessment mission

The following are crucial for a field assessment mission/survey to gather information rapidly and efficiently:

- ✓ Clear terms of reference that specify priorities for information gathering (based on existing information, past experience and priorities for decision-making)
- ✓ Reliable arrangements for transport, including vehicle fuel
- ✓ Permits to travel to and within the area(s), if required
- ✓ Reliable means of communication (phones and/or radios) to maintain contact with district, provincial and/or national headquarters
- ✓ Baseline (pre-disaster) information on the affected area(s) and populations
- ✓ Maps showing the locations of communities, health facilities, water sources and water and sewerage/sanitation installations
- ✓ Information on the impact of previous disasters in the same area(s), the response to those disasters and the lessons learned
- ✓ Names and addresses of important health service, local administration, NGO, UN agency and other contacts in:
 - the area(s) affected, and
 - neighbouring areas from where support may be provided

See also the personal readiness check-list in annex G1.

Assessment teams should also be aware of arrangements for assessment in related sectors and any specific information they could usefully gather to support those assessments when visiting remote areas.

Key principles of assessment

- ✓ **Focus based on existing knowledge:** While each emergency situation is unique and requires on-the-spot assessment, the general effects of most types of disaster are known from past experience. The initial assessment should be focused accordingly.
- ✓ **Prioritized information gathering and analysis:** The assessment must be organized to inform decisions on action to meet emergency medical and public health needs, then to address medium and long-term issues. (The collection of data to support future preparedness planning is an important but subsidiary concern.)
- ✓ **Capacities, causes and risks as well as 'needs':** The assessment should gather basic factual information on the present health situation and the ability of the community and local services to cope. It should also seek to identify the underlying causes of problems (ask Why?) and look ahead (ask What if?).
- ✓ **Coordinated efforts:** Many people and entities are involved in activities, and/or have information, relevant to public health.
- ✓ **Existing procedures:** Assessment should be conducted within the framework of the national disaster/emergency response plan (when there is an up-to-date plan), using previously trained personnel and existing forms and procedures (when they exist).
- ✓ **Interpretation based on local knowledge:** In most cases, information should be gathered and analysed by people who are familiar with the area, its epidemiology, the public health effects of previous disasters, and the effectiveness of previous emergency and post-disaster assistance operations.

- ✓ **Specific expertise, when needed:** In case of chemical pollution, a radiological accident or an unusual disease outbreak, relevant technical information and expertise must be immediately mobilized (nationally, through bilateral or regional mechanisms and/or through WHO and collaborating centres).
- ✓ **Separate arrangements for medical assistance:** Assessment (and surveillance) personnel should concentrate on assessing the overall problem and refrain from giving medical care. Backup medical assistance should be provided separately.

Where to seek information

Information should be obtained and compared from a wide variety of sources. Qualitative as well as quantitative information should be sought and recorded. Sources must always be recorded.

- ✓ **Review existing data** – profiles of the area and epidemiological data. Thus anticipate the impact and needs, specify what the assessment should focus on, and avoid spending time collecting information that is already available.
- ✓ **Review health facilities' records and reports.** Get reports from health administration offices, public and private hospitals and clinics, therapeutic feeding centres, etc. Review records during visits to such facilities.
- ✓ **Get reports from other relevant agencies.** Get reports from technical agencies and NGOs working in the health, water and sanitation sectors and from military and civil defense/protection units working in the area. Encourage the use of standard reporting forms.
- ✓ **Get reports from local administrations, communities and humanitarian workers.** Note, however, that information from community leaders, administrators and local authorities is likely to be unspecific and incomplete, and is often exaggerated.
- ✓ **Observe conditions:** During visits to communities, especially temporary settlements, look out for clinical signs of illness or malnutrition. Compare (triangulate) the information from reports and key informants with your own observations and discuss any divergences with local health workers.
- ✓ **Review media reports.** Reports from national and international news media may be among the first sources of information, However, technical relevance, accuracy and completeness usually do not match their speed and coverage. Use their information to orient professional assessments but don't rely on it for planning purposes.

Aerial observation – low-altitude over-flights, especially by helicopter – provide indications of the geographic extent of damage and of visible damage to premises, access routes and lines of communication, but such observations (and especially satellite imagery) are of little use in identifying urgent health problems and needs.

Assessment report outline and evaluation checklist

The *RHA Team Leader Checklist* (draft Feb 2007) lists the elements that a rapid health assessment needs to examine and report on. The table below presents that list together with some key points that should be considered when planning an RHA or evaluating the quality of an RHA report.

More detailed guidance on the use of the checklist is provided in *Comments to the RHA Team Leader Checklist* (draft Feb 2007).

<i>Elements to be examined and reported on</i>	<i>Critical elements for data collection planning, analysis and reporting</i>
	The pre-crisis situation used as a baseline – comparison of current data and capacities with the pre-disaster/pre-crisis situation. Maximum use of existing data, but careful review for accuracy, coverage and representativity.
1. Context	using available secondary data
1.1. Country profile (political, economic, social, and security conditions) 1.2. Recent history of disaster 1.3. Role of the State (general and disaster-specific) 1.4. Stakeholder mapping 1.5. Trend analysis (ongoing natural or human-generated hazards, security) 1.6. Possible scenarios for the near future(?)	The strength of State institutions, whether they can be strengthened or will have to be bypassed; Stakeholders' means and motivations (including all armed forces/groups); Trends in the security situation (risks for the population and humanitarian staff).
2. Geographical boundaries	using secondary and field data
2.1. Definition: area (administrative unit) or point location (camp, village)	Clarity on whether references are to areas or point locations; Breakdowns into relevant areas (may be pre-defined or "opportunistic neighbourhoods"); GPS coordinates whenever possible (for mapping and later reference);
2.2. Environment and infrastructure: [Climate, season; Security (UN phase), access, communication, electric power; Shelter, water source, disposal of excreta, control and disposal of waste; Temporary settlement: suitability of site (logistics, environmental factors, security)]	Particularly careful analysis of environmental health factors in cases of temporary settlement or massive destruction
3. Affected population	using largely secondary data
3.1. Population numbers (per area or point location)	Source, likely accuracy and sensitivity of population numbers; basis of any negotiated consensus/ compromise on figures Methods used for estimation in camps, etc. (e.g. Quadrat method, T-square method, possibly complemented by satellite imagery, aerial photography) Clear distinctions between the total population of a given area, the population affected (and in need of assistance?), and the population that can be reached

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<p>3.2. Demographic profile [Ethnic/religious groups (size); Population growth rate; Average family size; Male/female ratio and portion of under-5s]</p>	<p>Disaggregation by age and gender (an age-sex pyramid) essential in all cases; Disaggregation by ethnicity, religion, urban or rural population, if possible; Care in use (and definition) of 'household' or 'family'.</p>
<p>3.3. Vulnerable groups/individuals [Identity, numbers; Number or proportion of single-headed households]</p>	<p>Vulnerability linked to characteristics of individuals (e.g. disabled, old, single women, unaccompanied minors) or population groups (ethnicity, socio-economic status or location)</p>
<p>3.4. Population movement, if any [Category (IDPs, refugees, returnees, beneficiaries of humanitarian assistance); Direction, numbers, location; Demographic profile; Motivation; Trends]</p>	<p>Population movements in terms of: locations; numbers; motivations to leave or to stay; push- and pull-factors Whether displaced persons are dispersed in the local population or congregated separately in camps</p>
<p>4. Morbidity</p>	<p style="text-align: center;">using secondary and field data</p>
<p>4.1. Epidemiological profile: [First three causes of morbidity (disaggregated for under-5s); Most common killer diseases (disaggregated for under-5s); EPI coverage of under-5s (including Vit A distribution); Measles vaccination rate of under-5s; Incidence rates of major diseases (age- and sex-specific where possible); Case Fatality Rates of major diseases (age- and sex-specific where possible); Incidence of trauma/injury; Incidence of Sexual and Gender-Based Violence; Prevalence of endemic diseases (malaria, HIV/AIDS, tuberculosis, acute malnutrition etc.); Non-infectious agents (cold, heat, radiation, poisons, toxins etc.); Trends and impact of disaster on the above.]</p>	<p>A rough baseline epidemiological profile, then the specific effects of the disaster; Morbidity and mortality in all cases; other conditions relevant to the local context; Causes of trauma and injury (natural, technological, shells, gunshots, landmines or unexploded ordnance); For diseases with epidemic potential, incidence rates (if possible, otherwise absolute numbers) and case fatality rates, all disaggregated at least for under-5s. Natural trends to be anticipated (e.g. rainy season malaria, 'lean season' malnutrition); Existence and use of standard definitions for cases and (vaccination and service) coverage; Reports of sexual violence, if any. Specification of sources for all reported information (except sexual violence?).</p>
<p>4.2. Main health concerns [Reported by the population; Reported by health professionals]</p>	<p>Concerns of both health professionals <i>and</i> the population themselves.</p>
<p>4.3. Special disease control programmes; impact of disaster</p>	
<p>4.4. Health Information System [Performance of routine national Health Information System; impact of disaster; Steps undertaken for disease surveillance]</p>	<p>The performance of the existing HIS by the assessors; need for strengthening or a parallel surveillance system The symptoms or diagnoses reported Disaggregated for under-5s? Alert and response system – existence and triggers?</p>
<p>4.5. Diseases with epidemic potential [Functioning of surveillance system; Incidence rates; Case Fatality Rates; Means of diagnosis (rumour, clinical, laboratory confirmation)]</p>	<p>Outbreak thresholds used/observed? Diagnostic means used in case of reporting an outbreak (rumour, clinical diagnosis, laboratory confirmation?)</p>
<p>4.6. Specific diseases [HIV/AIDS (estimated seroprevalence, incidence of STDs, at risk for HIV transmission); Chronic illnesses (e.g. hypertension, diabetes); Others]</p>	<p>Rapid HIV/AIDS risk and vulnerability assessment included when context demands; Mental health/psycho-social disturbances especially after sudden catastrophes and among displaced populations; Interruption of treatments for chronic illnesses; (Endemic diseases such as tuberculosis will not be a priority at the RHA phase.)</p>
<p>5. Mortality</p>	<p style="text-align: center;">using secondary and field data</p>

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<p>5.1. Crude Mortality Rate (CMR) 5.2. Mortality rate for under-5s (U5MR) 5.3. Top three 'normal' causes of mortality (disaggregated for under-5s) 5.4. Top three causes of mortality at present (disaggregated for under-5s) 5.5. Sources and trends for the above (5.1. - 5.4.) 5.6. Existence of mortality surveillance (routine surveillance or ad hoc) 5.7. Steps undertaken to establish mortality surveillance system</p>	<p>Retrospective surveys, prospective data collection or routine surveillance?</p> <ul style="list-style-type: none"> • service-based mortality data will be incomplete, not representative; • population-based data must be from surveys using probability sampling preferably, independent from other assessments (in practice, may be nested within a 30×30 cluster nutritional survey); • data from community or religious leaders, health facilities, administrations or graveyard observations may be used for routine surveillance. <p>Analysis of likely biases – under-reporting or over-reporting/double counting; Population size (denominator) continuously updated; Careful analysis of <i>cause-specific mortality data</i>: hospital data are not representative; data from households must be restricted to a few very diseases clearly identifiable by the population.</p>
<p>6. Health system</p>	<p style="text-align: center;">using secondary and field data</p>
<p>6.1. Organisation of health care provision (public, private, faith-based, others)</p>	<p>The health system and its functioning before the disaster The impact of the disaster</p>
<p>6.2. Levels of health services (e.g. health post, health centre, district hospital; private clinics); Service profile per level</p>	<p>The functions/services provided at each level, (e.g.: community level (Community Health Worker); peripheral level (Health Post); first level health service (Health Centre); first level referral hospital (District Hospital); second level referral hospital (Provincial Hospital).) What each level can be relied upon for in relation to, disease surveillance and prevention, laboratory analysis, surgical care for trauma patients, etc. if given necessary supplies.</p>
<p>6.3. Coverage (e.g. rate of population to one doctor / nurse and to type of health facility, or portion of population who has access to first-level health services within one hour's walk)</p>	<p>Coverage and health-staff-to-population ratios compared with national pre-crisis or regional norms. In a camp situation, comparison with international benchmarks (e.g. 60 health workers per 10'000 population).</p>
<p>6.4. Drugs: distribution mechanisms (Ministry of Health, private, other); use of essential drug list?</p>	<p>The drug distribution system (e.g. through MoH at subsidised prices, or privatised and unregulated). The implications and likely effects of different possible interventions; trade-offs among control, efficiency, local ownership and sustainability. Whether there is a national essential drug policy.</p>
<p>6.5. Resources of health services [Infrastructure, including ancillary services (e.g. building, heating, water, sanitation, waste disposal, electricity supply); Equipment (availability/lack of essential equipment); Supplies (availability/lack of essential drugs and consumables); Human resources by category (presence, motivation, performance, including management); Finances (staff income, maintenance expenses); Present external support with resources (6.1.-6.5.)</p>	<p>Pre-crisis resource situation and the impact of events. Infrastructure, equipment and supplies compared with national norms. Human resources for (i) the provision of care, and (ii) management functions – whether health professionals have fled, been killed, migrated, been hired away, become concentrated in less affected areas, moved to the private sector, are still around and trying to cope or de-motivated. Vital ancillary services – e.g. sterilisation, laundry, incinerator, kitchen for referral services. Weak links/critical factors without which services cannot function (e.g. security, electricity, staff). Whether the system can be supported or (in the case of extreme weakness and urgency) a separate, parallel system is needed.</p>

