



European  
Commission



DG ECHO Thematic Policy Document n° 7

# Health

## General Guidelines

February 2014

*Humanitarian  
Aid and Civil  
Protection*



## **DG ECHO Thematic Policy Documents**

- N°1:** Food Assistance: From Food Aid to Food Assistance
- N°2:** Water, Sanitation and Hygiene: Meeting the challenge of rapidly increasing humanitarian needs in WASH
- N°3:** Cash and Vouchers: Increasing efficiency and effectiveness across all sectors
- N°4:** Nutrition: Addressing Undernutrition in Emergencies
- N°5:** Disaster Risk Reduction: Increasing resilience by reducing disaster risk in humanitarian action
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**Additional annexes available on the internet:**  
[http://ec.europa.eu/echo/policies/sectoral/health\\_en.htm](http://ec.europa.eu/echo/policies/sectoral/health_en.htm)

- Annex E:** *Health Technical Guidelines*
- Annex F:** *Health Facilities Checklist*
- Annex G:** *Fee for Service Guidelines*
- Annex H:** *HIV Guidelines available*
- Annex I:** *Overall Health Indicators*

# 1. Introduction

Health is both a **core sector** of humanitarian aid interventions, and the **main reference for measuring** overall humanitarian response. Over the past decade DG ECHO has allocated an average of around € 200 million on humanitarian health per year, which accounts for 20% – 30% of global humanitarian health funding<sup>1</sup>.

Over 300 million people each year<sup>2</sup> are in need of humanitarian health assistance as a result of natural disasters and conflicts. With the global trends of climate change<sup>3</sup> and a growing and ageing population, together with the increasing frequency and scale of natural disasters and the persistency of conflicts, humanitarian health needs are continuing to increase.

Furthermore, the role of health in humanitarian settings is both changing, and becoming more important. On the one hand, this is due to the persistent weakness of health systems in many of the areas of potential and active humanitarian health interventions. On the other hand, the changing role is related to the increasing range of health services now expected of health in humanitarian settings. For example, the change of disease patterns towards chronic non-communicable diseases, and the health risks associated to growing urban populations bring new challenges that need to be addressed with new strategies and approaches<sup>4</sup>.

Achieving affordable, quality health interventions that address these growing needs in humanitarian settings require improvements in the way of working for the humanitarian health sector. Given the significance of Commission humanitarian health assistance for the health sector in emergencies, and of the sector for Commission humanitarian health assistance, the following Guidelines set out to review how DG ECHO can contribute to improving the delivery of affordable health services, based on humanitarian health needs.

Building on DG ECHO's comparative advantages in supporting the provision of humanitarian health assistance, the main aims of these Consolidated Guidelines are to:

- Maximize the impact, relevance, effectiveness and efficiency of health assistance in coherence with DG ECHO's general objectives, mandate, and legal framework;
- Inform partners and stakeholders of DG ECHO's objectives, priorities and standards in the delivery of health assistance;
- Simplify DG ECHO's internal decision-making in the use of health assistance resources and increase their coherence;
- Improve coordination, synergy and coherence between DG ECHO, other EC services, member states and other donors in the provision of health assistance.

These Guidelines comprise a General Guidelines document that provides the basic parameters of DG ECHO humanitarian health assistance, complemented by specific Technical Guidance in annex.

*1 - According to UNOCHA Financial Tracking Service.*

*2 - According to CRED, University of Louvain, compiled by IFRC in the World Disasters Report of 2011 : 260 million people per year are affected by hydro-meteorological disasters, earthquakes and epidemics. According to UNHCR World Trends (2010), 43 million people were forcibly displaced in 2010.*

*3 - Notable climate change impact on health includes : vector borne diseases, zoonosis, water scarcity, insufficient food, environment deterioration, resilience*

*4 - Spiegel PB, Checchi F, Colombo S and Paik E; 2010: Health-care needs of people affected by conflict: future trends and changing frameworks; the Lancet 375: 341-45*

## 2. Objective and principles

### Objective

The overriding objective of DG ECHO's health assistance is to limit excess preventable mortality<sup>5</sup>, permanent disability, and disease associated with humanitarian crises.

### General principles

Deriving from the broader regulations and principles applied to DG ECHO<sup>6</sup>, those general principles that have particular relevance to humanitarian health are:

1. To adhere to the basic humanitarian principles of humanity, neutrality, impartiality, and independence. While DG ECHO is a needs-based donor, the general principle that should guide the humanitarian health response to emergencies is that progressive access to the highest attainable standard of health is one of the fundamental human rights<sup>7</sup> of any individual or group irrespective of gender, ethnicity, religion, political belief and economic or social status.
2. To allocate funding in an unbiased way to those with the greatest need and the highest level of vulnerability and in a way that allows all beneficiaries, women, girls, boys and men, to maintain dignity.
3. The interests of the crisis-affected population are always at the centre of interventions and are considered above all other concerns of those providing assistance.
4. To provide humanitarian assistance with strict adherence to the generally accepted standards and norms of international practice.
5. To deliver assistance in a way that is intended to do no harm: individual and population interests will be protected at all times from detrimental and unsafe practices.

“The overriding objective of DG ECHO's health assistance is to limit excess preventable mortality, permanent disability, and disease associated with humanitarian crises.”

<sup>5</sup> - An elevated mortality rate (either greater than 1/10,000 population/day for the general population or >2/10,000 for under-five children or more than twice the baseline rate for the area – see Sphere Project) is widely considered to be an appropriate trigger for response. Frequently, however, a quantitative measurement of mortality rates, or of incidence rates for diseases of particular concern, cannot be obtained promptly or accurately in the immediate aftermath of a precipitating event. In this case, an estimation of the vulnerability of the population, and of the risk of life-threatening or disabling diseases, based on the epidemiologic, demographic, and geographic characteristics of the population and on the nature of the precipitating event will contribute to the decision of whether or not to intervene.

<sup>6</sup> - In accordance with the orientation of the Humanitarian Aid Consensus, such as the needs based approach; in accordance with the Commission's humanitarian mandate defined by the humanitarian legal framework; to improve policy coherence, coordination and complementarity in the provision of humanitarian Health assistance; to inform Member States and other fellow donors, partners and other stakeholders of the European Commission's objectives, priorities and standards in the delivery of humanitarian Health assistance.

<sup>7</sup> - In accordance with the International Covenant of Economic, Social and Cultural Rights (article 12); and SPHERE, 2011 edition, page 291.



Medical examination, Mali refugee camp of Mbera, Mauritania 2012. © European Union, 2012 - photo by EC/ECHO//Cyprien Fabre

6. To ensure conformity with these principles, all interventions are conducted in a manner that allows for unhindered, objective, and independent monitoring.
7. To systematically identify, and where feasible, act on opportunities to reduce vulnerability to future humanitarian crises without compromising humanitarian principles.

#### Principles specific to the Humanitarian Health Sector

1. Commission humanitarian health assistance seeks to provide high quality assistance to those most in need. A quantitative assessment<sup>8</sup> of health-related needs will be conducted as quickly as possible and interventions will be designed and implemented in accordance with the findings. As health-related needs can change rapidly as a result of effective intervention and of evolving circumstances, needs assessments should be repeated frequently and programmes modified accordingly.
2. Health interventions are chosen on the basis of the best possible existing evidence of their effectiveness, as derived from published reports of research or of 'best practices'. Those interventions that have the highest potential to save most lives in a timely manner will be given highest priority. Other factors, including feasibility and cost will also influence the choice of intervention.
3. Commission humanitarian health assistance supports programmes that seek to restore or to reinforce disrupted essential health services and to provide additional services, as required by circumstances specific to the crisis, on a short-term basis. In protracted crises, this will include consideration of opportunities to consolidate and build the capacities of health services and to

<sup>8</sup> - For example [DG ECHO Initial Needs Assessment Checklist \(INAC\)](#).

reduce recurring needs for humanitarian assistance.

4. Commission humanitarian health assistance supports access to health services for all crisis-affected individuals. All obstacles to accessibility: geographic, economic and or socio-cultural will be addressed. Health services should be made available, without discrimination, to all segments of the population, including refugees, internally displaced persons, migrants and third-country nationals. When feasible, the health needs of the population living in close proximity to those directly affected will also be addressed, as a function of their vulnerability and risk.
5. All DG ECHO-funded assistance in the humanitarian health sector will adhere to recognised international standards such as those endorsed and promoted by WHO, the Global Health Cluster, the Sphere Project, or equivalent norms. Preventive and curative services, as well as pharmaceutical products and medical supplies and equipment will be of acceptable quality.
6. All efforts will be made to ensure the safety of health staff and supporting personnel, both local and expatriate, and patients. Appropriate levels of security will be provided to protect health facilities and ambulances at all levels, as well as pharmaceutical supplies and medical equipment.
7. DG ECHO supported humanitarian health assistance should always have the clearly focused objective of saving lives and limiting disability and disease during emergencies. However, while not always feasible, health interventions should be designed and implemented whenever possible in a way that allows for the fullest and most rapid recovery of health services and their return to normality. This means that emergency health interventions should facilitate the transition to development through constructive engagement with appropriate funding agencies and implementing partners. This collaboration will consist of the sharing in transparent way essential information regarding current and projected health needs, availability of human resources, supplies, projected costs, and other relevant factors that will promote the rapid transition from humanitarian to development interventions.

# 3. Entry & exit criteria

The decision to initiate the provision of humanitarian health assistance is based on the identification of a crisis which has exerted, or which will imminently exert a negative impact on the health of a population and which is of a scale and severity that exceeds the capacity or willingness of local authorities to respond in a timely and effective manner<sup>9</sup>.

Six types of crisis may lead to humanitarian health intervention<sup>10</sup>:

Man-made:

1. Acute and/or protracted conflict
2. Technological events

Natural:

3. Epidemics
4. Acute geophysical (i.e. earthquake)
5. Acute hydro-meteorological events (i.e. floods, cyclones)
6. Climatological events (i.e. slow onset drought)

Or a combination of the above<sup>11</sup>.

Generally DG ECHO will examine the following criteria when deciding whether to initiate a humanitarian health intervention:

1. The **magnitude and severity** of the crisis: a health programme will be initiated when either data from the current crisis or analyses from previous similar crises show that the level of mortality, morbidity, and/or disability has exceeded or will soon exceed commonly accepted emergency thresholds<sup>12</sup>. The size of the affected population, as well as the geographical extent of the disaster will also be taken into account.
2. The **capacity of the community and/or of local, national, or regional government authorities** to adequately respond. The ultimate responsibility for health services and interventions lies with the crisis-affected country or countries. DG ECHO may intervene only when the responsible authorities are either unable or unwilling to do so, or when they cannot fully cope with the circumstances without external assistance. In other words, both the decision to intervene, and the type and magnitude of the intervention are a function of the gap between the needs of the population and the capacity of the affected population and/or its government to meet those needs.

<sup>9</sup> - See Annex A. Indicative Decision Tree.

<sup>10</sup> - Specific aspects of responses to these crisis types are set out in Annex B Technical Guidelines. It should be noted that none of these scenarios is necessarily indicative of the magnitude of the response or of the specific components of the intervention package that DG ECHO might support. For example, interventions in the event of an earthquake that affects a low-lying area of a tropical country may be very different from those that are implemented in response to an earthquake occurring in a mountainous region of a cold-climate country. The level of response is a function of the number of people affected and the design of the response is determined by an analysis of their needs.

<sup>11</sup> - Fukushima in 2011 combined 3 types of events, each with their associated sets of proximal risk factors.

<sup>12</sup> - See footnote 5



Health center, Niger. © European Union, 2014 - photo by EC/ECHO

3. Central to the decision on responding to the humanitarian crisis will be the **degree to which DG ECHO and its partners are assured of independent access** to the affected population and of the possibility of conducting independent monitoring of DG ECHO-funded interventions.
4. In considering whether and how to respond to a crisis, DG ECHO will take into account the **comparative advantages** or disadvantages of the humanitarian financial instrument at its disposal. This will be done after careful analysis of the situation and in close consultation with both financial and operational partners (other donors, UN agencies, NGOs).

For disasters that are amenable to a *short-term response*, DG ECHO will consider phasing out its humanitarian health programme when it is established that morbidity and mortality rates and new crisis-related events leading to disability have stabilized, are below emergency thresholds or clearly show a trend in that direction, and when accessibility to basic health services has been re-established.

In *protracted crises* (such as those characterized by on-going conflict or where refugees require long-term support) and in settings where it is likely that disasters will regularly occur, on-going and future post-humanitarian (development, resilience) initiatives should be identified in partnership with other humanitarian and development agencies, prior to the progressive phasing out of DG ECHO support. Examples of these initiatives include the implementation of early warning systems, building emergency preparedness and response capacity, and ensuring sustainable access to health care.

### Case study 1: Comparative advantages

Commission humanitarian health assistance, provided through DG ECHO, has a comparative advantage through its technical expertise (RSO) and proximity to the context because of its worldwide network of field offices and international experts. This allows an up-to-date analysis of existing and forecasted needs in a given country or region, contributing to the development of intervention strategies and policies, providing technical support to DG ECHO funded operations, ensuring adequate monitoring of these interventions and facilitating donor's coordination at field level.

DG ECHO's needs-based approach allows it to respond timely to different demands in diverse humanitarian contexts, be it in acute emergencies, protracted or forgotten crises. The flexibility in its approach and funding allows DG ECHO to respond with a complete range of interventions in the health sector aiming at the highest possible impact, from preventive care measures, through basic package of health services to highly specialized health care like war surgery. Specific funding mechanisms, like the Epidemics Decision, allow DG ECHO to act fast to reduce morbidity and mortality in epidemic outbreaks.

The respect of humanitarian principles guarantees that health needs of the most vulnerable groups can be addressed in the most suitable manner. DG ECHO's clear mandate and separation from other tools of foreign policy (independence) allows a close collaboration with its partners, particularly in conflict situations. The neutrality and impartiality principles contribute to providing access to basic health services for those most in need.

# 4. Key determinants for intervention

In order to attain its objectives in all humanitarian crises, DG ECHO works by providing assistance to partners for the implementation of proposed activities. In order to determine whether or not the proposals to respond to the humanitarian health needs of a population are consistent with the goals and principles presented above, the following operational considerations are taken into account.

## 4.1 Quality

### Standards

While all proposed public health and medical interventions must adhere to accepted norms and standards<sup>13</sup> and <sup>14</sup>, the extent to which they are put into effect and the processes and approaches by which they are implemented must be adapted to the local context and take into account the level and characteristics of available funding, human resources, and technology.

*“DG ECHO funded assistance shall be delivered in a way that does not do harm to people, to the environment, or to the ability of existing health systems.”*

National guidelines should be respected whenever they exist, and as long as they are consistent with DG ECHO principles. However, if the most appropriate response to the humanitarian needs of the population requires an approach that differs from existing national recommendations, DG ECHO will endeavour to support those interventions

that most closely adhere to the principles enunciated in section 2 above. For example, if national guidelines for malaria control are deemed to be significantly less effective than current international standards, DG ECHO will advocate for and support those interventions that are most effective for saving lives.

### Do No Harm

DG ECHO funded assistance shall be delivered in a way that does not do harm to people, to the environment, or to the ability of existing health systems to recover:

- Individual and population needs are met in a way that does not expose recipients to unjustified risk from medical procedures or from public health interventions; while it is not always feasible in humanitarian settings, efforts should be made to inform populations and individuals on interventions, to obtain their

<sup>13</sup> - SPHERE, Global Health Cluster, WHO.

<sup>14</sup> - A good summary is presented in chapter 6 of: Howard N, Sondorp E and ter Veen A; 212: Conflict and Health; Open University Press.

voluntary informed consent, and to make provisions for the appropriate treatment of any secondary effects or adverse reactions arising from preventive or curative care.

- All DG ECHO-supported humanitarian health interventions will only use pharmaceutical products and other supplies that are safe and effective. When there is no guarantee that this is the case, precautions should be taken to ensure the quality of these products (FPA<sup>15</sup>). DG ECHO and partners should advocate with local authorities to remove any obstacles to the supply of safe and effective drugs.
- DG ECHO supports *medical neutrality*. Health personnel and supporting staff have increasingly become targets of violence in conflict settings; measures should be taken to provide them with the maximum level of protection possible. Where close personal interactions are involved at community level, as might be the case during mass vaccination campaigns, DG ECHO partners will ensure that appropriate security precautions are implemented. Similarly, health facilities such as hospitals, clinics and ambulances must be protected.
- When providing humanitarian assistance in the health sector, DG ECHO and its partners will ensure that there is minimal detrimental impact on the environment. Appropriate procedures regarding medical waste disposal will be supported.
- Humanitarian health agencies will avoid activities that could potentially undermine the existing health system or distort it in a way that would hinder its ability to resume normal functions when the crisis has subsided.
- The appropriateness of interventions targeting only one thematic area (e.g. mental health, reproductive health, etc.) or creating parallel health systems should be analysed. Integrated delivery of health services will be favoured. A proposal aiming at integrating thematic interventions, like those listed above, into existing health services can be supported, provided that partners agree on their integration and are willing and able to shift to the new modality of service delivery.