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<p>6.6. Limits to access to health care (e.g. security, geographical, social, user fees)</p>	<p>Pre-crisis levels of access</p> <p>Changes and current obstacles to access (e.g. geographical, cultural, financial/economic) in different areas and for different population groups due to the crisis</p> <p>Whether user fees are being waived temporarily (where relevant)</p>
<p>6.7. Overload of certain health services</p>	<p>Locations/areas where staff and facilities are/are not overloaded.</p>
<p>6.8. Performance of health services</p> <p><i>[Process indicators]</i></p> <p>Curative care process indicators (e.g. number of consultations, deliveries); trends</p> <p>Preventive care process indicators (e.g. EPI, antenatal care); trends</p> <p>User rate (new consultations per person per year); trend</p> <p>Contribution to Health Information System</p> <p><i>[Quality indicators]</i></p> <p>Standardised case management</p> <p>Referral mechanisms</p> <p>Quality of outpatient registers and inpatient records</p> <p>Quality of drug management system</p> <p>Universal precautions (e.g. sharps disposal)</p> <p>General hygiene</p> <p>Supervisory visits</p> <p><i>[Functioning of applicable and relevant subsectors and services (e.g. environmental health, laboratory, x-ray, mental health, mother-and-child health, reproductive health, emergency surgery, emergency obstetric care, HIV/AIDS, nutrition, EPI, communicable disease control, epidemiological surveillance, epidemic preparedness, health promotion)]</i></p>	<p><i>Process indicators:</i></p> <p>Trends in relation to the baseline level of activities (better than absolute numbers)</p> <p>Whether health facilities are crowded</p> <p><i>Quality indicators:</i></p> <p>Observations on tracer indicators such as:</p> <ul style="list-style-type: none"> • availability and use of guidelines for standardised case management; • practice of universal precautions for infection control (e.g. new, single-use disposable injection equipment for all injections, discarding sharps, disinfection of equipment, screening of blood units etc.); • state of drug storage and record-keeping; • up-to-date duty rosters and immunisation charts on display; • hygiene standards. <p><i>Functioning of applicable and relevant subsectors:</i></p> <p>In a nutritional crisis: growth monitoring, supplementary feeding and referral for therapeutic feeding.</p> <p>In an epidemic: laboratory services and surveillance.</p> <p>After an earthquake: emergency trauma care (including pre-hospital care) to save lives.</p>
<p>6.9. Impact of disaster on the health system (all of the above headings, 6.1-6.8, unless the impact is described under each heading, as a clearly separate add-on)</p>	<p>Whether the health system and individual services are adapting and continue to function, are disintegrating, or have collapsed.</p> <p>Motivation of personnel; confidence of the population.</p> <p>Whether managerial capacity and processes can support the revival of services, if necessary material and resources are provided.</p>
7. Humanitarian Intervention	
<p>7.1. Local response capacities and strategies to cope with the disaster</p> <p>7.2. External actors' current response capacity</p> <p>7.3. External actors' presumed future response capacity</p> <p>7.4. Capacity of all actors to cope with health needs</p> <p>7.5. Coordination: who is in charge of coordination of health (nutrition/WASH/shelter) activities and of other clusters?</p> <p>7.6. Critical constraints for humanitarian intervention</p>	<p>Local capacities and strategies (in short and medium terms) to prevent excess mortality</p> <p>Realistic expectations of what external actors may be able to initiate and sustain</p> <p>Prospects for effective collaboration and coordination among health agencies and with other sectors/clusters</p> <p>Critical constraints (e.g. security, logistics)</p>
8. Cross-cutting issues	

ANNEX F – MATERIALS RELATING TO COORDINATION

<p>8.1. Gender</p> <p>[What diseases affect men and women differently within the context of the disaster? Is there a pattern of gender differentiation in terms of exposure to, and perceptions of risk, response, physical and psychological impact, as well as capacity to recover?]</p>	<p>Data and analyses disaggregated by sex and age to identify different risks</p> <p>Inclusion of women in community consultation and decision-making processes</p>
<p>8.2. Protection</p> <p>[Narrative accounts of violations of Human Rights and International Humanitarian Law; Critical security incidents (e.g. shelling, kidnapping, explosion of landmines); Role of authorities and police forces protect people]</p>	<p>Identification of suffering due to injustices, discrimination, etc.</p> <p>Confidentiality for anyone reporting violations of human rights or core humanitarian values.</p> <p>Individuals reporting violations are informed of the possible implications of publication.</p>



Checklist for an initial assessment ⁸

The global 3-cluster Initial Rapid Assessment (IRA) guidelines should be followed in any major emergency where Clusters exist. The checklist below may be useful in other situations. It covers aspects that an initial assessment should seek to determine and report on as quickly as possible (within 1-3 days, depending on the extent and accessibility of the area affected). The details of what is required vary depending on the type of situation. Summary details only need to be reported to the RO and HQ-HAC.

The general situation/context

- ✓ the nature and cause(s) of the emergency
- ✓ the area(s) affected
- ✓ means of access to the affected area(s) for personnel and supplies
- ✓ any secondary hazards that threaten
- ✓ the size and characteristics of the affected population
- ✓ any population movements (evacuation or displacement)
- ✓ the likely evolution of the situation

Sources: phone reports, aerial observations, existing census data, area profiles and past experience.

Baseline health conditions in the area (pre-crisis)

- ✓ endemic diseases (types, distribution, seasonal characteristics)
- ✓ pre-crisis mortality, morbidity and nutritional status
- ✓ vaccination coverage
- ✓ the coverage and effectiveness of government and other facility-based health services, outreach services (including cold chain) and surveillance activities prior to the crisis/disaster
- ✓ the coverage and effectiveness of environmental health and disease control activities prior to the crisis/disaster

Sources: existing ('secondary') data available at national level.

Direct impact on health

Immediate impacts (especially for sudden-onset events)

- ✓ number and type of casualties requiring surgical/hospital interventions
- ✓ number of people requiring on-site treatment for minor injuries
- ✓ number of sick people requiring immediate medical treatment by major diagnostic categories
- ✓ specific respiratory and other health problems aggravated by or arising from exposure of the population and/or rescue workers to dust, smoke, ash or toxic chemicals (pollution)

Present situation (especially for slow-onset crises)

- ✓ crude and under-5 mortality rates compared with seasonal norms
- ✓ prevalence of endemic diseases compared with seasonal norms
- ✓ rates of acute malnutrition compared with seasonal norms

⁸ Reproduced from WPRO *Emergency Response Manual* 2003, section 9.4

[All rates should be disaggregated by area and/or distinct population subgroup, if possible. Specify the indicators and formulae used and the sources of data. Ensure that appropriate denominators are used.]

Sources: hospitals, health centres, community health workers, medical/ rescue teams, pharmacies, evacuation centres, local officials and leaders, Red Cross/Crescent, NGOs, community organizations.

Cross-check data whenever possible.

Potential indirect impacts on health

Describe the present situation and what may be expected:

- ✓ injuries likely from secondary hazards and during rescue, evacuation or clean-up operations
- ✓ exposure of the population and/or rescue workers to cold or other environmental factors
 - health problems that could be aggravated by or arise from this exposure
- ✓ disruption of water supplies, sanitation systems or normal disease control measures
 - endemic diseases that may increase in the general population as a result of the disruption, reduced personal hygiene and the disease vectors present
- ✓ sanitary and general environmental health conditions in evacuation centres or camps for displaced people
 - endemic diseases that could propagate in these locations as a result of these conditions and the disease vectors present
- ✓ health problems likely to be introduced from outside the area (by displaced people, migrants, relief workers) or be experienced by displaced people coming from a different environment

Sources: environmental health personnel, water/sanitation departments, medical/rescue teams, social workers, local officials and leaders, Red Cross/Crescent, NGOs, existing epidemiological data, technical sources (for chemical pollution).

Impact on health services

- ✓ the extent of damage (if any) to premises, equipment and stocks
- ✓ the functioning of electricity and water supplies
- ✓ the impact on staff – deaths, injuries, displacement
- ✓ the damage/disruption (if any) to supply lines and means transport and communication

Sources: health facility staff/managers, local officials, Red Cross/Crescent, NGOs.

Present action and capacity of health services: resources available

- ✓ the present level of functioning (numbers of interventions, etc.) of the normal health facilities: number of casualties appearing each day for treatment, other patients, admissions, vacant beds, deaths, ambulatory patients broken down by broad age range and diagnostic categories
- ✓ the present level of functioning (numbers of interventions, etc.) of outreach services (including cold chain) and surveillance activities
- ✓ the present level of functioning of environmental health and disease control activities
- ✓ the number, type, resources and activities of additional medical/ health personnel/teams already arrived in the area; their locations and expected length of stay
- ✓ gaps (if any) in coverage by key personnel
- ✓ availability of key medicines, blood, vaccines, laboratory and other supplies (e.g. casting plaster, x-ray film) and equipment; essential supplies in short supply
- ✓ specific operating problems (e.g. water, power problems)

Sources: health facility staff/managers, local officials, Red Cross/Crescent, NGOs.

Other vital needs of the population

ANNEX F – MATERIALS RELATING TO COORDINATION

In relation to the following: the impact, the present situation, the action being taken (specify by whom) and any critical unmet needs:

- ✓ water supplies and quality
- ✓ sanitation (excreta disposal) and personal hygiene
- ✓ food, cooking fuel and utensils
- ✓ shelter, clothing, blankets, heating (where needed)
- ✓ recording of deaths and disposal of dead bodies
- ✓ recording and tracing missing persons

Sources: health personnel; medical/relief teams; local officials and leaders, religious leaders, Red Cross/Crescent, NGOs, UNICEF, WFP, UNHCR (for refugees).

Operational systems, capacities and constraints

Systems and capacities

- ✓ extent to which the national emergency plan, procedures, guidelines and expertise are being applied (when they exist)
- ✓ overall management of the health sector response (including the direction of resources according to priority needs)
- ✓ management of health sector (human and material) resources at field level
- ✓ health information reporting, data analysis and the use of information

Coordination

- ✓ operational coordination (at field and higher levels) among all actors in the health, water, sanitation and nutrition sectors
- ✓ strategic coordination at national level among the government (MoH), UN country team, donors, bilateral donors and regional partners
 - cooperation with neighbouring countries

Constraints

- ✓ logistics (transport and storage capacity)
- ✓ telecommunications
- ✓ political/social
- ✓ security

Preliminary conclusions

Judgements based on the information on impact, capacity, pre-disaster conditions and past experience:


Priority concerns

- ✓ geographic areas and population groups of priority concern
- ✓ present and projected demand for local emergency medical care
- ✓ need for evacuation of injured or ill persons to specialist facilities
- ✓ present and projected demand for in- and out-patient care; whether mortality and morbidity are usually high for the time of year and/or expected to increase in the coming weeks

Recommendations for immediate action

- ✓ priority actions to reduce avoidable mortality and morbidity
- ✓ what must be done in the next 1-3 weeks
- ✓ what must be done in the next 1-3 months

ANNEX F – MATERIALS RELATING TO COORDINATION

- ✓ health-related risks to be monitored
 - ✓ additional inputs (human, material, financial) needed for the above
 - ✓ any enhancement of management systems needed for the above
- 

Planning a field visit – check-list ⁹

Preparing for a field visit

Participants

The team should:

- include individuals with complementary mix of skills;
- be formed jointly with representatives of the MoH, other relevant government entities and/or other organizations, whenever possible.

Information and instructions to be obtained before leaving

- available baseline data on the area
- available information on the current situation (arising from investigations and enquiries already made)
- list of the government officials and other organizations to be contacted; (have they been informed of your mission?)
- information on the vehicles or other means of transport that have been arranged or are expected to be available in the field
- guidelines on personal security (if there is insecurity)
- precautions to safeguard your own health
- guidelines for contacts with journalists
- the extent/limits of your authority to commit WHO or disburse funds
- knowledge/lists of other organizations or individuals to whom requests that are not appropriate for WHO should be referred.

Leave behind details of your proposed itinerary and possible contact points.

Things to take

- any permits or letters of introduction necessary – or at least desirable – to travelling to and within the area; (in some high risk situations it may be necessary to have an official escort)
- other personal needs: be as independent as possible in food and personal necessities (see 8.x)
- telecommunications equipment, if needed (see 8.x)
- laptop, portable printer and printing paper
- forms, felt-tip pens, stapler, adhesive tape
- if travelling by road: water (for drinking and the radiator), fuel, oil and basic spare parts
- if travelling in remote and/or insecure areas: survival items

Things to do on arrival

On arrival, or as quickly as possible thereafter:

- establish communications with the WHO country office and report back regularly
- contact local officials, medical officers, health workers, community leaders and representatives of local and other outside organizations that are already present
- visit health facilities, water and sanitation installations, family dwellings, any temporary settlements, any existing public health assistance operations, social service institutions, medical and other relief stores, logistics facilities

⁹ Check-lists adapted from WFP *Emergency Field Operations Pocketbook*, 2002

Sample headings for a field trip report

- Date and itinerary
- Participants
- Purpose/terms of reference
- Persons contacted
- Summary findings/observations (noting differences between different communities/localities)
 - public health conditions and services/operations
 - nutritional status
 - other basic needs and their impact on health
 - special problems of children and women
 - community and local authority structures and capacity
 - special information concerning particular locations and institutions
- Summary conclusions: follow-up actions required

N.B. Copy important information from documents found in the field. Don't take the originals away with you!



Key elements for planning a health information/surveillance system

[Adapted from WPRO emergency response manual, 5.2]

Objectives of the information/surveillance system

The objectives of the *public health information/surveillance system (HIS)* are to:

- provide regular information to:
- identify evolving public health priorities
- inform day-to-day planning and management decisions on public health action and resource allocations
- support resource mobilization
- detect – provide early warning of – any outbreak of disease of epidemic potential to enable appropriate control measures to be taken
- monitor the implementation and outcomes of specific health interventions

HIS organization and management

Responsibilities must be clearly defined within a structure adapted to the situation. In general:

- a (central) surveillance team should be established at the level at which the overall emergency relief operation is being managed
- where the emergency-affected areas are large and/or dispersed, local (e.g. district level) surveillance teams should also be formed
- a surveillance focal point should be designated in each health facility

The central team would normally be convened by the Emergency Health Coordinator (EHC) and include national epidemiological personnel and representatives of other health agencies and the authorities responsible for water and environmental sanitation. It would be responsible for putting an appropriate reporting system in place, monitoring the reception of reports, analysing data and preparing summary epidemiological reports and recommendations, and assuring outbreak investigations and response.

The local level teams would normally be convened by the local health coordinators and include clinical workers, community health workers, a water and sanitation specialist and a representative of the local authority.

What data? From where?

Data are required regularly on the following in all emergency/post-disaster operations:

- mortality (rates and causes)
- morbidity (disease incidence)
- environmental health conditions (basic/vital needs)
- service provision (programme activities)

Data are also needed on the following in certain situations:

- trauma: data on the number of injured by major injury-types – required when dealing with mass casualties
- demography: population figures and trends – required whenever there are significant population movements/displacement including temporary evacuations
- nutrition: malnutrition rates and deficiency disorders – required whenever food security is undermined, especially during droughts/crop failures and social and economic crises

The usual sources of these data are shown in the table at the end of this annex. Where they already exist, and in slow-onset or long-duration crises, sentinel sites may be used.

In addition, news media reports and unconfirmed public rumours should be noted and investigated. They may be important early warning signs. If they are unfounded, that needs to be demonstrated and action taken to defuse the rumours.

Reporting and surveillance priorities

Mortality, morbidity and trauma reporting from health facilities and emergency teams:

- should build on existing system(s) but reporting formats and frequencies be **adapted** to the needs of the situation and reports be received from emergency teams as well as existing health facilities
- should normally be **syndrome-based**, following a sudden disaster (and in any situation where diagnostic skills and facilities are limited), and limited to a small number of priority conditions
- may be daily during the acute phase, then weekly

Ideally, surveillance priorities – and corresponding report formats – will have been defined for particular types of disaster or emergency situation as part of preparedness. If not, the EHC, following rapid consultations with the national epidemiological service and members of the emergency Health Coordination Committee (HCC), should determine the syndromes/diseases and other information to be included.

Standard case definitions must be used – normally those already established by the MoH and/or based on relevant WHO guidelines and health workers have corresponding guidelines and training.

Further details are provided in ... and a sample reporting form in ... (A separate format should be used for the immediate notification of syndromes/diseases of epidemic potential – see ...)

For other data:

- Data on demography and nutrition, when needed, will be gathered from the responsible authorities or agencies (either directly by the local surveillance team, see below, or by local health facilities).
- Basic data on health service provision will be reported by health facilities and emergency teams. Additional data (on access and quality) will be gathered directly by (local) surveillance teams and/or collaborating agencies.