*Health volunteers in settlements follow-up the progress of patients; they are trained to treat minor injuries and provide medicines for common diseases. Volunteers also assist pregnant women in reaching government-run health structures, often far away. India. © European Union, 2012 - photo by EC/ECHO*

### Multi-sectorial and Integrated approaches

Health outcomes are dependent on multiple sector interventions. Therefore, a multi-sectorial integrated approach should be encouraged in the situations where this is the most appropriate response, particularly with the WASH, Nutrition, Food Security and Shelter sectors. For example, the role of health early warning and epidemiological surveillance is critical to other life-saving sectors.

Further, the Protection component of humanitarian assistance, as reflected in

<sup>15</sup> - See: [http://ec.europa.eu/echo/files/partners/humanitarian\\_aid/fpa/training/interface.html](http://ec.europa.eu/echo/files/partners/humanitarian_aid/fpa/training/interface.html)

<sup>16</sup> - See: [http://ec.europa.eu/echo/files/policies/sectoral/Prot\\_Funding\\_Guidelines.pdf](http://ec.europa.eu/echo/files/policies/sectoral/Prot_Funding_Guidelines.pdf)

## Case study 2: Panzi Hospital

*Medical and Psychosocial Assistance to Survivors of Sexual Violence and Women in Need of Specialised Gynaecological Care in South Kivu (PMU Interlife) - Panzi Hospital*

*The chronic conflict in the eastern part of the DRC is characterized by a huge incidence of sexual and gender based violence (SGBV). Over the years, the response by the humanitarian (and development) actors has scaled up and thousands of victims receive some form of assistance each year.*

*The Panzi hospital is one of the main providers of services for victims of SGBV in South Kivu. While some institutions have limited capacity and can address only part of the needs, the Panzi Hospital aims at providing services that are holistic as well as personalized, combining medical and psychosocial assistance as well as referral for legal assistance*

*(if requested by the victim). In addition to the comprehensive services for the victims of SGBV, women with complex gynaecological problems (e.g. fistula) are offered surgical care.*

*Efforts to roll out this comprehensive approach further to community-level should be encouraged. Health providers at the primary healthcare facilities are critical in offering and coordinating care and services needed by those victims.*

*The European Commission Humanitarian Aid department (DG ECHO) has supported Panzi Hospital since 2004 through the SSV (Survivors of Sexual Violence)-project which is co-financed and implemented by PMU). Between 2004 and 2012, the project supported by DG ECHO financing has provided care for 29,408 patients.*

DG ECHO's guidelines on protection<sup>16</sup>, should always be taken into account in health interventions. In the health sector this would include any kind of medical and psycho-social assistance to victims of violence. For the same reason any discrimination in access to health care should be opposed and sensitisation/training interventions based on equal access to health services should be encouraged and implemented. In particular, health interventions should assess the need to offer care to survivors of sexual and gender based violence (SGBV), given the core role of medical care in a comprehensive response to SGBV as set out in DG ECHO's Gender Policy<sup>17</sup>.

Similarly, positive health outcomes are dependent on the ability of partners to provide a broad range of services. Individual interventions should thus be encouraged to be as broad as possible as determined by health needs, and not be based on agency preferences. For example, mental health and reproductive health programmes should be integrated into primary health care instead of being implemented through vertical approaches.

### Needs Assessment and Response

The initiation of humanitarian assistance does not need necessarily to wait for a quantitative needs assessment to be completed. Early assistance should, however, include the conduct of a needs assessment, which should also produce gender and age disaggregated data<sup>18</sup>. The results of this early needs assessment will determine the nature and magnitude of the overall health sector response, although the planning and early initiation of certain common interventions, such as vaccination, can be carried out without waiting for its results. Needs assessments, as well as other monitoring activities, should be conducted regularly to determine, on an on-going basis, the scale and nature of assistance required.

<sup>17</sup> - See: SWD on Gender in Humanitarian Assistance: Different Needs, Adapted Assistance [http://ec.europa.eu/echo/files/policies/sectoral/gender\\_thematic\\_policy\\_document\\_en.pdf](http://ec.europa.eu/echo/files/policies/sectoral/gender_thematic_policy_document_en.pdf); IASC, *Guidelines on Gender-Based Violence Interventions in Humanitarian Settings, 2005* and the *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations*.

<sup>18</sup> - See also DG ECHO gender policy and DG ECHO gender marker toolkit both to be approved soon.



Ebola in Guinea © European Union - photo by EC/ECHO

Such assistance must attend to the specific health needs of different groups of the affected populations, including women (for example, sexual and reproductive health in emergencies) and elderly persons (who may have specific medical conditions and reduced mobility).

### *Case study 3: Role of civil protection in complementing the Commission humanitarian health operations*

*Particularly in rapid onset natural disasters such as earthquakes, floods, cyclones, nuclear or environmental disasters, there is a great opportunity, in the acute phase, to promote increased cooperation between the Commission funded health actions and the emergency health civil protection components supported by EU member states.*

*Both humanitarian assistance and civil protection contribute to the direct health response activities immediately after the disaster struck. Joint needs assessments (between humanitarian aid and civil protection components of DG ECHO), joint planning and strategizing will be encouraged and should lead to joint actions by the two components.*

*Civil protection teams and humanitarian partners will be called upon to establish immediate triage systems, medical evacuation and emergency health posts and trauma treatment centres.*

*In addition, measures to prevent and mitigate public health hazards will have to be established immediately*

*after the first response, while the health delivery system (preventive and curative) is recovered as quickly as possible.*

*In a typical case, foreign medical civil protection teams will set up a field hospital for hundred thousand affected people in an acute crisis. This hospital, if cost-effective, may be handed over to a DG ECHO-financed partner. If well-coordinated and streamlined, this “in kind” support, often complemented by technical assistance provided by the EU Civil Protection teams can enhance considerably the capacity of the EC and Member States to support the affected country and the humanitarian partners in their response to a crisis, when running costs are affordable.*

*Commission humanitarian partners are potential recipients of assets brought in by the Civil Protection teams. Civil protection teams should ensure adequate installation and appropriate initial use of the assets and guarantee that sufficient know-how and expertise is available after handover.*

*Free access to care.* As a general rule, health services provided under DG ECHO funding should be free at the point of health care delivery<sup>19</sup>.

An early response to the needs assessment will typically include a *Basic Package of Health Services* – a package of interventions designed to meet the most important health needs of all segments of the population at community, primary care and, at times, hospital level.

“In some humanitarian settings, the health needs of the population are not limited to acute conditions and do not match up well with the short-term assistance that DG ECHO is mandated to provide.”

In some humanitarian settings, the health needs of the population are not limited to acute conditions and do not match up well with the short-term assistance that DG ECHO is mandated to provide. For example, *chronic infectious diseases* such as AIDS and tuberculosis may be highly prevalent in some crisis-affected populations. Further, and especially in

middle- and high-income countries, addressing *chronic non-communicable diseases* such as diabetes and cardiovascular conditions may constitute an “appropriate level of care”. Furthermore, the demographic patterns are changing and elderly persons may require specific assistance during emergencies, including in poor settings.

<sup>19</sup> - See: Annex D - DG ECHO Position Paper on User Fees. [http://ec.europa.eu/echo/files/policies/sectoral/health\\_2009\\_note\\_on\\_user\\_fees.pdf](http://ec.europa.eu/echo/files/policies/sectoral/health_2009_note_on_user_fees.pdf)

## Case study 4: Basic Package of Health Services (BPHS)

BPHS are policy documents prepared by the Ministry of Health describing the services that should be available at different levels of the health care system of the country. Usually, levels of health care system concerned by BPHS range from Community level to District Hospital (or first level of hospital referral); the intermediate level includes different types of health clinics.

Many countries in post conflict situation have adopted a BPHS, for instance: Afghanistan, Sierra Leone, South Sudan and Liberia.

The rationale for adopting a BPHS is to optimise the allocation of resources available for the health sector in order to have the best possible impact on the burden of diseases. The contents of the BPHS depend on the level of resources allocated to the health sector, the available technical capacity as well as the local health situation and epidemiological profile.

The types of services usually included in the BPHS are:

- Maternal and Child Health
- Immunisation
- Nutrition
- Control of Communicable diseases
- Mental Health

In some cases BPHS include interventions at community level, such as school health or environmental health.

BPHS often include regulation on Drug Supply and Blood Transfusion policies.

For each service included in the BPHS there is a description of the types of intervention taking place at different levels of the health system.

For each level, a description of staff involved in service delivery, with their job description, equipment and drugs used is usually provided.

In the context of a DG ECHO intervention, it is important to be aware of the presence of a BPHS in the country, to appraise its relevance and level of implementation, especially with regard to the presence and level of personnel, medicines and equipment available. The funding situation of the BPHS should be assessed as well.