Analysis, epidemiological reports and feed back

Each health service level (facility, district, province, etc.) should rapidly analyse the data received and, when needed, initiate action within the framework of pre-set standard procedures – but reporting up the chain should not be delayed.

The central surveillance team should prepare summary epidemiological reports of overall findings and recommendations for action and:

- present them to the national authorities and the HCC
- disseminate them quickly to local authorities, all organizations involved in public health activities, and donors, through newsletters and/or a Website
- provide feed back to the reporting units

Categories and sources of surveillance data	
Categories	Sources
<i>Required regularly in all emergency/ post-disaster operations</i>	
Mortality (crude and under-5 rates and causes)	Regular reports from hospitals, clinics, home visitors, community workers, religious leaders, grave watchers, (consolidated locally by health staff and/or local authorities)
Morbidity (incidence of disease and trauma)	Regular reports from health facilities, medical relief teams, community health workers (and/or sentinel sites) Immediate notification by health facilities/workers (for diseases of epidemic potential)

ANNEX F – MATERIALS RELATING TO COORDINATION

	Ad hoc surveys if regular reports are unreliable or their coverage is incomplete
Environmental health conditions & food (basic needs)	<p>Reports from government departments and other agencies involved in water, sanitation, shelter and food distribution activities</p> <p>Observations from local health workers</p> <p>Ad hoc surveys of people's access to shelter, food, water, sanitation and hygiene facilities</p>
Health service provision (immunization and other programme activities)	<p>Regular reports from health facilities, outreach teams, EPI programme, other special programmes</p> <p>Ad hoc surveys of the quality/effectiveness/coverage of services, and of people's access to and use of services</p>
<i>Required (during the initial acute phase) whenever there are mass casualties</i>	
Trauma cases	Reports from emergency medical teams and hospitals
<i>Required whenever there are significant population movements/displacement including temporary evacuations</i>	
Demography (population movements and trends)	<p>Census data, local government, religious leaders</p> <p>In temporary settlements: registration records, site managers (government or agencies), religious leaders, rapid enumeration methods/surveys</p>
<i>Required whenever the food security of some groups is undermined, especially in droughts, social and economic crises</i>	
Nutrition	Nutritional status surveys (by health and/or food distribution agencies)

Annex series F
Materials relating to Coordination
(ref. chapter 9)

TOR for Cluster Leads

Inter-Agency Standing Committee (IASC)

OPERATIONAL GUIDANCE ON DESIGNATING SECTOR/CLUSTER LEADS IN MAJOR NEW EMERGENCIES

Detailed guidance on the cluster approach is provided in the *IASC Guidance Note on Using the Cluster Approach to Strengthen Humanitarian Response (November 2006)*.

Why is there a need to designate sector/cluster leads in major new emergencies?

- The aim of the cluster approach is to strengthen humanitarian response by ensuring high standards of predictability, accountability and partnership in all sectors or areas of activity.
- The IASC has agreed that the cluster approach should be used in all contingency planning for major new emergencies; in all responses to major new emergencies; and eventually in all countries with Humanitarian Coordinators (HCs).
- In a major new emergency, the cluster approach requires that sector/cluster leads be designated at the earliest possible opportunity in order to ensure an adequate response.

What constitutes a “major new emergency”?

- For IASC operational purposes, a “major new emergency” is defined as any situation where humanitarian needs are of a sufficiently large scale and complexity that significant external assistance and resources are required, and where a multi-sectoral response is needed with the engagement of a wide range of international humanitarian actors.

Can the cluster approach be used in countries where there is a UN Resident Coordinator but no Humanitarian Coordinator?

- Yes. In addition to countries where there is an HC, the cluster approach can be used in countries where there is no HC but where the UN Resident Coordinator (RC) is coordinating the international response to a major new emergency.

What is a “sector/cluster lead”?

- A “cluster lead” is an agency/organization that formally commits to take on a leadership role within the international humanitarian community in a particular sector/area of activity, to ensure adequate response and high standards of predictability, accountability & partnership. A “cluster lead” takes on the commitment to act as the “provider of last resort” in that particular sector/area of activity, where this is necessary.
- A “cluster” is essentially a “sectoral group” and there should be no differentiation between the two in terms of their objectives and activities; the aim of filling gaps and ensuring adequate preparedness and response should be the same.

What are the responsibilities of sector/cluster leads and who is accountable to the HC?

- The sector/cluster lead for any given sector is an agency, not a person. For that reason, at the country level it is the Country Director/Representative of the agency/organization designated as sector/cluster lead who is ultimately responsible for ensuring that relevant sector/cluster leadership activities are carried out effectively.
- The specific responsibilities of sector/cluster leads are described in detail in the *IASC Generic Terms of Reference for Sector/Cluster Leads (Annex 1 of the Guidance Note on Using the*

Cluster Approach to Strengthen Humanitarian Response). These lay out minimum standards for all sector/cluster leads, including the need to ensure that agreed priority cross-cutting issues such as age, diversity, environment, gender, HIV/AIDS and human rights are effectively addressed in all sectors. The IASC Generic Terms of Reference may be contextualized and added to, but may not be reduced.

- Sector/cluster leads are responsible for ensuring that within their sectors focal points are nominated for Early Recovery and for agreed priority cross-cutting issues, as appropriate, to ensure that these issues are included in sector work plans and appeals.
- Sector/cluster leads at the country level are responsible for ensuring adherence to norms, policies and standards agreed at the global level and should treat the global level clusters as a resource that can be called upon for advice on global standards, policies and ‘best practice’, as well as for operational support, general guidance and training programmes.
- Sector/cluster lead agencies at the country level are responsible for appointing appropriate individuals, with the necessary seniority, facilitation skills and expertise to be the sector/cluster coordinators. In some cases, there may be a need for sector/cluster lead agencies to appoint dedicated, full-time sector/cluster coordinators with no other programme responsibilities.
- Country Directors/Representatives of agencies designated as sector/cluster leads are responsible for ensuring that the HC, OCHA and the Humanitarian Country Team are informed of the names and contact details of the individuals designated as sector/cluster coordinators and that they are kept regularly informed of any changes.
- In cases where stakeholders consider that a sector/cluster lead agency at the country level is not adequately carrying out its responsibilities, it is the responsibility of the HC to consult the Country Director/Representative of the agency/organization concerned and where necessary, following consultations with the Humanitarian Country Team, to propose alternative arrangements.

What is expected of sector/cluster partners?

- Humanitarian actors who participate in the development of common humanitarian action plans are expected to be proactive partners in assessing needs, developing strategies and plans for the sector, and implementing agreed priority activities. Provisions should also be made in sectoral groups for those humanitarian actors who may wish to participate as observers, mainly for information-sharing purposes.

How are sector/cluster leads expected to relate to local government structures?

- “Each State has the responsibility first and foremost to take care of the victims of natural disasters and other emergencies occurring on its territory. Hence, the affected State has the primary role in the initiation, organization, coordination, and implementation of humanitarian assistance within its territory.” (GA Resolution 46/182)*
- A key responsibility of sector/cluster leads at the country level is to ensure that humanitarian actors build on local capacities and maintain appropriate links with Government and local authorities, State institutions, civil society and other stakeholders. The nature of these links will depend on the situation in each country and the willingness and capacity of each of these actors to lead or participate in humanitarian activities.
- From the very outset of an emergency, it is the responsibility of sector/cluster leads to ensure close consultation with national authorities/counterparts on issues related to their respective sectors.
- By designating clear focal points within the international humanitarian community for all key sectors or areas of activity, the cluster approach should help governments and local authorities to know who to approach for support. This should help ensure more timely, predictable and adequate responses.

What sectors/clusters should be established and who should lead them?

- In terms of what sectors/clusters are established at the country level, this may differ from the set of sectors/clusters established at the global level. For example, there may be cases where

particular sectors are merged (e.g. Health and Nutrition). There may also be cases where particular sectoral groups are not needed (e.g. Logistics or Emergency Telecommunications). Sector/cluster leads should only be designated for the sectors relevant to the emergency.

- In the case of Protection, at the global level there are focal point agencies for issues such as Gender Based Violence (UNFPA). Similar arrangements can be made at the country level, as appropriate.
- In terms of who should lead each of the sectors/clusters at the country level, to enhance predictability, where possible sector lead arrangements at the country level should be in line with the lead agency arrangements at the global level. This principle should, however, be applied flexibly, taking account of capacities and strengths of humanitarian organizations already in the country/region. This may mean that in some cases sector lead arrangements at the country level do not replicate those at the global level. In such cases, it is particularly important that sector/cluster leads at the country level consult and maintain good communications with the respective global cluster leads, to ensure that agreed global standards/procedures are applied and to help mobilize the necessary operational support from the global level.
- The designation of sector/cluster leads should be based on transparent consultations within the Humanitarian Country Team and should take account of existing operations and capacities.
- Any IASC member can be a sector/cluster lead; it does not have to be a UN agency.
- Early Recovery planning should be integrated into the work of all sectoral groups. For this reason, rather than establishing separate Early Recovery clusters/sectoral groups at the country level, it is recommended that each cluster nominate an Early Recovery focal point. The focal points should form a “network” to ensure joint planning and integrated response.
- To complement and support the clusters, thematic groups should also be established where needed to address priority cross-cutting issues.
- In some cases (e.g. where regional “hubs” have been established) NGOs or other humanitarian partners may act as sector focal points in parts of the country where they have a comparative advantage or where the cluster lead has no presence.
- In all instances clusters/sectoral groups at the country level should be inclusive of those organizations with real operational capacities in their respective sectors. They should be results-oriented, with a clear focus on ensuring adequate humanitarian response. This includes addressing any gaps that may exist in the overall response.

How long should sectors/clusters continue to function?

- The HC (or RC), in consultation with humanitarian partners, is responsible for adapting coordination structures over time, taking into consideration the capacities of the host Government, development partners, local organizations etc.
- Sector/cluster leads are responsible for ensuring the development of exit or transition strategies for their clusters. These strategies should be developed in close consultation with national authorities and development actors, in order to strengthen national coordination capacities. Some clusters may phase out or transition into other arrangements earlier than others.

STANDARD OPERATING PROCEDURES

FOR DESIGNATING SECTOR/CLUSTER LEADS IN MAJOR NEW EMERGENCIES

At the onset of the emergency (if possible, within the first 24 hours):

Step 1. The HC (or RC, in countries where an HC has not been appointed) consults national authorities/counterparts and relevant IASC partners at the country level (NGOs, international organizations, the International Red Cross and Red Crescent Movement and UN agencies) to determine priority sectors or areas of activity for the emergency; which agencies are best placed to assume the role of sector/cluster lead for each one; what thematic groups are needed to address cross-cutting issues; and what support is needed from OCHA and other actors in terms of common tools and services.

Step 2. Based on these consultations, the HC (or RC) draws up a proposed list of sectors with designated sector/cluster leads for each. The HC (or RC) may also propose the establishment of thematic groups for particular priority cross-cutting issues. The HC (or RC) forwards this list to the Emergency Relief Coordinator (ERC), addressed to holmes@un.org, requesting endorsement within 24 hours from the full IASC at the global level.

Step 3. The ERC shares this proposal with the IASC, requesting endorsement or alternative proposals.

Within 24 hours of receiving the proposal from the HC (or RC)

Step 4. The ERC ensures agreement is reached within the IASC at the global level. Where agencies at the global level propose arrangements that differ from those initially proposed by the HC (or RC), the ERC consults the HC (or RC) and IASC further in order to reach agreement.

Step 5. The ERC communicates the decision reached to the HC (or RC) and all relevant partners at global level.

Step 6. The HC (or RC) informs the host government and all relevant country-level partners of agreed arrangements within the international humanitarian response. Common Humanitarian Action Plans and appeal documents should clearly state the agreed priority sectors and the designated leads for each.

Prepared by the IASC Task Team on the Cluster Approach

Geneva, 23 May 2007



Some Simple Coordination Formats

Detailed guidance and tools for coordination are being developed by the Global Health Cluster and should be used in any major operation for which clusters are formed. The formats below may be useful in other situations.

Gap Identification Formats ¹⁰

The format below (derived from the table of key health services and functions in Annex C7) can be used to record, for each area/site, the team or organization that is taking responsibility for each of the functions listed in each area or at each site. This then reveals the gaps that are uncovered.

During a first, quick stock-taking, the inventory may be made only in terms of the four main categories of activity in the first column. This may then be refined as soon as possible in relation to all the main services/functions listed in the third column.

<i>Level of assessment</i>		<i>Main Health services/functions</i>		<i>Area/Site 1</i>	<i>Area/Site 2</i>	<i>Area/Site 3</i>
POINT OF DELIVERY	A. Community Care	A1	Collection of vital statistic			
		A2	Community mobilization			
		A3	Health education			
		A4	Nutrition			
		A5	Detection and treatment of selected diseases			
		A6	Psycho-social support			
		A7	Maternal health			
	B. Primary Care	B1	Routine curative services			
		B2	Communicable diseases			
		B3	Non-communicable diseases			
		B4	HIV/AIDS			
		B5	GBV			
		B6	Child health			
		B7	Maternal & newborn health			
		B8	Nutrition			
		B9	Basic services			
	C. Secondary and Tertiary Care	C1	Routine curative services			
		C2	Non-communicable diseases			
		C3	Comprehensive essential obstetric care			
		C4	Basic services			
	D. Public Health Administration	D1	Health planning and management			
D2		Primary care facilities network (infrastructure)				
D3		Human resources				
D4		Drug and medical supply				
D5		Health financing				
D6		Health information system				

¹⁰ Adapted from Technical and Administrative Implications of Applying "WHO Core Corporate Commitments in Emergencies" at field level – Document 2, annex 3, draft, D A Bradt, 31 October 2001

Actor Mapping Formats¹¹

The following can be used to record where different organizations are working, what they are doing and with what resources. Separate tables may be prepared for UN agencies, inter-governmental organizations, national NGOs, international NGOs, and bilateral aid teams.

Where particular organizations are working and with what resources						
Organization	Present locations	Programme/project focus?	Since when	Until when	Number of personnel/ resources/ capabilities	Contact Information

The following can be used to record details of donors.

Donor profiles					
Organization	Characteristics	Interests	Resources	Requirements	Contact Information

¹¹ Adapted from CARE Emergency Training Team materials as reproduced in ALNAP training module 2, 2002

Team building – hints for a coordinator

"Coordination is a seriously abused term. It was never supposed to mean centralisation, or dogmatic rigidity. The best coordination is that which identifies ways in which human capacities can be released and enhanced in themselves and in a synergistic interaction with each other. It may often lead to decentralisation. It is a process which, by definition, cannot be carried out by one person, only by and in a team. Thus, all the members of such a team become coordinators."

[Director-General for Development and International Economic Cooperation, UN]

Coordination is teamwork: make each partner feel part of it. Without being too strict on the sequence, you can adopt a progressive approach.

1. As a start, have the partners sharing information

- on their mandates, objectives, roles and responsibilities
- on their resources and capabilities
- on the type and quantity of assistance that they can provide
- on their areas of operations
- on the priorities that they want to address
- on their projects
- on their sources of data
- on their perception of the general context.

2. As next step, have the partners working together

- at assessing needs
- at setting the standards of assistance
- at mobilising external resources
- at ensuring access to the beneficiaries
- at building local and national capacities
- at training their own staff.

3. In a more advanced phase, you will find that the team can share plans and resources:

- through joint contingency planning ('..what if?')
- through joint strategic planning
- through joint operational planning
- by sharing their experts
- by sharing security systems
- by sharing logistics (communication and transport)
- by implementing joint operations.

You can measure success at coordination by:

- the frequency of contact with all partners, at all levels
- the frequency of joint field missions
- the number of units/organizations regularly providing information and contributing constructively at coordination meetings
- the clarity of objectives and responsibilities of different partners
- the clarity of procedures for mobilising and deploying external assistance
- the existence of an overall plan of action and the resources to implement it, and the extent to which the activities of all partners fit within the plan

Chairing/facilitating a Meeting ¹²

The success of a meeting depends on good preparation and good chairing or facilitation. The topic(s) must also be ones the participants are concerned about.

Before the meeting

Why meet? Set clear, realistic objectives

- What is the purpose of the meeting – Informing/exchanging information? Planning? Solving specific problems?
- What can you and the other participants realistically expect to get out of it?
- Is a meeting necessary? Can the objectives be achieved by a smaller group, a series of phone calls, or by email?

Be specific! Write down the objectives.

Decide on the type of meeting and chairing/facilitation

- Who needs to attend?
- Should the meeting be formal or informal?
- Who should chair and/or facilitate? – Designate a good/experienced chairperson or facilitator

Chairing or facilitating ...

'Chairing' indicates a degree of formality - the chairperson is the focus of authority, participants address the chair for permission to speak, The chairperson has considerable real or potential power.

'Facilitating' indicates relative informality with the focus on communication, problem-solving, planning or decision-making as a group. The facilitator is not necessarily a focus of authority but has the task of helping the group to achieve its objective(s). Emphasis is placed on active and creative participation of group members.

Prepare the agenda

- Develop a written agenda with clear objectives and approximate timing for each item; include a broad statement of why the meeting is needed
- Make sure that the agenda is realistic – not too many items – and sequence the items appropriately
- Put difficult, important issues near the beginning (but deal first with something quick and simple)
- Plan breaks if the meeting is more than 1½ hours in length
- Circulate the agenda and any background documentation (such as minutes of previous meetings) a few days in advance, together with the invitation and the list of participants

Make practical arrangements

- Prepare essential hand-outs/audio-visual materials in advance
- If the meeting is large, check the room and ensure the availability of flip charts, audio-visual equipment (if needed), water/refreshments, secretarial help, arrangements for urgent messages to be received outside the room (to avoid interruptions)
- Organize the room/seating arrangements

¹² Reproduced from WPRO emergency response manual 9.15, synthesized from *Chairing and facilitating meetings*, TRS 3, UNHCR 1990, and material prepared by the Asian Disaster Preparedness Center (ADPC)

Seating arrangements

Everyone should be able to see each other!

For a relatively formal meeting, choose a circular or rectangular table arrangement. Avoid a long, narrow table, if possible, as this makes communication difficult.

For an informal meeting, a semi-circle of chairs facing a flip chart is best for a small group, or number of separate tables oriented towards a focal point

At the beginning of the meeting

- Start on time!
- Have the participants introduce themselves if they do not know each other
- Clarify the objective(s) of the meeting and review the agenda and time limits
- Outline how the meeting will be conducted
- Identify the rapporteur/secretary for the meeting
- Ask if participants agree the agenda – accept minor changes if there is consensus
- If applicable, review action items of previous meeting(s)

During the meeting

The chairperson/facilitator should:

- start with an initial statement that sets the desired tone for the meeting
- be impartial and be seen to be impartial – avoid talking too much and getting personally involved in discussions
- stick to the agenda and keep the objective(s) in mind – keep the discussion focused on key issues and stop digressions; allow flexibility within agenda items for participants to express and develop closely-related issues and concerns if time allows
- encourage wide participation – ask for information and opinions
- summarize/reformulate and record key points – have the rapporteur/ secretary use the flip chart to record important points as they arise: this helps the group to stay focused, avoid repetition and reach consensus
- get agreement on specific proposals – write proposals on the flip chart then seek agreement on it and on who should do what, when

Facilitative behaviours

Listen actively

Ask open-ended questions

Be positive - encourage participation, focus on desired outcomes

Don't be defensive; do not take comments personally

Clarify and elaborate when needed

Test for consensus

Anticipate problems and try to prevent them; defuse clashes; deal calmly with difficult participants

After the meeting

Immediately after the meeting, discuss briefly with various participants how the meeting went and what changes could be made to improve the next meeting.

Within a few days, prepare and distribute a record of the meeting including:

- the conclusions/decisions/recommendations and the follow-up action required, by agenda item, with the name of the organization or person responsible for action

ANNEX F – MATERIALS RELATING TO COORDINATION

- the list of participants and those who were invited but unable to attend
- the time, date and place of the next meeting, if applicable.

Follow up to ensure that agreed actions are being taken.



Fostering partnerships¹³

How to foster effective partnerships

Serve as a facilitator. Provide leadership when necessary, but emphasize that the assessment is a joint effort. Don't expect others to "support WFP". The following are some basic do's and don'ts:

- ☑ Draw up a table summarizing the expertise and capacities that each partner can bring to the assessment, their particular interests, and where they are working. Share it with everyone and use it as a basis to discuss and agree who should do what, when and where.
- ☑ Encourage frank and open discussions, and keep everyone informed of progress and any issues that may arise, but avoid too many large meetings.
- ☑ Get everyone to agree on objectives.
- ☑ Form small groups to follow up on specific technical issues, such as sampling methods and the design of data collection instruments, and prepare agreed-upon guidance notes. Ensure that everyone receives copies.
- ☑ Secure realistic commitments concerning the personnel and other resources everyone will provide for the assessment, when and for what period they will be available.
- ☑ Write it all down – who will be responsible for what within what time period – and give/send copies to everyone rapidly.
- ☑ Organize briefing and training sessions, when needed.
- ☑ Be sensitive to the expectations (and agendas) of different individuals/ organizations, and to possible conflicts of interest.
- ☑ Ensure that the process of analysing the data and preparing recommendations is transparent.
- ☑ Ensure that contributions are acknowledged.
- ☑ Stick to what has been agreed. Avoid unilateral actions (going it alone).

How deal with problems in partnerships

When a problem arises, address it quickly and openly:

- ☑ Take a problem-solving approach; avoid confrontation.
- ☑ Focus on what can be agreed and try to find a mutually acceptable compromise that respects the essential objectives and objectivity of the assessment.
- ☑ If the problem is fundamental to the whole assessment, ensure that it is thoroughly discussed among all partners and seek the broadest possible consensus on how to proceed.
- ☑ If no resolution or acceptable compromise can be found, agree that a 'joint' assessment is not possible but that both parties will continue to exchange information and coordinate their assessment activities.

Consult the RO HQ-HAC, if necessary.

¹³ Reproduced from *Emergency Food Security Assessment Handbook*, WFP 2005, chapter 2

WHO/ UNHCR memorandum of understanding (MOU) ¹⁴

The MOU has the following general objectives:

- 2.1 To reduce the mortality, morbidity and disability among the beneficiaries.
- 2.2 To promote the adequate, timely and cost-effective provision of health services for the beneficiaries.
- 2.3 To ensure effective coordination of health and nutrition policies at the international level as they affect the beneficiaries, with a view to achieving and reinforcing globally accepted standards.
- 2.4 To facilitate the sustainable reintegration of beneficiaries in their national communities.
- 2.5 To promote the development of institutional capacities to anticipate and address the health needs of beneficiaries both at the level of national health services, through their extension and reinforcement as necessary, and at the international level, including in particular with non-governmental organizations (NGOs).

Responsibilities in relation to beneficiaries

Refugees

- 3.1 UNHCR is responsible for the international protection and welfare of refugees, which may include the provision of assistance, including health care, in cooperation with host Governments and in line with their international obligations. The implementation of UNHCR assistance projects is normally entrusted to implementing partners, which are often non-governmental organizations. In large-scale emergencies or major operations, UNHCR will appoint health and nutrition coordinators, responsible for the implementation of its programmes and for coordination with host Governments, WHO and others concerned.
- 3.2 WHO will provide technical support and normative guidance to host Governments, UNHCR and other relevant organizations and assist the host Government in the extension of national health services to refugees where this is possible.

Returnees

- 3.3 UNHCR and WHO will consult each other to ensure complementarity of activities for returnees.
- 3.4 WHO will seek to ensure that national health plans take into account the returnees' needs and give appropriate priority to the areas to which return is taking place. WHO will extend its country health programme activities as required to take account of the will extend its country health programme activities as required to take account of the needs of returnees, will the aim of successful reintegration into the national health system.
- 3.5 UNHCR seeks to ensure that voluntary repatriation takes place under conditions of safety and with dignity the duration and scope of UNHCR's activities in favour of the reintegration of returnees are limited and vary according to the needs for each operation and may be the subject of an operation-operation-specific agreement with the countries concerned. These activities are generally within the framework of wider recovery plans for countries emerging from conflict.
- 3.6 UNHCR will coordinate any UNHCR-supported assistance in the health sector in returnee areas with the Government, WHO and others concerned in order to ensure that UNHCR activities are compatible with medium- and long-term national health plans, and are sustainable. In large-scale reintegration operations UNHCR may appoint a health coordinator for its programmes.

Internally displaced persons (IDPs)

- 3.7. The interventions of WHO and UNHCR in favour of IDPs are usually part of a broader United Nations coordinated plan of action. In UNHCR's case, these interventions are selective, as explained in 1.3 above, and UNHCR's involvement in health care will depend on the specific situation.
- 3.8. WHO will assist Governments and other authorities to coordinate and fulfil their obligations for the health care of IDPs. Within the context of the country programme, WHO will also focus on capacity-building of the Government and technical support to national programmes for the provision of essential health and related services.

Affected local host populations

- 3.9. WHO, through its country programme activities with national authorities, will support their actions to ensure that the health needs and well-being of the local host population are addressed.

¹⁴ The following are the operative sections of the MOU signed in March 1997

3.10. The involvement of UNHCR with affected local populations is selective and normally focuses on those living within the areas where beneficiaries are located.

3.11. WHO and UNHCR will seek to mobilize support for national health services so that such services to the local population do not suffer unnecessarily from the presence of refugees, returnees or IDPs. Where beneficiary numbers are significant relative to locals in the same area, and where the health care available to locals would benefit thereby, UNHCR will seek to extend health services for beneficiaries to the local population, in agreement with the national authorities and WHO.

Main areas of cooperation

Areas of collaboration between WHO and UNHCR include, but are not limited to, the following:

4.1 Coordinated contingency planning, normally undertaken in full cooperation with the national authorities and others concerned. With this framework, UNHCR will invite WHO to participate in planning for possible refugee influxes or reintegration programmes.

4.2 Enhancement of the effectiveness of a collaborative response, including by keeping each other informed (as relevant) of potential or new population movements, and of potential or new health risks for beneficiaries.

4.3 Development of joint methodologies for assessing, monitoring and evaluating the health situation of beneficiaries and exchanging information of action required and intended.

4.4 Development of guidelines and best practices for the benefit of operations in favour of the beneficiaries on both technical/medical and managerial/programme issues.

4.5 Development of training materials and training activities for governmental and non-governmental organizations for the purpose of building institutional and operational capacity.

4.6. Development of applied research on technical and operational subjects, as requested by UNHCR, with a view to improving international knowledge on specific issues relevant to the health care of beneficiaries.

Specific responsibilities of UNHCR and WHO

5.1 UNHCR will:

- 5.1.1 Consult and seek technical guidance from WHO on matters related to health care for beneficiaries.
- 5.1.2 Provide WHO with clear terms of reference of specifications for all assistance requested.
- 5.1.3 Seek WHO's support at the regional and country level when negotiating with the Government on the provision of health care services to the beneficiaries.
- 5.1.4 Coordinate with WHO in efforts to integrate beneficiary health care activities within the national health services.
- 5.1.5 Consult with WHO in order to identify suitable candidates for the consultancies/posts of UNHCR health and nutrition personnel.
- 5.1.6 To the extent possible and practical, provide logistical and other support to WHO staff working with UNHCR in the field within the framework of this MOU.

5.2 WHO will:

- 5.2.1 Expand, where possible, its ongoing support and assistance to Governments, including for the affected host population.
- 5.2.2 At the request of UNHCR, provide technical support, and short-term assistance, sectoral coordination, in areas including, but not limited to, the following:
 - Defining health priorities in emergency response.
 - Health and nutrition assessment.
 - Prevention and control of communicable diseases.
 - Reproductive health.
 - Mental health and psychosocial welfare.
 - Health systems development and monitoring.
 - Training of national and NGO staff.
 - Epidemiological surveillance.
- 5.2.3 Contribute to further development and adaptation of training materials, guidelines and joint technical publications on health care for beneficiaries, in close collaboration with UNHCR, NGOs, academic institutions and others.

Implementation of the MOU

6.1 UNHCR designates its Director, Division of Operational Support (DOS) and WHO, its Director, Division of Emergency and Humanitarian Action (EHA), as responsible for the implementation of this Memorandum. UNHCR requests for WHO assistance, for example with the provision of staff support, shall be made through EHA. Communication regarding technical information and advice may take place directly with the responsible WHO unit, keeping EHA informed as appropriate.

6.2 At the field level, the WHO Representative or Regional Office (as appropriate) and the UNHCR Representative (through the UNHCR health coordinator where applicable) shall cooperate closely and, whenever feasible and appropriate, prepare a field-level Letter of Understanding translating the general provisions of this MOU into action required by the particular circumstances and needs of the beneficiaries.

6.3 Where WHO assigns staff to assist UNHCR in the field, their administration will remain the responsibility of WHO unless otherwise agreed. Such staff will have as a general responsibility to assure best possible practices in their field. They will report to a designated UNHCR officer in the field in respect of activities relating to UNHCR's overall responsibilities for the management and coordination of assistance to the beneficiaries. As with UNHCR's own technical field staff, they will have a functional responsibility to the health unit at UNHCR headquarters with respect to relevant UNHCR operational policies and guidelines. Whether technical support and backup is provided by UNHCR or WHO will be agreed on a case by case basis.

6.4 Each organization is responsible for mobilizing the resources necessary to discharge the responsibilities set out herein. For certain special operations, a decision may be taken to issue a joint appeal. Both organizations will participate in DHA[now OCHA]-coordinated consolidated inter-agency appeal processes.

Annex series G
Personal Skills and Conduct

Personal readiness check-list

The following check-list is intended for WHO staff. It is adapted from *WFP Emergency Field Operations Pocketbook*, 2002. Adapt it to the local situation, especially climate.