DG ECHO interventions can temporary support a relevant BPHS in circumstances where the support by the government has been disrupted by a crisis.

Interventions not included in the BPHS can be proposed to cover emerging needs that were not considered in the BPHS.

The expansion of the geographical scope of the BPHS can be considered when targeted populations are located in an area with low or no coverage, or when the displacement of population temporarily overwhelms existing local health system. The extension must pay attention to existing human resources and supply systems



Vaccination in West Africa. © European Union, 2009 - photo by EC/ECHO

DG ECHO will strive to ensure access to continued care for patients with *chronic diseases*, in line with national policies. In all instances, when DG ECHO, through its partners, takes responsibility for continuation of treatment, it must also make all efforts to ensure that medical care for all patients being supported continues if and when it decides to end its funding of the humanitarian intervention. It can do so through consultation with other donors, development partners, and, if appropriate, national authorities.

Consequently, in the interests of affordability and quality, a credible exit strategy is required for engaging partners in providing humanitarian assistance to patients with chronic conditions. The decision on addressing chronic conditions is challenging. In an acute crisis, such a natural disaster, DG ECHO is clearly not the most appropriate agency to provide support for patients requiring long-term care and its partners should be encouraged to seek other sources of funding. However, in certain circumstances, and possibly when DG ECHO support is provided, on an exceptional basis, for a longer period, consideration can be given to supporting the treatment and management of newly-diagnosed chronic health conditions.

Public health and medical care rely on support systems that may or may not be identified in a rapid needs assessment. For example, support to *diagnostic laboratories* may be one of the priorities<sup>20</sup>. When more sophisticated equipment is required and where distance or other factors might hinder the ability of patients to access appropriate treatment in a timely manner, DG ECHO will decide its support on a case-by-case basis.

## Case study 5: High impact interventions

*In crisis settings, mass vaccination campaigns are a means to immunize a large population, in order to prevent an epidemic risk.*

*In some countries with a weak health system, regular and planned mass campaigns are sometimes used to compensate the gaps of routine immunization programmes and to increase the coverage of the population. These campaigns are carried out with a door-to-door approach to reach the highest coverage. The best example is the NID (National Immunization Days), a strategy used to eradicate Polio (1 campaign every 6 months)*

*Many activities which are not well carried out on a routine basis may be conducted during those campaigns:*

- *Measles immunization.*
- *Health education and hygiene promotion.*
- *Vitamin A supplementation.*
- *De-worming.*
- *Screening of US children for malnutrition.*
- *NFI Kit delivery: Hygiene/Wash kit (e.g. soap, Aquatabs) to prevent diarrhoea and cholera, LLIN to prevent malaria.*

*These specific preventive activities require mobilizing staff and a strong logistics, but only during a short period. They will ensure a better coverage than through routine activities, but should not substitute for regular programmes that need to be strengthened.*

<sup>20</sup> - Where appropriate and where the quality of diagnostic products can be assured, for example for malaria, cholera, and pregnancy, DG ECHO will prefer to support the provision and use of rapid diagnostic tests that can be applied at community or first-level health facilities, but will also support the installation of new laboratories and the strengthening of existing laboratories to support primary health care activities or to meet basic hospital needs.



Patients receive health attention at the mobile clinic set up, Leogane, Haiti. © European Union, 2010 - photo by EC/ECHO/Paul Hahn Johanniter

### Monitoring and evaluation

In all humanitarian settings where it intervenes, DG ECHO will support the establishment, if absent, or the strengthening of early warning systems<sup>21</sup> in order to be informed of the occurrence of diseases of epidemic potential at the earliest possible moment, and to be able to support a rapid and effective response.

Similarly, DG ECHO encourages the implementation of routine epidemiological surveillance systems in order to be able to better monitor trends of common diseases. As a general rule, DG ECHO strongly encourages the disaggregation of epidemiological data by gender and by age. All reporting mechanisms should be harmonized to the extent possible with existing systems and use established reporting channels, wherever it is feasible.

In all humanitarian settings, monitoring of humanitarian interventions should be unhindered, objective, and independent.

21 - [http://www.who.int/diseasecontrol\\_emergencies/publications/who\\_hse\\_epr\\_dce\\_2012.1/en](http://www.who.int/diseasecontrol_emergencies/publications/who_hse_epr_dce_2012.1/en)

## Participation

Health programmes will be designed to the extent possible with the participation of:

- The affected populations.
- Other stakeholders such as legal/traditional representatives of populations.

The cultural values of the affected communities, which may differ across populations, should be respected and taken into account in the design of interventions, as long as they are consistent with the humanitarian principles presented in section 2 above. Community participation in the implementation of relief programs is important. Appropriate representation from all segments of society, especially the most vulnerable, should be sought.

For humanitarian health assistance, community participation may be more appropriate when deciding how to implement interventions than for deciding what interventions to implement. Interventions should be based solely on the health needs of the population and not only on their preferences<sup>22</sup>. For example, communities might not consider a measles vaccination campaign as a high priority, although the evidence has clearly shown that measles can be a leading cause of death in humanitarian settings. However, community participation concerning issues such as the best times to vaccinate, selection of vaccination sites, and provision of security measures would be invaluable.

*“Interventions should be based solely on the health needs of the population.”*

## 4.2 Improving responses

### Innovation and research

DG ECHO will consider funding activities, including innovative or previously untested approaches, methods or instruments and tools, which are aimed at advancing the evidence base and the quality of practice in the humanitarian health sector when:

- a) The ultimate goal is to significantly improve the health status of the affected populations. Research should aim to overcome barriers to the successful implementation of health programmes in humanitarian settings and should always be in the interest of the beneficiaries. DG ECHO does not support basic research or any research that is not specifically directed at emergency interventions and could be conducted in stable settings and populations.
- b) Research is secondary to operations and should not be the entry point or the justification for the initiation of any country program.
- c) Any research must adhere to the highest international ethical standards and all research protocols must have been submitted and approved by the relevant and established ethical review board (National and International).
- d) Research results either positive or negative should always be reported with free access and explained to the involved populations.

<sup>22</sup> - The Humanitarian Emergency Settings Perceived Needs Scale (HESPER) provides an example on how community perceptions and priorities can be usefully gathered [http://www.who.int/mental\\_health/publications/hesper\\_manual/en/index.html](http://www.who.int/mental_health/publications/hesper_manual/en/index.html)

- e) Partners should have the required technical expertise to conduct research – evidence must be available to support this.

### Resilience, DRR and Preparedness<sup>23</sup>

DRR, disaster preparedness and resilience are relevant in every aspect of a health sector humanitarian response. ECHO requires that all humanitarian action it supports be based on a sound assessment of risk and the intervention should seek to reduce immediate and future risks.

DG ECHO expects partners to reach an understanding why health systems were vulnerable, why there were health needs and to identify opportunities where humanitarian assistance can contribute to building health system capacities, and to contribute to reducing vulnerabilities and health risks, subject to maintaining humanitarian principles.

*“ECHO requires that all humanitarian action it supports be based on a sound assessment of risk and the intervention should seek to reduce immediate and future risks.”*

Wherever possible, Partners are expected to co-ordinate with development partners, from different sectors and at different levels (e.g. local and national), and to ensure their interventions contribute to, or lay the foundations for, longer term strategies to reduce future humanitarian health needs. This

is particularly important in protracted or recurrent crises where a greater emphasis must be placed on building capacities and addressing causal reasons for vulnerability.

### Human resources and local capacity building

Commission humanitarian health assistance should be risk informed, including provisions to respond to further demands if risks materialise, and to consider contributing to capacity building that will reduce future humanitarian health needs. Specifically, health responses require qualified staff to implement the interventions. Increasing the competence of local staff, women and men<sup>24</sup>, to allow them to make a maximum contribution is often necessary. In many settings there is a lack of sufficiently trained local staff to implement humanitarian interventions. Consequently, there is a need to upgrade the capacity of available staff to deliver quality services. Contracting already qualified local staff working in the public or private national health sector should be kept at a minimum, as a means to address those needs and paying attention to the negative effects that this may exert on the capacity of the health system.



Many humanitarian workers providing life saving care around the world are women. In this image, a nurse with one of ECHO's partners in Haiti, Johanniter, takes care of a woman injured in the 2012 earthquake. ECHO funding has helped hundreds of injured people heal their wounds, receive prosthetic limbs and psychological support. © European Union, 2010 - photo by EC/ECHO/Johanniter/Paul Hahn Juli

<sup>23</sup> - Commission Resilience Communication and SWD [http://ec.europa.eu/echo/policies/resilience/resilience\\_en.htm](http://ec.europa.eu/echo/policies/resilience/resilience_en.htm); and DG ECHO Disaster Risk Reduction Policy Document [http://ec.europa.eu/echo/files/policies/prevention\\_preparedness/DRR\\_thematic\\_policy\\_doc.pdf](http://ec.europa.eu/echo/files/policies/prevention_preparedness/DRR_thematic_policy_doc.pdf)

<sup>24</sup> - A balanced staff composition (women and men) better addresses the needs of the women, girls, boys and men.