Mission readiness check-lists for consultants being recruited from other countries for emergency assignments are presented in *Mission Readiness Checklist* in SOP 8.6.

<p>Documents</p> <ul style="list-style-type: none"> • UN laissez passer/national passport with a valid visa/residence permit • vaccination card (all vaccinations up-to-date) • WHO/UN identity card • valid (international, if appropriate) driving licence • photocopies of all the above • extra passport photos <p>Professional items</p> <ul style="list-style-type: none"> • personal credit card and cheques, if available • cash and/or traveller's cheques • business cards • note books, pens, highlighters, 'post-it' notes • frequently-used reference materials • pocket calculator • maps • electrical adapters • spare computer diskettes • camera with films (at own risk) • pocket-size binoculars (at own risk) • GPS (if available; at own risk if a personal item) • Laptop computer with internet/email connections (if available) 	<p>Personal items</p> <ul style="list-style-type: none"> • several changes of clothes suitable to the climate (including track-suit type night attire) • sturdy footwear • personal health/first aid kit (including own prescription medicines and malaria tablets, if appropriate) • toilet articles (soap, toothpaste, etc.) • padlocks (for luggage and room doors) • flashlight with spare batteries • alarm clock (or watch) • short-wave radio with spare batteries • pocket knife ('Swiss Army' or 'Leatherman' type)¹⁵ • ear plugs (for noisy flights) • detergent for washing clothes • nylon cord for washing line • candles and matches • insect repellent • sunscreen cream • sun glasses • hat and/or umbrella (for sun and rain) • spare spectacles/prescription lenses, if used • water bottle • water purification tablets (or filter) • mosquito net, if required <p>.....</p>
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¹⁵ Remember, however, that knives cannot be carried on aircraft in hand baggage.

Preparing for your departure to the crisis-affected country (for international consultants)

Getting prepared for an emergency assignment is not easy. No matter what information you have, no matter how good the source, you will always meet with the unexpected. However, by careful preparation you can be equipped and ready to manage unforeseen events and eliminate many problems before they arise.

This annex gives some general indications on how to prepare yourself for the mission and provides a detailed check-list. Discuss with the HAC Desk Officer and the Logistics Officer in order to understand more about the task ahead and your needs in the area of assignment.

Some points in the checklist are so common and self-evident that they are often overlooked. Others that are very important to your peace of mind are not common and thus they are often not thought about.

The main topics are:

- **FAMILY WELFARE.** Discuss the Readiness Checklist with your spouse or another responsible adult. This can help avoid many unnecessary problems.
- **BANKING INFORMATION.** If your bank records are in order before you leave, deposits, withdrawals and payments while you are on mission will be easier.
- **BUSINESS AND FINANCE.** Make sure your finances are in good order before you leave. When you are away from home and working under stressful conditions the last thing you want to worry about is an unpaid bill or whether your family is having financial problems!
- **AUTO REPAIRS AND MAINTENANCE.** Avoid automobile worries during your absence.
- **HOME SECURITY, REPAIRS AND MAINTENANCE.** Feel at ease about home security during your absence.

See annex G1 for guidance on what to take with you. The list there must be adapted to the situation and your own individual choices. Keep personal items within acceptable weight and value limits. Consider that in an emergency you may have to leave your luggage behind. Be sure you have:

- Suitcase should be solid and lockable to prevent theft and damage.
- An international driver's license is important.
- At least 12 spare passport photographs for additional visas or ID cards.
- Valid International Vaccination Card with all necessary shots for your destination.
- Sufficient per diem advance for duration of mission, some of it in cash: US\$ or a medium of exchange that is accepted in the area of assignment. Vary the denominations and enquire whether date of issue is a consideration - consult Desk Officer for more information.
- Travellers cheques. Ask your Desk Officer if they can be easily exchanged at destination. Keep separate record of cheque numbers.
- Credit cards. As above, plus closest contact number in case of theft or loss.
- Clothing appropriate to location, season and assignment. Take sturdy walking shoes with good ankle support, water proofing & comfort. Don't forget hat, sunglasses and sunscreen for protection from sun, or gloves for cold weather. Rubber sandals for showering.
- Toiletries (soap, razors, tampons, etc.) - do not assume availability of anything at destination.
- Watch. An inexpensive digital is generally ideal; take also an alarm clock.
- Any medications you may need; inform WHO of any relevant medical history that may affect treatment in case of accident (e.g. allergies and/or any prescription medicines). Make sure you have enough prescription medicine for the duration of your mission.

- WHO medical kit.
- Condoms.
- Waterproof flashlight and spare batteries.
- Short-wave radio and spare "long life" or rechargeable batteries.
- Camera, film and batteries.
- Swiss Army Knife or similar.
- Adapters for all electrical appliances and voltage converters (110v → 220v or vice versa).
- Pocket calculator.
- Travel/language books for the region will greatly assist you.
- Mosquito repellents and net, if required.

Tips

Photocopy important documents (Travel Authorisation; Laissez-Passer; vaccination card; drivers license etc.) and keep separately in safe place.

Note your blood type on your vaccination card.

If you are required to carry valuables for your work, arrange for extra insurance on your Travel Authorisation.

Operational equipment

Study the list of emergency equipment available at HQ and at the Regional Office and decide what you will need for the mission in consultation with Logistics Officer.

- Laptops and printers are a priority and, if you have a team, each team member should have his/her own. Ensure they are functioning and comply with the configuration and software requirements required for the mission. Ensure there are no passwords on the computer or the software programmes.
- Satellite telephone can be another priority at the emergency site. Ensure it is fully functioning and that it interfaces with the issued laptops for data transfer. Test the data and fax capability of the sat-phone before departure. Check that the user manual is enclosed.
- Operating manual for the e-mail software package used by WHO and the access numbers and codes, if any, to operate it.
- A video camera, batteries and film to record activities in the field.
- Ensure all electronic devices have appropriate power supply and plugs for destination country.
- Stationery: paper, ink jet cartridges, notebooks, pens, pencils, WHO official stamp, travel claims, letterhead stationery, etc.
- Identification: WHO armbands, T-shirts, pennants, vehicle decals, etc.
- Ask what is available at WHO office in affected country. Co-ordinate with the Logistics Officer for extra freight allowance if needed.

Essential documentation

Read as much as you can on the country of assignment and on the features of the emergency before you leave. This will greatly facilitate your work once you are there.

Ask your Desk Officer for:

- situation reports "sitreps" and any documents relevant to the country and the emergency;
- all WHO correspondence pertaining to your mission and to the emergency;
- reports from other UN agencies and NGOs involved;

- reference material on the country and the surrounding region: history, demography, economy, etc.;
- maps of the country and the surrounding region; have digitised maps installed in your laptop;
- the list of national and international contact persons in the affected country and surrounding region;
- the WHO technical divisions' guidelines that you may need according to your terms of reference;
- reports of other WHO emergency operations.

Look on the Web for additional information on the country and the current crisis (see list of web sites Annex 12.).

If you are to work in a team, familiarise yourself with the CVs of the other team members.

Essential briefings

The first briefing may take place at WHO Headquarters. After this, it is WHO procedure that before proceeding to the country of assignment, every staff member has a briefing at the Regional Office concerned. Upon arriving at the Regional Office you should:

- review with your supervisor and have a clear understanding of:
 - your Terms of Reference
 - the aims and objectives of the mission
 - whom to report to and the frequency and format of reports;
- be briefed by the Desk Officer for the affected country or sub-region; ask for the latest security update from UNSECOORD, including which means of transport you are entitled to use locally;
- discuss administrative and logistical matters with the Administrative/Logistics Officer;
- be briefed by the Regional Logistics Officer on the state of logistics in the affected country and get a list of equipment available at HQ for emergency operations;
- be briefed by Finance on imprests and proper financial reporting;
- get clear information on focal points, mechanisms and procedures for the mobilisation of technical and administrative assistance from the Regional Office;
- get a realistic estimate of the lead-time that will pass between your request and the Regional response;
- be briefed by the EHA focal point on methods of focusing donor attention. How you can assist one another in coordinating donor appeals; get a clear understanding on the information that you can release to the media.

Clarify the scope - and limits - of decisions that you are authorized to take. Make sure that they are consistent with your Terms of Reference. Get a clear understanding of all other relevant sections of the WHO Manual, including Section XV.4.

Be ready for difficult travelling conditions in the field. Do not assume that you will be always able to travel by regular, commercial means of transport. There may be times when you will have to negotiate your transportation with other UN agencies, NGOs, the Military, etc. Consider that:

- special flights or convoys can often accommodate only a limited number of passengers and require special clearances; often they are very costly and payment sometimes has to be in cash;
- depending on the mean of transport, you may have to travel very light. In this case, consider carefully which are the essential items to carry with you;
- cargo planes are uncomfortable and can be very cold, even in the tropics. Take a sweater with you and do not assume that you will find water or a toilet on board;
- you may have to sign a waiver, discharging the organisation that provides the transport of any responsibility concerning accidents during the travel: discuss this possibility with your supervisor.

Mission readiness checklists

Go through these checklists carefully. Some items are so common and self-evident they are often overlooked. Others are very important to your well being but are uncommon and thus often forgotten.

A-FAMILY WELFARE

Discuss and complete the following items with your spouse or another **responsible adult (r.a.)**. This can help avoid many unnecessary problems.

	YES	NO
a. Mission discussed with family?	<input type="radio"/>	<input type="radio"/>
b. Mission extension possibilities discussed?	<input type="radio"/>	<input type="radio"/>
c. Family support system established?	<input type="radio"/>	<input type="radio"/>
d. Quick access to emergency phone numbers?	<input type="radio"/>	<input type="radio"/>
e. Family communication plan established, including the use of e-mail, fax, etc. (mission address, phone/fax numbers, UN pouch)?	<input type="radio"/>	<input type="radio"/>
f. Guardianship agreements completed?	<input type="radio"/>	<input type="radio"/>
g. Passports and visas current for all family?	<input type="radio"/>	<input type="radio"/>
h. Power of Attorney currently completed?	<input type="radio"/>	<input type="radio"/>
i. Wills: yours and spouses completed?	<input type="radio"/>	<input type="radio"/>
j. UN insurance beneficiaries designated?	<input type="radio"/>	<input type="radio"/>
k. Pension fund number available to responsible adult (r.a.)?	<input type="radio"/>	<input type="radio"/>
l. Birth certificate available to r.a.?	<input type="radio"/>	<input type="radio"/>
m. Social Security numbers recorded and known to r.a.?	<input type="radio"/>	<input type="radio"/>
n. Marriage certificate available to r.a.?	<input type="radio"/>	<input type="radio"/>
o. High-risk-mission insurance current?	<input type="radio"/>	<input type="radio"/>
p. All insurance policy data available to r.a.?	<input type="radio"/>	<input type="radio"/>

B-BANKING INFORMATION

If your bank records are in order before you leave, deposits and withdrawals from your mission location will be easier.

	YES	NO
a. Name and address of all banks or credit union accounts available to r.a.?	<input type="radio"/>	<input type="radio"/>
b. Direct-deposit account established?	<input type="radio"/>	<input type="radio"/>
c. Savings/checking accounts established?	<input type="radio"/>	<input type="radio"/>
d. Is r.a. able to access bank accounts?	<input type="radio"/>	<input type="radio"/>
e. Credit card numbers known to r.a.?	<input type="radio"/>	<input type="radio"/>
f. Other important banking information reported?	<input type="radio"/>	<input type="radio"/>

C-BUSINESS AND FINANCE

Make sure your finances are in good order before you leave.

	YES	NO
a. Stockbroker name and certificate numbers available?	<input type="radio"/>	<input type="radio"/>
b. Bond company and certificate numbers available?	<input type="radio"/>	<input type="radio"/>
c. Mutual fund company and certificate numbers available?	<input type="radio"/>	<input type="radio"/>
d. Business and finance records in a safe place where r.a. has access?	<input type="radio"/>	<input type="radio"/>
e. Family budget well planned?	<input type="radio"/>	<input type="radio"/>

- | | | | |
|----|---|-----------------------|-----------------------|
| f. | Outstanding bill/loan payment method current? | <input type="radio"/> | <input type="radio"/> |
| g. | Signed UN contract available to r.a.? | <input type="radio"/> | <input type="radio"/> |
| h. | Income-tax data available to r.a.? | <input type="radio"/> | <input type="radio"/> |
| i. | Home/apartment: sold? rented? sublet? | <input type="radio"/> | <input type="radio"/> |
| j. | Personal property high-dollar-item insurance? | <input type="radio"/> | <input type="radio"/> |

D-AUTO REPAIRS AND MAINTENANCE

Avoid automobile worries during your absence.

- | | | YES | NO |
|----|---|-----------------------|-----------------------|
| a. | Auto repair book available to r.a.? | <input type="radio"/> | <input type="radio"/> |
| b. | Next service on auto due? | <input type="radio"/> | <input type="radio"/> |
| c. | Warranty book available to r.a.? | <input type="radio"/> | <input type="radio"/> |
| d. | Tire rotation due? | <input type="radio"/> | <input type="radio"/> |
| e. | Oil change due? | <input type="radio"/> | <input type="radio"/> |
| f. | Tune-up required? | <input type="radio"/> | <input type="radio"/> |
| g. | Dealers address available? | <input type="radio"/> | <input type="radio"/> |
| h. | Vehicle insurance and registration current? | <input type="radio"/> | <input type="radio"/> |

E-HOME SECURITY, REPAIRS AND MAINTENANCE

Feel at ease about home security during your absence

- | | | YES | NO |
|----|--|-----------------------|-----------------------|
| a. | Heating & refrigeration repair phone Numbers? | <input type="radio"/> | <input type="radio"/> |
| b. | Plumbing repair phone numbers? | <input type="radio"/> | <input type="radio"/> |
| c. | Electricity repair phone numbers? | <input type="radio"/> | <input type="radio"/> |
| d. | Small appliance repair phone numbers? | <input type="radio"/> | <input type="radio"/> |
| e. | Roofing repair phone numbers? | <input type="radio"/> | <input type="radio"/> |
| f. | Keys secure with responsible adult? | <input type="radio"/> | <input type="radio"/> |
| g. | Mail and newspapers re-routed? | <input type="radio"/> | <input type="radio"/> |
| h. | Phone calls forwarded/answering machine updated? | <input type="radio"/> | <input type="radio"/> |

H-TRANSPORTATION AND COMMUNICATION SKILLS

Gaining skills in these areas will enable you to be independently mobile and to communicate well in an emergency situation.

- | | | YES | NO |
|----|--|-----------------------|-----------------------|
| a. | Operation of a vehicle with manual transmission? | <input type="radio"/> | <input type="radio"/> |
| b. | Operation of 4-wheel-drive vehicle? | <input type="radio"/> | <input type="radio"/> |
| c. | Auto-repair trouble-shooting ability? | <input type="radio"/> | <input type="radio"/> |
| d. | Two-way-radio operation ability? | <input type="radio"/> | <input type="radio"/> |
| e. | Satellite telephone operation skills? | <input type="radio"/> | <input type="radio"/> |
| f. | Knowledge of e-mail and data transfer package? | <input type="radio"/> | <input type="radio"/> |

F-GEOPOLITICAL AND CULTURAL AWARENESS

Investigating the items listed in this section will help you integrate more quickly and comfortably into the new work environment.