To alleviate this situation DG ECHO financed interventions can be delivered via the existing health system and/or can include a capacity building or on-the-job-training component, with a direct impact on the quality of services provided, with the added benefit that those capacities may remain and serve as stepping stone for the eventual post-crisis. This has to be organised in line with the existing national training framework and human resources management, so to facilitate the integration of trained staff into the national health system. Training programmes should be harmonised with those implemented by other partners and supported by other donors.

### Case study 6: Health interventions in building Resilience<sup>25</sup>

*“Resilience is the ability of an individual, a household, a community, a country or a region to withstand, adapt and to quickly recover from stresses and shocks” (EU Communication on Resilience).*

*Building resilience involves joint action by development and humanitarian stakeholders to identify and address underlying causes of vulnerability and risk in the short, medium and long term. This requires a multi-sectorial, and multi-level, approach aimed at reducing risks and improving coping capacities of vulnerable communities and households/individuals.*

*In addition to activities in food security/agriculture, nutrition, WASH and livelihood support, the following health interventions play an important role in the resilience building process at different levels:*

#### **At Individual/household level:**

- Preventive and promotional health activities, for instance health education, hygiene promotion and immunization.
- Help the most vulnerable groups cope with problems in accessing health care services through solidarity mechanisms, for instance the fees exemption systems for vulnerable groups (US and PW).

#### **At community level:**

- Strengthen the capacity of the community to cope with recurrent crisis (epidemics,

*flood, drought), through community based interventions in order to mitigate the impact on their health.*

- Community based programmes through multi sector approach (Health, Wash, Nutrition) designed and implemented with the community.
  - Community Health worker network strengthening
  - Promotion of outreach services to access remote and forgotten populations
  - Disaster Risk Management, for instance training in first aid and community disease surveillance.
- Advocate with local decentralized administrations for sustainable financing of the community based interventions.

#### **At national level:**

- Support health system in the delivery of Basic Package of preventive and curative health services at periphery level.
- Support multi-sectorial platforms to coordinate the resilience interventions.
- Promote better integration of nutrition interventions into the health sector.
- Strengthen Risk Analysis and Mapping, Early Warning and Surveillance.
- Strengthen Emergency/Disaster preparedness within the health sector.
- Promote the ‘safe hospital’ concept.

# 5. Coordination

## Case study 7: Global Coordination and Global Capacity Building

*In order to maximize impact, promote quality and the best use of funds to ensure health delivery in humanitarian settings, DG ECHO strongly supports coordination across the humanitarian health sector at global level. The Global Health Cluster has an important role, both for participating agencies and other major health actors. The role of the Global Health Cluster should be independent of any agency specific concerns, and with demonstrable benefits both for those agencies that decide to participate and cooperate with this mechanism.*

*Global health coordination should build on, and facilitate effective coordination at country and regional level, and should provide the ultimate surge capacity to support a health coordinated response to major humanitarian crises. It should be the repository of learning and best practice for humanitarian health response, and the main forum for the identification of priority areas to be addressed, including through global capacity building, to ensure the best delivery of health care in humanitarian settings.*

Achieving the objective of humanitarian aid requires maximizing impact, avoiding gaps and duplication, increasing coverage, scaling-up interventions and facilitating the post-crisis handing over of activities to the health authorities and to the development actors who have initiatives in health. DG ECHO will pay particular attention to enhanced coordination and will strive for a higher degree of coherence and complementarity in four different ways:

1. DG ECHO will fully cooperate with and support the aims of the Transformative Agenda and its endeavours to optimize operational and strategic coordination on country (or regional) basis. Where there is no contradiction with basic principles, such as the neutral and non-partisan nature of humanitarian assistance, this will include support to the Humanitarian Coordinator and the Humanitarian Country Team; and in particular to its health programme coordination tools (be it the health cluster or an equivalent Government structure functioning as main coordinating body for the health sector). This will include support to the joint humanitarian planning process for the health sector, including joint needs assessment, joint humanitarian strategy and joint action plan.
2. DG ECHO will aim at full coordination and streamlining of its health programmes with other parts of the EU (Commission and EU member states) and with other donors (humanitarian and development). For example, in the context of LRRD and Resilience building programmes this approach will result in seeking the best transitional solutions, avoiding isolated humanitarian actions without sustainability and participating in priority setting for research with great potential impact on humanitarian needs.
3. Health assistance in humanitarian contexts will be designed and carried out to the maximum extent possible in close coordination, alignment and harmony with the existing national policies and strategies. DG ECHO interventions will comply with national standards and regulations related to the implementation of health activities, as long as they do not contradict the basic principles of DG ECHO's health assistance<sup>26</sup>.

<sup>26</sup> - See section 4.1 Quality: Standards.

4. Internationally deployed military forces involved in peace operations or disaster response should provide direct or indirect health assistance to civilians only as a last resort, i.e. in the absence of any comparable civilian alternative and to meet the critical needs of the affected population. Maintaining humanitarian identity, independence and neutrality is paramount. Humanitarian actors should be aware of the perceptions of stakeholders and how different degrees of civil-military coordination may change local perceptions of their impartiality, as stated in the global health cluster position paper on civil-military coordination<sup>27</sup>.

“ Humanitarian actors should be aware of the perceptions of stakeholders and how different degrees of civil-military coordination may change local perceptions of their impartiality. ”

### Case study 8: Humanitarian Health for Refugees

*Humanitarian Health for Refugees is a good example of coordination needs, both regarding the specific needs in refugee situations, and the need to remain coordinated with the broader learning of global health coordination bodies such as the Global Health Cluster. In the beginning of a refugee emergency the risk for epidemics and excess mortality through common diseases (diarrhoea, ARI, malaria) is usually very high. This is usually related to overcrowding, hardship, lack of adequate water, sanitation, shelter and the consequences of the displacement itself.*

*Organisation of health services in this phase is largely directed to avoid excess mortality while other services are being organized. It is very important to provide basic curative health care services as a priority (including secondary care). Other urgent measures are measles vaccination, setup of a surveillance system to detect epidemics and monitor mortality rates and coordination.*

*Refugee settings are also characterized by high number of patients using health services especially in the emergency phase. Usually local health services cannot cope which may aggravate tensions with the local population. Therefore in a lot of cases parallel health services are set up.*

*In the post-emergency phase the usual setup for refugee health care:*

- 1. A referral hospital: especially needed for surgery and obstetric emergencies (if possible in an existing facility).*
- 2. A central health facility: this facility should be able to cope with most diseases and should include basic hospitalization and 24 hours services.*
- 3. Peripheral health services which should only deal with the basic diseases.*
- 4. An outreach program with home visitors. They act as the link between population and the health facilities and should especially be involved in active case finding, defaulter tracing and health information campaigns.*

*However, there is no single model for organisation of health services for refugees as it is largely defined by the context (urban refugees, camps or dispersed along local population), the disease patterns and existing resources and health facilities.*

*In the setup for health services after the emergency should also be looked at the setup/continuation of other services like HIV, TB and non-communicable diseases (hypertension, diabetes).*

## 6. Advocacy

1. DG ECHO's overall advocacy towards different actors on the respect of IHL in conflict as well as of humanitarian principles and space should include: the issue of humanitarian health workers, health facilities and ambulances increasingly becoming targets of violence and the need for respect of the medical mission.
2. Where the evidence basis for health interventions in humanitarian settings is either weak or not available DG ECHO will advocate with partners, research institutions and other stakeholders to improve evidence-based actions in these areas.
3. Advocacy beyond the humanitarian sphere for durable solutions before, during and after humanitarian emergencies requires action in different areas. This may include advocacy with development donors and agencies for the promotion of free access to health care in emergencies and enlarged free access to primary health care services. In line with the resilience paradigm, this will also include a contiguous multi-sectorial approach. Finally, DG ECHO will promote a greater involvement of the humanitarian health community in the development and follow-through of the post 2015 Hyogo framework for Preparedness and DRR, as well as the post 2015 Millennium Development Goals health agenda.
4. To maximise the impact of advocacy messages, DG ECHO will consider its engagement in common humanitarian advocacy platforms, such as the advocacy component of the Global Health Cluster.



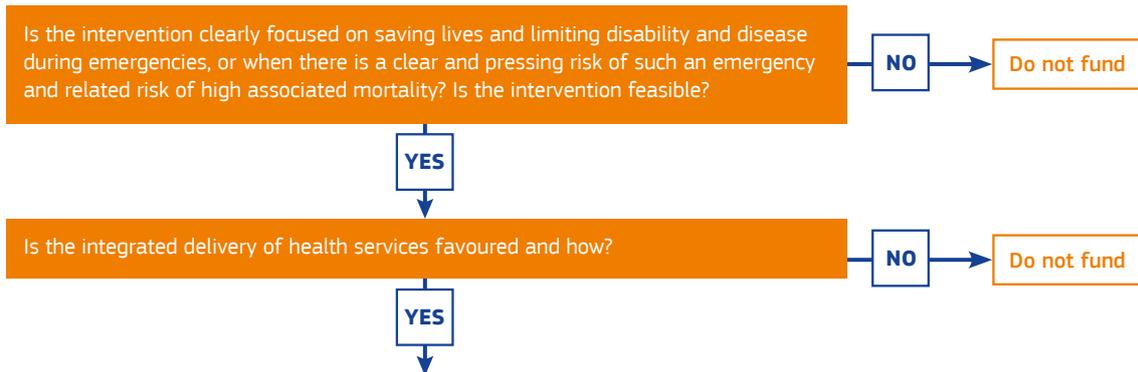
Overall, humanitarian health needs are both increasing, and becoming increasingly complex. Beyond the funding implications, the capacity of dedicated humanitarian health actors is becoming surpassed. This is especially the case in prolonged and complex man-made disasters. In the broader context, ensuring effective and sustainable health systems in the many fragile and vulnerable contexts where humanitarian assistance is most often required remains highly problematic. This is a challenge to increase the impact of available resources within, and beyond, the humanitarian health sphere. Advocacy for humanitarian health should build on the measures set out in these Guidelines in a way to achieve concrete progress in addressing the looming challenges for humanitarian health assistance.

# Annexes

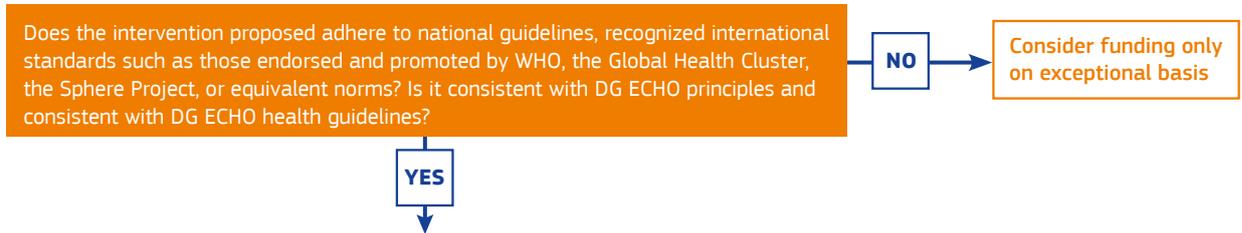
## Annex A: Indicative Decision Trees

### Concise Indicative Decision Tree for Emergencies

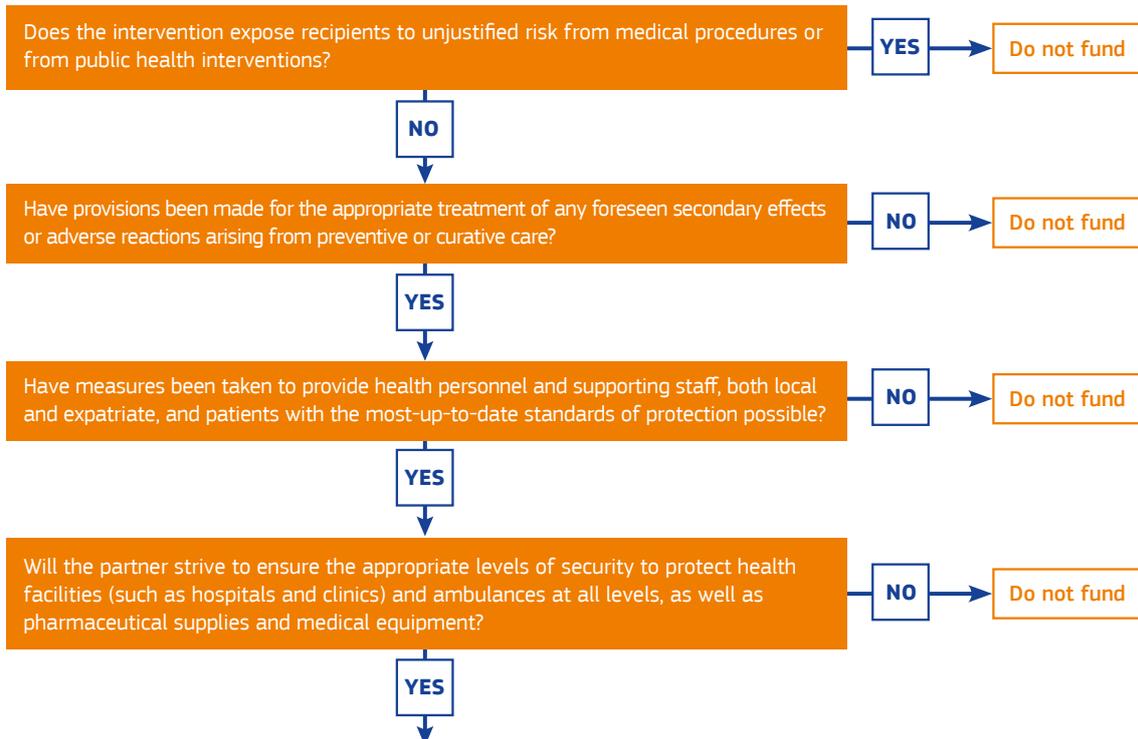
#### 1) Does Proposal Respond to Needs?



#### 2) Does Proposal Adhere to Standards?



#### 3) Does Proposal Do No Harm?



#### 4) Does Proposal Have Beneficiary Participation?

Does the intervention preserve the dignity of the beneficiaries (i.e. women, girls, boys, men, elderly, disabled, psychiatric patients)?

NO

Do not fund

YES

#### 5) Is Proposal Integrated?

Is the proposed intervention articulated with other sectors within the larger public health approach - namely with WASH, Nutrition, Food Security and Shelter?

NO

Consider funding only on exceptional basis

YES

Is the protection component of humanitarian assistance, particularly Sexual and Gender Based Violence (SGBV) integrated?

NO

Consider funding only on exceptional basis

YES

#### 6) Is there a Monitoring and Evaluation Component?

Is an early warning system available or will it be set up, to inform of the occurrence of diseases of epidemic potential at the earliest possible moment, and to support a rapid and effective response?

NO

Do not fund

YES

Will health services be provided for free at the point of health care delivery?

NO

Do not fund

YES

Does the intervention explain the coordination with the health sector?