	YES	NO
a. Geographical location known?	<input type="radio"/>	<input type="radio"/>
b. Government type known?	<input type="radio"/>	<input type="radio"/>
c. Major ethnic groups known?	<input type="radio"/>	<input type="radio"/>
d. Traditions and customs (do's and don'ts) known?	<input type="radio"/>	<input type="radio"/>
e. Major religions known?	<input type="radio"/>	<input type="radio"/>
g. Primary languages spoken?	<input type="radio"/>	<input type="radio"/>
h. Basic language skills developed?	<input type="radio"/>	<input type="radio"/>
i. Basic language skills training material obtained?	<input type="radio"/>	<input type="radio"/>
j. Major industries known?	<input type="radio"/>	<input type="radio"/>
k. Income per capita known?	<input type="radio"/>	<input type="radio"/>
l. Natural resources known?	<input type="radio"/>	<input type="radio"/>
m. Health and disease patterns known?	<input type="radio"/>	<input type="radio"/>

G-HEALTH

Physical fitness and a healthy lifestyle do not come overnight, so you should act on the points in this section well before you leave. This will increase your effectiveness and your sense of well being once you are in the field.

	YES	NO
a. UN medical and vaccines for area?	<input type="radio"/>	<input type="radio"/>
b. Is anti-malaria prophylaxis indicated?	<input type="radio"/>	<input type="radio"/>
c. Sufficient prescription medicines?	<input type="radio"/>	<input type="radio"/>
d. Stress management information?	<input type="radio"/>	<input type="radio"/>
e. Substance-abuse awareness: The Big Three (nicotine, alcohol & caffeine)?	<input type="radio"/>	<input type="radio"/>
g. Awareness of sexually transmitted diseases (STD) prevention?	<input type="radio"/>	<input type="radio"/>
h. Lifestyle balance (work, play, rest, sleep)?	<input type="radio"/>	<input type="radio"/>
i. Recreational and educational need awareness?	<input type="radio"/>	<input type="radio"/>
j. Extra pairs of eyeglasses or contact lenses?	<input type="radio"/>	<input type="radio"/>
k. Did you have a dental check?	<input type="radio"/>	<input type="radio"/>
l. Health and dental care plans established for your family?	<input type="radio"/>	<input type="radio"/>

H-WHO ADMINISTRATIVE ISSUES

The following WHO administrative procedures must be completed before leaving on mission.

	YES	NO
a. Does your contract cover the duration of mission?	<input type="radio"/>	<input type="radio"/>
b. Does Finance have your personal banking details?	<input type="radio"/>	<input type="radio"/>
c. Have you received your Travel Authorization?	<input type="radio"/>	<input type="radio"/>
d. Is Laissez-Passer valid to end of mission?	<input type="radio"/>	<input type="radio"/>
e. Necessary visas for affected area?	<input type="radio"/>	<input type="radio"/>
f. Letter of introduction to WR or host government?	<input type="radio"/>	<input type="radio"/>
g. Next-of-kin details are with Desk Officer?	<input type="radio"/>	<input type="radio"/>
h. Per diem received in suitable medium of exchange?	<input type="radio"/>	<input type="radio"/>
i. Medical/Pension/Life insurance forms completed?	<input type="radio"/>	<input type="radio"/>

Departure for and arriving in the country (for international consultants)

Departing for the field

Having completed the preparations indicated in Annex G2, you are now ready to depart.

If the destination is designated as being in an emergency phase, you may need to have security clearances. If you do not have the **security clearance** to enter a country where this is required by the UN, you will not be covered by insurance. In situations where security is an issue, you are advised to read the contents of Annex series H for guidance on protective and precautionary measures.

If you travel as part of a **team**, try to obtain seats together so that you can discuss last-minute details during the flight. Always re-confirm flights before departure.

Make sure that the WR and the UN Resident Coordinator in the country of assignment are informed of your **arrival time and flight number**. Where possible, ensure that hotel bookings and transportation from airport are pre-arranged.

It is advisable that you travel carrying the following on you or in your **hand baggage**:

- Travel tickets and confirmation of hotel bookings;
- National passport, Laissez Passer, driving license and vaccination card;
- Currency, travellers cheques and credit cards;
- Travel Authorisation, terms of reference and contract;
- All satellite phones and laptop computers;
- Spare set of clothing and toilet bag;
- Prescription medicines and malaria prophylaxis, if necessary;
- Any item of personal value.

IMPORTANT: when you are on mission, the following expenses are reimbursable, so **keep all receipts** and attach them to your travel claim at the end of the mission:

- transportation expenses (i.e. carrier fare);
- terminal expenses (e.g. taxi fare, airport taxes);
- necessary additional expenses incurred during travel.

Arriving in the field

On arrival at your destination, look for a UN protocol officer (from any agency) who can assist in speeding up formalities. If you are travelling in a team, complete all immigration and customs formalities together.

Normally you will be met by someone from the WHO (or UNDP) country office. If you have not been met:

- After clearing the entry procedures, look out for and other WHO staff or for other UN staff who can help you get a lift from the airport.
- Go immediately to the hotel and ensure a room is available. If necessary, the accommodation can serve as a temporary office until more suitable premises can be found.
- Once you have obtained a room and completed all hotel formalities, contact the WHO office or that of the UN Resident Coordinator and inform him/her of your arrival (and the team's composition).
- Get a briefing from the WHO country office and get copies of the reports and other documents relevant to your mission.

- Contact the Regional Office and report your safe arrival to your supervisor there. Give hotel/residence and office contact numbers.

After this:

- meet with the Government officials concerned with the emergency;
- meet with the UN Resident Coordinator and explain your mission;
- identify and meet with other UN agencies and NGOs currently working in the area;
- identify and meet with national experts who may be able to assist you.



Arriving in the field – hints for a WHO emergency officer

Gathering information

In most cases you will not start from zero; more often than not, your task will be to compile and interpret available information rather than to collect new data. You will find data in the WCO and in reports or bulletins from the Ministry of Health, UNICEF and NGOs. Consult also the reports of UNDP, WFP, UNHCR and FAO, and news-media clippings. In this way you will be able to put together a considerable quantity of secondary data.

Make the best use of the available (secondary) information before starting to try to collect new, primary data. Carefully review and evaluate all secondary data (including hearsay) but discard nothing without good reason. Be aware of potential biases and coverage limitations.

Work with as many partners as possible. Always involve national or local staff.

Be creative when looking for sources: local churches, mosques, village elders, community organisations and journalists can provide useful information on population numbers, movements, mortality, etc.

Collect, analyse and present the data disaggregated to the smallest administrative division possible (e.g. block, village, camp, etc.).

Use estimates, trends and proxy indicators where hard data are not available:

- population figures are essential for calculating rates and for planning responses; these "denominators" must be estimated, discussed and accepted by all involved in the humanitarian response;
- triangulate (cross-match) data from different sources in order to get a picture of the overall situation as well as the quality of the information available and to arrive at a convergence of evidence and informed estimates (or at least educated guesses);
- do not let necessary action be blocked by shortage of "hard" data, but remember that you are responsible for your analysis of the data available and the conclusions and recommendations you put forward.

When collecting data, use existing data collection formats whenever possible (e.g. those developed by the country-level Cluster or the national Health Information System). This will make it easier for local health workers to answer to you, and for officials at the central level of MOH to understand your findings.

"Map" your information and mark on the map those areas for which you have good information, little information ("grey zones"), and no information ("black holes"):

- if data are *lacking* for/from a particular area or sector, try to find out why – the absence of information indicates a problem;
- if certain areas are *inaccessible*, ask key informants in neighbouring areas what they know and to what extent the situation in the inaccessible areas is believed to differ from their own areas;
- in an *armed conflict*, ICRC and/or some other agencies may have some freedom of cross-line movements and be able to provide insights on what's going – *respect their need for discretion*.

Up-date information regularly: in an emergency the situation can change rapidly.

Whoever gives you information gives you a service: show your appreciation and return the favour – share your own data and analysis. This will encourage more information exchange and other forms of collaboration.

Drawing conclusions

Once needs and resources have been assessed, priorities can be defined. Develop an initial plan with your partners. Define who does what, where, when and how. Donors can then be alerted to the type of assistance needed and the urgency of the requirements.

Ensure that any response plan is endorsed by the government (local and national), If a legitimate government is in place.

Send assessment reports to the WR with copies to the RO and HQ-HAC.



Managing stress¹⁶

- ✓ Manage your own stress
- ✓ Support colleagues who are stressed or have experienced a traumatic incident

A certain level of stress can be positive and motivating and can lead to increased performance. Excessive cumulative stress results in poor performance, sickness and eventually 'burnout' (physical and mental exhaustion).

Violent and unexpected incidents can cause trauma. They overwhelm a person's normal coping skills. The effects may be immediate or delayed and may require treatment.

Different individuals react differently and have different capacities to cope with stress.

Signs and symptoms

Some common signs and symptoms are listed in the box below:

Common signs and symptoms of excessive stress	
Physical Excessive sweating Dizzy spells Increased heart rate Elevated blood pressure Rapid breathing	Behavioural Changed behaviour patterns Changed eating patterns (e.g. compulsive eating) Decreased personal hygiene Withdrawal from others Prolonged silences
Cognitive (mental) Confusion in thinking Difficulty in making decisions Lowered concentration Memory problems	Emotional Anxiety, fear, grief Anger, irritability Depression, hopelessness Feeling overwhelmed
Interpersonal skills and belief systems are also affected	

Some signs of 'burnout'

- chronic fatigue, headaches
- sleep problems, nightmares
- increased anxiety, nervousness, verbal outbursts, accidents
- muscular tension: aching back, neck, shoulders
- increased smoking or use of alcohol or medication such as tranquillizers
- digestive problems (nausea, vomiting or diarrhoea)
- loss of interest in sex
- quarrels with family and/or friends
- inability to concentrate, apathy
- feelings of depression, hopelessness, helplessness

Burnout requires a change of environment, and sometimes therapy.

How to prevent and cope with stress

- ✓ **Get a good briefing** before going into a new situation.

¹⁶ Reproduced from *WFP Emergency Field Operations Pocketbook*, WFP 2002

- ✓ **Watch yourself:** recognize signs of stress and learn which situations/events stress you most; consciously try to minimize your exposure to these stress triggers.
- ✓ **Be positive**, and proactive: look for solutions rather than dwelling on problems.
- ✓ **Eat a well-balanced diet** and eat regularly.
- ✓ **Exercise regularly:** daily if possible.
- ✓ **Manage your time well:** set realistic goals, define priorities and take regular breaks; plan your free time constructively and productively.
- ✓ **Get the sleep you need:** you will feel more alert, perform better, be less irritable and find it easier to handle stress.
- ✓ **Calm yourself, be patient, be flexible:** at regular intervals and whenever you feel stress increasing, stop a moment, stretch and take long, slow, deep breaths.
- ✓ **Relax and meditate:** with your eyes closed, visualize yourself in an ideal location for relaxation (on a beach, in your favourite room or field); slow down and deepen your breathing as you visually experience the relaxing scene for ten minutes.
- ✓ **Share your thoughts, concerns and emotions:** find an individual (or individuals) with whom you can talk intimately.
- ⊗ **Avoid negative thoughts:** when you find yourself being negative and critical, make a conscious choice to be understanding and see what can be learned from each experience.
- ⊗ **Avoid excessive use of alcohol, nicotine and caffeine:** alcohol in moderation is all right, but not when it is used as an escape; avoid all forms of tobacco, if possible.

Laughter and a good sense of humour are powerful stress-reducing agents. Yoga and massage therapy are also beneficial.

Supporting someone who has had a traumatic experience

Defusing and debriefing meetings led by a trained counsellor will be important for the affected person's health and well-being. Friends and colleagues can also help someone who has had a traumatic experience by:

- welcoming them back and treating them as normal;
- reassuring them that they are safe, and normal;
- being patient; giving them the opportunity to resume normal activities if/when they wish, but allowing them time to settle themselves in private;
- helping them with routine tasks and official procedures;
- helping them to contact their family and closest friends;
- listening carefully and sympathetically whenever they want to talk about the event and their emotions; gently encouraging them to express their feelings;
- not taking their anger or other feelings personally;
- respecting the confidentiality of whatever they tell you;
- making sure that other colleagues understand the effects of traumatic stress and the possibility of delayed reactions; *and*
- calling for professional help when needed.

Conducting semi-structured interviews

Semi-structured interviews with key informants¹⁷

Preparation for the interviews

- ✓ Study the checklist thoroughly before setting out for the field. This means that you will not have to continually refer to the checklist during interviews.
- ✓ Work in teams of two people. One asks the question while the other takes notes.
- ✓ If translators are used, brief them thoroughly about the purpose of the interviews and give them copies of the checklist. Explain any tools that will be used (see **Section 9.7**).
- ✓ Dress respectably for the culture, but do not “over-dress”. Wearing expensive clothes in a poor neighbourhood can increase the psychological distance between interviewer and informants.

Conduct of the interviews

- ✓ Ask the informant if he/she is happy to talk. Explain the reason for the visit and the ways in which the information will be used.
 - ✓ Try to fit in with the household as much as possible. If they are sitting on the floor, you should do so too. Accept offers of tea, snacks etc.
 - ✓ Start the interview slowly. Talk about general issues (the weather, the family, politics etc.). Be sympathetic and friendly.
 - ✓ Gradually lead in to the questions on the checklist. Give the informants time to express themselves in their own words. If issues are unclear, let them finish, then ask for clarification. Do not worry about the order in which the issues on the checklist are addressed. It is more important to let the conversation flow.
 - ✓ Be alert to information that was not anticipated.
 - ✓ Think about the responses that people give and compare it with information that you received previously (either in this interview or from other sources). If there seem to be contradictions, ask for more explanation or find different ways of asking the same questions.
 - ✓ Avoid looking at the checklist frequently, as this disrupts the flow of the interview.
 - ✓ Be alert to signs that the informant is getting bored or irritated, or has other things to do. Terminate the interview politely if this happens (people have no obligation to talk to EFSA teams).
-

Semi-structured interviews with community groups¹⁸

Preparation for the discussion

- ✓ Identify the groups with whom you wish to talk and individuals from those groups through consultation with local people.
- ✓ Ensure that there are not large power differences between the individuals (for example, local chief and member of a marginalised clan). With power differentials, the more powerful people tend to dominate the discussion and the less powerful people may be reluctant to express their opinions openly.
- ✓ The group should ideally consist of between six and ten people. If there are fewer than six, the benefits of accumulated knowledge and group dynamics are reduced. If there are more than ten, the group becomes difficult to manage and individuals do not get enough time to speak.