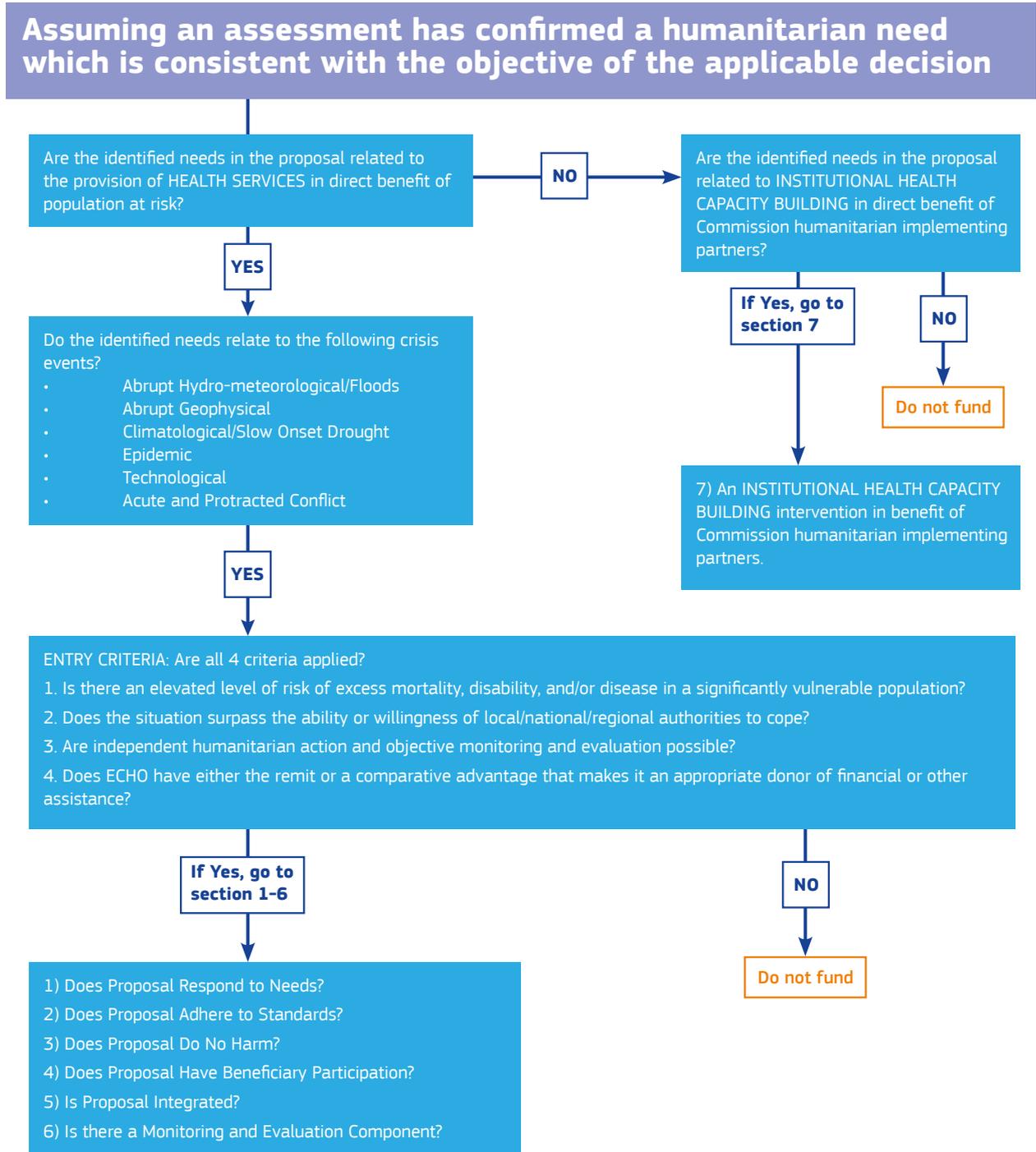
NO

Do not fund

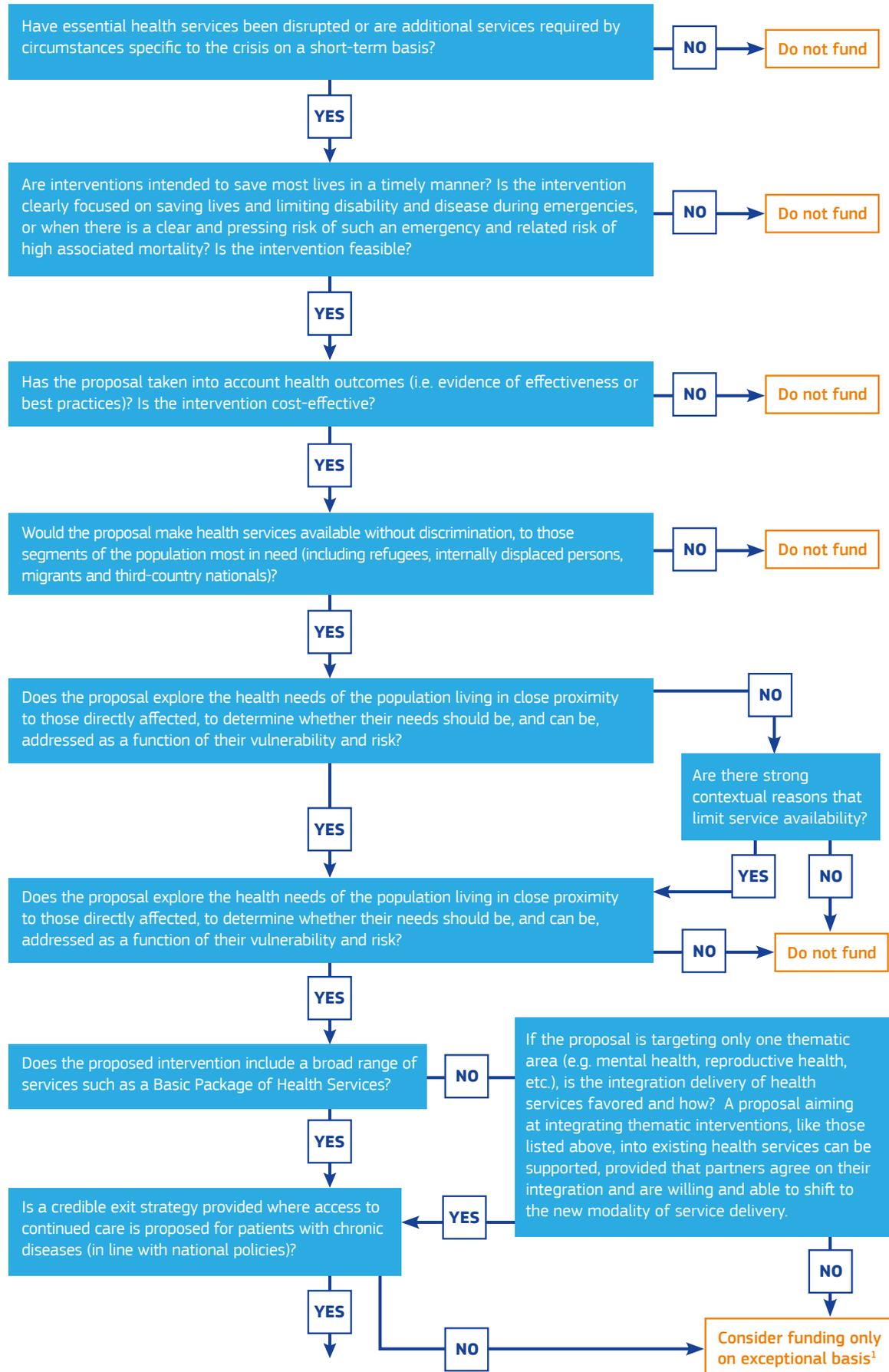
YES

Consider funding

Full indicative decision tree

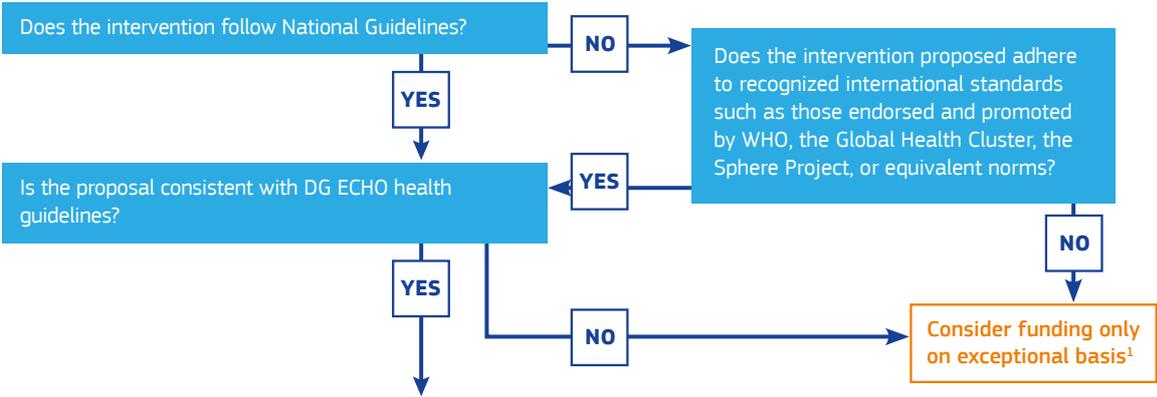


## 1) Does Proposal Respond to Needs?

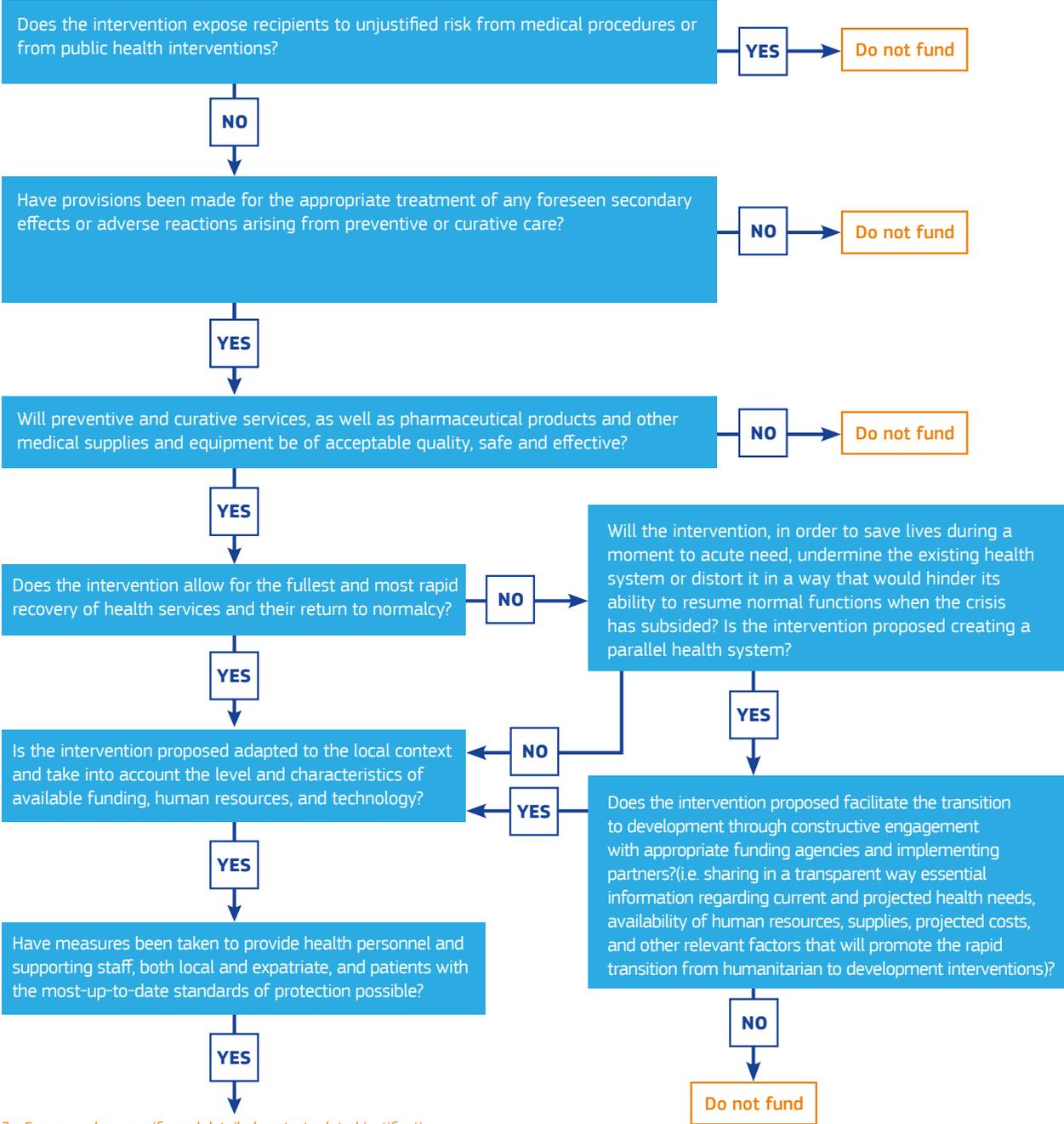


<sup>1</sup> - Criteria would include: the appropriateness of DG ECHO comparative advantages in addressing the needs, and the clear and substantiated lack