¹⁷ Reproduced from *Emergency Food Security Assessment Handbook*, 2nd edition, draft, WFP 2007

¹⁸ Reproduced from *Emergency Food Security Assessment Handbook*, 2nd edition, draft, WFP 2007

- ✓ Draw up a checklist for use during the interview. This should be specific to the context and particular type of group.
- ✓ Agree upon a time and a place for the discussion. If possible, hold the discussion in a secluded place. If it is held in a public area, curious onlookers may come to observe or participate and the group may quickly become unmanageable.
- ✓ Dress respectably but not over-formally.
- ✓ Where possible, have two interviewers: one to ask questions (the interviewer), while the other records the answers (the recorder).
- ✓ The assessment team as a whole agrees upon a format for recording the information received during focus group discussions. The precise details are not important, but the format must be used consistently between teams to facilitate analysis.

Conduct of the discussion

- ✓ Arrange the seating so that everyone is at the same level (either all on the floor or all on chairs). Sit in a circle.
- ✓ The interviewer introduces himself/herself and explains the objectives of the exercise.
- ✓ The interviewer explains the “rules” for the discussion: everybody has an equal opportunity to talk, and any views can be expressed.
- ✓ The interviewer uses a checklist in the same way as in a semi-structured interview: topics are introduced into the conversation and the group is invited to give their input. The interviewer ensures that all the issues are covered, while looking out for new information that was not predicted.
- ✓ The recorder writes down the responses.
- ✓ The interviewer needs to use his/her judgement to decide when to let the discussion take its own course, and when to bring it back to the topics on the checklist.
- ✓ The interviewer tries to ensure that all people in the group participate. Often one or two people dominate the discussion. If this starts to happen, the interviewer politely asks these people to wait and invites input from the less forceful members of the group. Considerable tact may be needed!
- ✓ There are usually disagreements between the group members. For example, one person might say that all people are receiving relief assistance, while another says that people in certain districts receive more assistance than. The interviewer “works through” the issue by bringing other people into the discussion and probing to discover the source of the disagreement. This is one of the main advantages of using focus groups: it provides an opportunity for instant cross-checking.
- ✓ The interviewer gradually moves through the topics on the checklist. At the end of each he/she summarises the conclusions to ensure that he/she has properly understood what the group has been saying.
- ✓ At the end of the discussion, the interviewer again summarises conclusions and explains how the information will be used.

After the discussion

The interviewer and the recorder agree upon the results and structure them in the pre-agreed format.

How to ask questions during a semi-structured interview
<p>Ask clear and direct questions, e.g.: How...? Where...? When...? Who...? What...? How much...?</p> <p>Keep asking: Why?</p> <p>Ask questions about groups of people, not individual informants, e.g.: “How many goats do most poor families have?” (not “How many goats do you have?”).</p> <p>Ask one question at a time; don’t ask more than one question in the same sentence.</p> <p>Only ask questions to which the respondents can be expected to know the answers.</p>

Be clear about the time period to which the question refers.

Keep sensitive issues until later in the interview or discussion, and avoid asking sensitive questions directly, if possible (e.g. don't ask about total income, but about things that will allow you to estimate income, such as the number of days worked and daily labour rates).

Ensure that each question is clearly understood, especially when working with an interpreter.

Don't phrase questions in a way that assumes or implies that the informant(s) should follow (or have followed) a specific course of action.

Avoid leading questions, in particular questions that invite people to paint a very pessimistic picture. Examples of such questions are: "Has anyone died of famine in this area?" or "How many households need food assistance?" or "What have been the main problems with crop production this year?"

Don't induce particular answers by helping the group, or interviewee, to respond.

[Reproduced from *Emergency Food Security Assessment Handbook*, 1st edition, WFP 2005]



Special considerations in a situation of conflict or repression

When visiting health facilities and local communities, and interviewing health staff and community members:

- **Be careful about whom you go with:** When you visit and meet with people who are identified with one side of the conflict, avoid being accompanied by anyone who could be identified with, or suspected as being from, another side, or anyone from a group with a history of cultural animosity towards those whom you are visiting. This applies to your own national staff and your driver as well as local officials or the staffs of other organizations.
- Sometimes people may be distinguished by ethnic origin and occasionally by their clothing, but **be aware that it can be difficult to distinguish different groups:** In some situations there are no obvious distinguishing features between different parties to the conflict, and you will never be able to be sure who is present or the allegiances of those with whom you are talking.
- **Be careful what you carry with you:** Some documents or pieces of equipment may raise suspicions. Be ready to explain everything you have in your bag/pockets!
- **Mobilize anthropologists with local language skills:** This will enable you to: (i) understand what is going on and the interactions among different groups, and (ii) 'read between the lines' of what is (and is not) being said, and interpret body language. It will help you to avoid aggravating tensions.
- **Explain who you are and why you are there:** Explain your relationship with the government and all other parties.
- **Emphasize your independence:** Avoid being accompanied by government officials, if possible, but ask local health and extension workers to join you. Find ways to talk with all groups in the community, not just those who present themselves as 'leaders'.
- **Expect biased information:** Many people will either have an interest in presenting a biased picture or be afraid to tell the truth, especially if other people are present.
- **Be sensitive to the situation:** People you meet and talk with may be under threat or putting themselves at risk merely by being seen talking with you.
- **Don't ask sensitive questions:** Never ask about allegiances. Avoid direct questions about anything that could have political or military significance.
- **Never provoke an argument:** the stakes could be high for the people involved!
- **Don't ask for names:** If you ask for names, your interlocutors may be less willing to talk honestly, and you could be putting them at risk in case your notes were to fall into the 'wrong' hands.
- **Avoid crowds.**
- **Be ready to withdraw** if the situation is, or becomes, tense.

In any situation of open repression: remember what you are told; record as little as possible at the time; write up your notes after you have left the area. People are likely to talk less and less honestly if they see you writing everything down. They could be put at risk if your notes were to fall into the 'wrong' hands.

N.B. If you aggravate tensions, you will not only increase problems locally but also undermine the organization's ability to work effectively anywhere in the area.

[Reproduced from Emergency Food Security Assessment Handbook, WFP 2005, Table 11-A]

Working with an interpreter

1. Meet regularly with the interpreter in order to keep communications open and facilitate an understanding of the goals and purpose of the interview, meeting, or counselling session.
2. Speak in short units of speech – not long involved sentences or paragraphs. Avoid long complex discussion of several topics in a single interview.
3. Avoid technical terminology, abbreviations, and professional jargon.
4. Avoid colloquialisms, abstractions, idiomatic expressions, slang, similes, and metaphors.
5. Encourage the interpreter to translate the interviewee's own words as much as possible rather than paraphrasing or "polishing" it into professional jargon. This gives a better sense of the interviewee's concept of what is going on, his or her emotional state, and other important information.
6. Encourage the interpreter to refrain from inserting his or her own ideas or interpretations or omitting information.
7. To check the interviewee's understanding, and the accuracy of the translation, ask the interviewee to repeat instructions or whatever has been communicated in his or her own words, with the translator facilitating.
8. During the interaction, look at and speak directly to the interviewee, not the interpreter.
9. Listen to the interviewee and watch their nonverbal communication. Often you can learn a lot regarding the affective aspects of the interviewee; responses by observing facial expressions, voice intonations, and body movements.
10. Be patient. An interpreted interview takes longer. Careful interpretation often requires that the interpreter use long explanatory phrases.

Even if you are using an interpreter, there are ways you can become more actively involved in the communication process.

1. Learn proper forms of address in the interviewee's language. Use of titles conveys respect for the interviewee and demonstrates your willingness to learn about their culture.
2. Learn basic words and sentences of the interviewee's language. Become familiar with special terminology used by interviewees. Even though you can't speak well enough to communicate directly, the more you understand the greater the chance you will pick up on misinterpretations and misunderstandings in the interpreter-interviewee interchange.
3. Use a positive tone of voice that conveys your interest in the interviewee. Never be condescending, judgmental, or patronizing.
4. Repeat important information more than once.
5. Reinforce verbal interaction with materials written in the interviewee's language and with visual aids.

Source: Randal-David, Elizabeth; *Strategies for Working with Culturally Diverse Communities and Interviewees*; Association for the Care of Children's Health; Washington D.C. 1989, reproduced from WFP emergency food security assessment handbook, annex C4.

Annex series H
Materials relating to Security and Critical Incident Management

Personal security¹⁹

This annex provides reminders of only a few key points. Be aware of and keep with you the more detailed information and guidance in:

- *Security in the field*, UN;
- *Security awareness - an aide mémoire*, UN/UNHCR;
- *Security awareness training programme – participant's guide*, WFP;
- guidelines issued by the country-level UN security management team (SMT).

See 3.5 concerning measures to ensure security and crowd control at food distribution sites.

Personal security responsibilities

Preparedness.

Ensure that at all times you have:

- your laissez passer/passport, visa, identity card(s), family certificate and health certificate, and that any return travel tickets are valid;
- cash (local currency and US\$) and traveller's cheques to hand;
- a supply of food, water and candles, flashlights and a first aid kit.

Ensure that your vehicle is in good working order and has a reasonable quantity of fuel at all times.

Information and instructions

- ✓ Inform the office/security officer of travel plans and get clearance if needed.
- ✓ Get security briefings before travelling to an insecure area and when you arrive. Follow local UN/WFP advice and instructions.
- ✓ Know the UN security plan for the location you are in, and the warden responsible. Keep the warden (as well as the office) informed of where you are and when and where you propose to travel.
- ✓ Follow the instructions of the Designated Official for UN Security (DO, usually the UN resident co-ordinator), the warden for the area you are in, or the CD.

International staff must deposit up-to-date household and personal effects inventory forms with the country office. (If not, you will not be entitled to any compensation in the event of loss.)

A refusal to comply with an evacuation instruction may be considered as an act of defiance and could lead to suspension pending investigation. You would be staying on at your own risk and it might not be possible to include you in subsequent evacuation arrangements. WFP would not be able to take further responsibility for your protection.

Precautions

- ✓ Always be alert and aware of your surroundings. Look out for the unusual and be suspicious. Follow your instincts.
- ✓ Avoid routines. Use different routes to and from the office, etc. Vary times of departure to the extent possible.
- ✓ Be discrete and keep a low profile. Select your friends with care. Avoid ostentatious behaviour. Respect local cultural norms.
- ✓ Stay away from situations that might present or attract threats (e.g. political rallies).

¹⁹ Reproduced from *WFP Emergency Field Operations Pocketbook*, WFP 2002

ANNEX I – USEFUL CONTACTS

- ✓ Be certain that you can explain everything that you have on your person. Don't carry any items that may call into question your motives or status within the mission.
- ✓ In hotels: avoid ground floor rooms that are accessible from the outside, and rooms at the end of long corridors; check that doors and windows are secure; check that the telephone works.
- ⊗ Don't be provoked by hostile comments. Don't say or do anything that might provoke resentment.
- ⊗ Don't carry large amounts of money. Don't display jewellery or keys.
- ⊗ Don't touch suspicious objects or packages: report them to local security personnel.

When an emergency strikes, if you are unable to contact the warden or CD, consult the local government, local security personnel and/or any representatives of ICRC or other international agencies present in the locality. Contact the CD or any WFP office as soon as possible.

Mines and unexploded ordnance

- ✓ Get a briefing on and description of the kind of mines and unexploded ordnance likely to be found in the area.
- ✓ Ask local people for advice as to possible locations of mines.
- ✓ Never touch any suspicious object, nor pull or cut any wires; avoid walking in the immediate area; mark the spot and inform your colleagues, local people and the authorities.
- ✓ Avoid the edges of roads and what appear to be fresh road repairs. Get out of a vehicle in the middle of the road, not at the edge.
- ✓ Stop well before any obstacle (something suspicious) in the road. Inspect from a distance (use binoculars). Don't proceed if you are in doubt.
- ✓ If you find yourself in an area where there are mines, 'freeze', then retrace your steps slowly and very carefully.

Surviving as a hostage

- ⊗ At the time of your seizure, don't attempt to fight back. Don't play the hero, your job is to survive. Don't talk back or 'act tough'. The first 15 to 45 minutes are the most dangerous.
- ✓ Fear is a normal reaction. Try to relax, pause, take a deep breath and accept the situation.
- ✓ Be co-operative without appearing either servile or antagonistic. Follow the instructions of your captors. Keep a low profile.
- ✓ Try to gain your captors' respect and try to build a rapport with them. An excellent topic of discussion is family and children.
- ✓ Emphasise that as a UN/WFP employee, you are neutral and not involved in politics.
- ✓ Encourage your captors to let the authorities know your condition and whereabouts.
- ✓ Take care of yourself: exercise, stay well groomed, eat and drink even when you are not hungry.
- ✓ Be patient and mentally prepared for isolation. Focus your mind on pleasant scenes memories or prayers.
- ⊗ Never beg, plead or cry.
- ⊗ Don't make threats against your captors or indicate that you would testify against them.
- ⊗ Avoid appearing to study your captors' features, dress and mannerisms.
- ⊗ Don't attempt to escape unless you are certain you will be successful.
- ✓ If there is a rescue attempt by force, drop to the floor and keep your hands over your head. Once the situation has stabilized, identify yourself.

UN Security phases and their meanings²⁰

Phase	Internationally recruited staff	Locally recruited staff
1	<u>Precautionary</u> Exercise caution All travel into the area requires advance clearance by the DO	Alerted in same manner as international staff Same DO travel clearance is required
2	<u>Restricted movement</u> Staff and families remain at home No travel into or within the country unless authorized by DO	Staff do not report for work unless otherwise instructed
3	<u>Relocation</u> Staff and families are temporarily concentrated or relocated to specified sites/ locations <i>and/or</i> Eligible dependants are relocated outside the country	According to the local UN security plan and the decision of the DO/CD, staff may: leave the duty station on special leave with pay, <i>or</i>
4	<u>Emergency programmes only</u> All staff who are not directly concerned with emergency or humanitarian relief operations or security matters are relocated outside the country	be relocated to a safe area within the county with up to 30-days DSA, <i>and</i> receive up to 3 months salary advance and, if needed, a grant to cover transport costs for themselves and eligible dependants
5	<u>Evacuation</u> (SG approval) All remaining staff leave	

Arrangements for national staff

National staff members are helped to ensure their own security and may be relocated within the country. They can be evacuated from the country only under the most exceptional circumstances when decided by the UN Secretary-General.

Minimum Operating Security Standards (MOSS)

The Baseline MOSS table (on the CD-ROM) specifies the telecommunications nature of the security plan and the telecommunications facilities and other equipment that are mandatory for Phase 1, Phase 2, and Phases 3, 4 and 5. Requirements are specified for country offices, offices outside the capital, vehicles and individual staff members.

²⁰ Reproduced from *Emergency Field Operations Pocketbook*, WFP 2002

Guidelines for the use of armed guards and escorts²¹

Guards (armed when necessary in accordance with UN security policy in the country) may be engaged to ensure the security of WHO premises.

As a general rule, humanitarian convoys do *not* use armed or military escorts. Armed escorts *may* be used in exceptional circumstances (see box below). In such cases:

- all humanitarian organizations seeking armed or military escorts for their convoys should adopt a common approach;
- whenever possible they should negotiate as a team for such escorts and seek to establish common policies towards terms and conditions, including any payments.

The costs of essential security measures are an integral part of emergency project budgets.

Use of armed or military escorts

Armed or military escorts may be considered as a last resort and only when:

- the sovereign power or local controlling authority is unwilling to provide a secure environment without the use of military or armed escorts;
- the lack of humanitarian assistance would lead to unacceptable human suffering, and such assistance cannot be delivered without the use of military or armed escorts;
- armed or military escorts would provide a credible and necessary deterrent to enhance the safety of humanitarian personnel and the capacity to provide assistance, without compromising the security of beneficiaries and other local populations; *and*
- the use of armed or military escorts would not compromise the longer-term capacity of the organization to fulfil its mandate safely and effectively.

[Policy agreed by the Inter-Agency Standing Committee Working Group, 2001.]

²¹ Reproduced from *Emergency Field Operations Pocketbook*, WFP 2002, section 1.4.

Security incident reporting

Reporting of incidents

All security incidents involving WHO staff, assets and property must be reported by the WR, or Head of CO, to:

- the Designated Official for Security at the duty station;
- the Chief Security Advisor or Field Security Coordination Officer;
- RO-DAF; *and*
- the Coordinator, Security Services/HQ.

The standard Security Incident Report format (on the CD-ROM) should be used.

What to do in the event of the arrest or detention of a staff member

Should a WHO staff member or a dependant of a staff member be arrested or detained by government authorities or by unauthorized or unknown persons, other WHO staff in the country who become aware of the arrest or detention should immediately inform the Designated Official, the WHO Representative, if any, the regional director and, at Headquarters, the Coordinator, Security Services.

The Designated Official enters into contact without delay with government representatives to obtain, if possible, information about the arrest or detention and access to the person concerned and sends a full report of the circumstances to United Nations headquarters. The report is transmitted to the Director-General of WHO who determines what further action may be required in cooperation, if appropriate, with the Secretary-General and the United Nations Office of Legal Affairs.

Medical evacuation (medevac) procedures

This annex reproduces extracts from MedEvac Administrative Procedure (PSU/CSA) 2004.

1. PURPOSE

The purpose of medical evacuation is to allow staff members and eligible dependants the opportunity to secure essential medical care or treatment for a severe illness or injury requiring medical intervention which is locally unavailable or inadequate. Medical evacuation is authorized under [Staff Rules 810.7 and 820.2.8 \(dependants\)](#), which state that in the case of illness or injury requiring special facilities for treatment of a staff member or a dependant whom the Organization has an obligation to repatriate, the Director-General may authorize return travel between the official station and the nearest place where such facilities exist. The Regional Staff Physician (in consultation with HMS/HQ when necessary) advises on the location of the facilities.

2. ELIGIBILITY

The following persons are entitled to be medically evacuated:

- Internationally recruited staff members (including STCs, TLPs and STPs) based in the Regions;
- HQ and regional staff members (including STCs, TLPs or STPs) on duty travel;
- Spouses and recognized dependants of internationally recruited staff members whom the Organization has an obligation to repatriate.

Temporary Advisors, persons employed under Special Services Agreements (SSAs) and Agreements for Performance of Work (APW) are not entitled to medical evacuation (except in the case of service-incurred illness or accident, where exceptional medical evacuation may be granted). In such cases, requests should be submitted to Director, HRS through the Secretary, Advisory Committee on Compensation Claims along with the recommendation from Director, HMS.

The Medical Evacuation Checklist (Annex A) can be used to establish eligibility for medical evacuation.

2.1 Escorts

Subject to the endorsement of Chief Medical Officer, HMS, an evacuee may be accompanied by either a medical escort (doctor or nurse) or a family member if circumstances warrant.

2.2 Exceptions

The terms of [Staff Rule 810.7](#) do not enable the evacuation of fixed-term locally recruited Professional or General Service staff members (including National Professional Officers). However, exceptional approval of a medical evacuation in life-threatening situations, for such staff, (but not their family members) may be granted by Director, HRS. Requests for exceptions are considered on a case-by-case basis in consultation with HMS. If a request for an exception is refused, the Organization may nevertheless facilitate the staff member's travel on the strict understanding that the total cost is borne by the staff member. In general, exceptions to [Staff Rule 810.7](#) are not extended to short-term locally recruited staff members.

3. DESTINATION

Staff should be evacuated to the nearest place where adequate medical facilities exist. The UN examining physician (or UN dispensary physician (Annex B) at the duty station in consultation with the Regional Staff Physician and Chief Medical Officer, HMS/HQ as necessary will determine the destination (Annex C: Emergency Contact List). A staff member may elect to travel to another country than that recommended by the Regional Staff Physician/HMS, on the understanding that the Organization's liability for the cost of travel and per diem will be limited to "duty station-recommended location-duty station" or "duty station-place of treatment-duty station" whichever is less.

4. APPROVAL PROCEDURES

4.1 For evacuation within the region

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- The UN examining physician (or UN dispensary physician) at the duty station should be provided with the necessary medical information to enable him/her to evaluate the situation.
- He/she should then contact the WHO Regional Physician who will make a medical recommendation to the Regional Director.
- In the absence of the WHO Regional Physician, HMS/HQ should be contacted (Annex C).
- It is essential that a fully detailed medical report is faxed to the Regional Physician (or HMS/HQ if necessary).
- At all times, the WHO Representative in the country should be kept informed.
- In the absence of a UN physician at the duty station, the WHO Representative should contact the Regional Physician or HMS direct (in all cases a medical report is required).

Pending the final approval by the Regional Office, action should be taken on the spot (WR's office/Regional Personnel Officer) to prepare the evacuation (i.e. organize the transportation and medical assistance (if necessary) and ensure that the staff member is provided with an adequate per diem advance as well as the *HMS Report on Medical Evacuations* form (Annex D) for completion by the treating physician at the destination. On receipt of approval from the Regional Office, immediate action should be taken to complete the evacuation. Medical evacuations within the region are dealt with exclusively by the regional office.

4.2 For evacuation outside the region

- The UN examining physician (or UN dispensary physician) at the duty station should be provided with the necessary medical information to enable him/her to evaluate the situation.
- He/she should then contact the WHO Regional Physician who will make a medical recommendation to HMS/HQ.
- In the absence of the WHO Regional Physician, HMS/HQ should be contacted direct.
- It is essential that a fully detailed medical report is faxed to the Regional Physician and to HMS/HQ.
- At all times, the WHO Representative in the country should be kept informed.
- In the absence of a UN physician at the duty station, the WHO Representative should contact the Regional Physician or HMS direct (in all cases a medical report is required).

Pending the final approval by Director, HRS/HQ, action should be taken on the spot (WR's office/Regional Personnel Officer) to prepare the evacuation (i.e. organize the transportation and medical assistance (if necessary) and ensure that the staff member is provided with an adequate per diem advance as well as the *HMS Report on Medical Evacuations* form (Annex D) for completion by the treating physician at the destination. On receipt of approval from HQ, immediate action should be taken to complete the evacuation.

4.3 Headquarters Staff on duty travel and Inter-Regional HQ staff on mission in the regions

The same procedure as set out in points 3 and 4.2 should be followed. On receipt of a recommendation from HMS, Coordinator, PSU will fax or e-mail the Regional Personnel Officer and the WHO Representative with the final approval/decision, providing a copy to the staff member's Cluster (MSU/Personnel). The MSU/PER is then responsible for the administrative procedures, such as issuance of the travel authorization, co-ordination with WHO Representative and settlement of travel claim.

4.4 Regional and country staff requiring evacuation outside the region

The same procedure as set out in points 3 and 4.1 should be followed. On receipt of a recommendation from HMS, Coordinator, PSU will fax or e-mail the Regional Personnel Officer and the WHO Representative with the final approval/decision. The Regional Personnel Officer is responsible for the administrative procedures. Per diem requests related to medical evacuations should be addressed to PSU/CSA who, upon consultation with HMS, will approve payment and advise the Regional Personnel Officer on the applicable rates.

4.5 Cases of acute emergency

In cases of acute emergency, and in the absence of a UN examining physician, prior approval for the evacuation may be given by the WHO Representative, preferably after consultation with HMS/HQ. However it is realized that circumstances may not permit such prior consultation. The provisional

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approval must be confirmed on receipt of medical reports and the WHO Representative should inform Director HMS and Coordinator, PSU as well as the Regional Director (if evacuation is from the field).

4.6 SOS

In highly exceptional cases and in acute emergencies where no adequate or timely flight arrangements can be made, the services of **SOS International** may be called upon (Annex E). The procedures for seeking approval for medical evacuations remain the same, except that copies of correspondence should also be provided to Coordinator, SFS. Annex F contains the list of Authorized WHO Approvers provided to *SOS International*, as well as details of the 24 hour alarm centres. The process in cases of acute emergency requiring use of the SOS service is:

- Staff member in the field contacts the WR informing him/her of details (if possible with medical report);
- The WR obtains Regional Director approval to go ahead with the SOS evacuation and, using the access card provided by the WHO Approver, contacts SOS to initiate evacuation;
- Before departure the staff member or medical attendant should be provided with a list of contact numbers at the HQ, RO and WR levels.
- *SOS International* will send the bill for the evacuation to Coordinator, HRS/HPA for on-forwarding to the Region or Cluster concerned for payment.

Action in case of the death of a colleague²²

If a staff member dies while on mission, the senior WHO staff member present or closest to the scene must take charge. As several immediate actions must be taken, he/she should draw on available assistance from fellow staff. From the beginning, the responsible officer should document every action taken and make copies of all documentation relating to the deceased.

The following must be addressed:

- (a) identification of remains;
- (b) cause of death;
- (c) official notification procedures;
- (d) Next of Kin notification;
- (e) documentation; *and*
- (f) disposition and repatriation of remains.

IDENTIFICATION OF REMAINS

Identifying the deceased party or parties is the first priority. Although in some situations it may prove to be difficult, positive identification must be established as quickly as possible. After identifying the body, ensure it is tagged with the correct name of the deceased. Record all items found with the body.

CAUSE OF DEATH

As much information as possible should be compiled on the cause of the staff member's death and the events leading up to it. A summary must be made by the senior staff member and forwarded, confidentially, to the WR. All witness and official reports must be copied to the WR.

OFFICIAL NOTIFICATION

Once death and identity have been confirmed, the senior WHO staff member present should immediately inform the WR. The WR will then inform the UN Resident Coordinator, as well as the Regional Office and WHO HQ. If there is any embassy or consulate of the country of the deceased staff member, officials there must be informed and given regular updates.

NEXT OF KIN NOTIFICATION

The WR must contact the relatives of the deceased and inform them.

DOCUMENTATION

A number of documents will be required. Three are indispensable:

- Death certificate;
- Police report;
- Post mortem/autopsy report.

The death certificate will be required by various authorities in the country of assignment (Ministry of Foreign Affairs, customs and immigration, etc.), as well as by authorities in the staff member's country of origin, by WHO and by insurance companies. It must be signed by the attending physician and include the date and the official stamp of the clinic or the hospital. The causes of death should be briefly described. As most authorities insist on original or notarized copies, it is a good idea to have a large number of photocopies with original signatures and stamps.

In most countries, a police report will be needed. Again, this document will be required in numerous copies. Police authorities usually do not agree to the removal of a body pending investigation. A statement to the effect that the remains of the deceased are no longer required by the police authorities will have to be issued prior to the removal of the body for burial.

²² Reproduced from *Handbook for Emergency Field Operations*, EHA/FIELD/99.1, annex 3.12

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In case of violent death, a post mortem/autopsy report will be required, to determine the exact cause of death or to assist in the investigation of a crime. Absolutely, the agreement of the next of kin must be obtained, in writing, before such a procedure is undertaken. A faxed copy will often have to do. The availability of proper forensic expertise and facilities in the country to carry out an autopsy should also be borne in mind. Again, a detailed post mortem report should be prepared in a proper format.

Many countries will not accept post mortem reports from nationals of another country. In order to ensure that two post mortems are not conducted, thereby causing more discomfort to family members, the nearest embassy should be consulted as to the legal requirements of repatriating remains.

Under certain circumstances, embassy officials and WHO staff members may be required to attend the post mortem.

DISPOSITION OF REMAINS

The instructions of the family of the deceased should be observed as closely as possible. They will vary greatly, according to religious, national and cultural customs, or personal preferences. Very often they will differ from the customs of the country of assignment.

The body of the deceased will need to be repatriated to his/her home country by air. Airlines have strict regulations for the transportation of human remains, and they should be consulted immediately. UNDP often has extensive experience in these matters and will be an invaluable source of information and advice. Some of the larger embassies may be able to recommend an agent or funeral parlor they have dealt with in the past. Funeral parlours in major cities often have the expertise to complete all procedures. It may be necessary to engage the services of a shipping agent experienced in the transportation of remains.

If the remains are transported, there must be no deterioration during transit. Not all hospitals have properly equipped mortuaries. Some cooling system or a refrigerated room may be needed. Airlines may request a certificate of embalmment before accepting the shipment. In many parts of the world, embalmment of bodies is not a common occurrence, and you may have to prepare a special request to the authorities for this procedure.

For transportation of human remains, airlines will accept only well-constructed coffins built to strict specifications. Such coffins should not only be sturdy but also have a metal lining. Just prior to shipment, the coffin must be lead-sealed in the metal container to make it completely airtight. Most embassies have a stock of coffins that meet airline requirements, and they can make these available to the UN. In many cases, a representative of the embassy of the deceased will need to witness the sealing of the casket.

Various documents may be required, depending on the country. Typically, a letter from the Foreign Ministry, a copy of the passport of the deceased, a customs clearance certificate and a doctor's certificate stating that the deceased did not suffer from communicable diseases may be needed, in addition to copies of the death certificate, the police report and the embalming certificate, if applicable.

Airlines also require the name, address and telephone/fax number of the consignee e.g. an undertaker, in order to verify that arrangements have been made at the receiving end. It is important that a confirmation be received, otherwise airlines will not accept the body for shipment.

In some instances a fellow staff member will escort the body. This person should be chosen for his/her familiarity with the deceased and because of his/her knowledge of the customs and culture of the destination country.

Once arrangements are finalised, the family of the deceased should be informed of the date and time of arrival of the body. If there is an escort, the family members should be aware of this and know the name of the escort.

It is good policy to inform the funeral parlour or agent receiving the body of the following:

- Airwaybill number
- Carrier
- Flight number
- Estimated time of arrival

Fax the funeral parlour copies of relevant documentation (death certificate, airwaybill etc.) so they can make advance preparations.

CONCLUSION

Situations and requirements will vary from country to country and from one case to another. All the steps taken should be well documented and copies of all documentation should be kept in a confidential file. This will avoid problems later, when questions may arise in respect of the procedures followed, from relatives, or insurance companies, the Government or UN authorities carrying out any investigations. All the staff involved in the various arrangements must use utmost discretion, tact and sensitivity, particularly when dealing with the family of the deceased.

The WR should also consider the effects that the death of one staff member will have on colleagues and on those closely involved in the incident. Assistance should be requested to provide immediate psychological support and stress management education to such staff and/or dependants. See stress management SOP 8.17.

At all stages, the family of the deceased should be kept informed on the progress of repatriating the remains. They should not feel that WHO has neglected them or considers them unimportant.