of alternatives (including advocacy); the gravity of the consequences of DG ECHO not engaging being greater than those of a DG ECHO engagement which, having started, cannot be sustained; and a clear communication on the limitations for any sustained DG ECHO engagement.

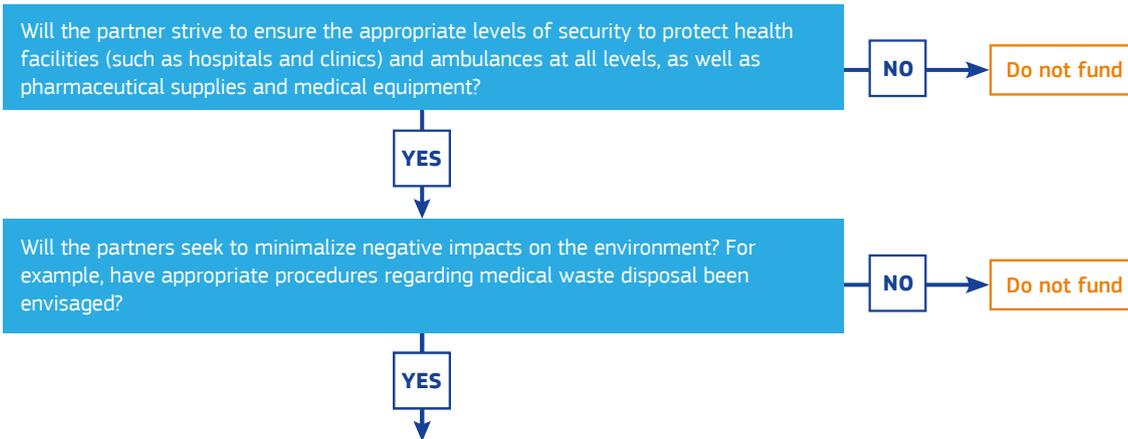
## 2) Does Proposal Adhere to Standards?



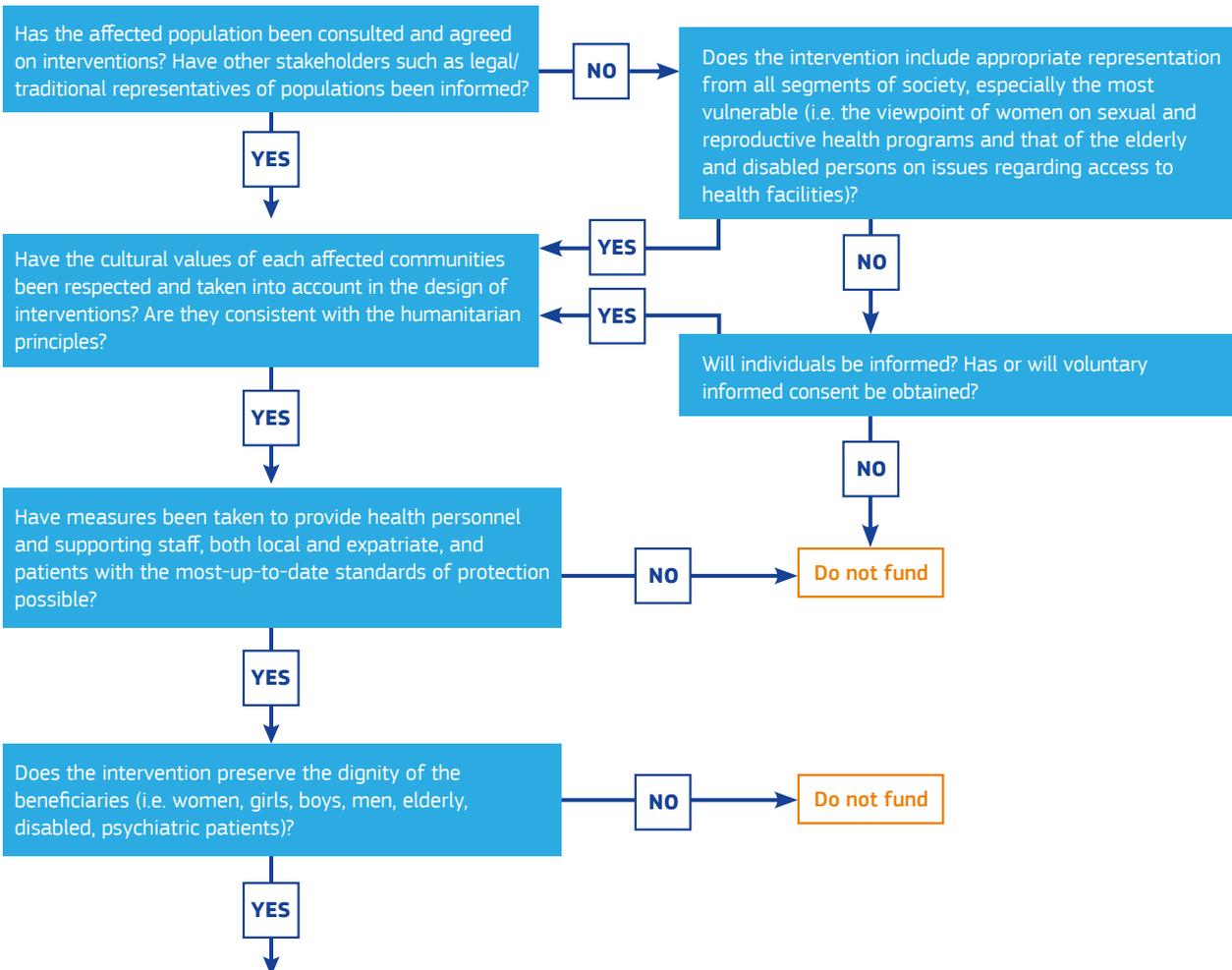
## 3) Does the Proposal Do No Harm?



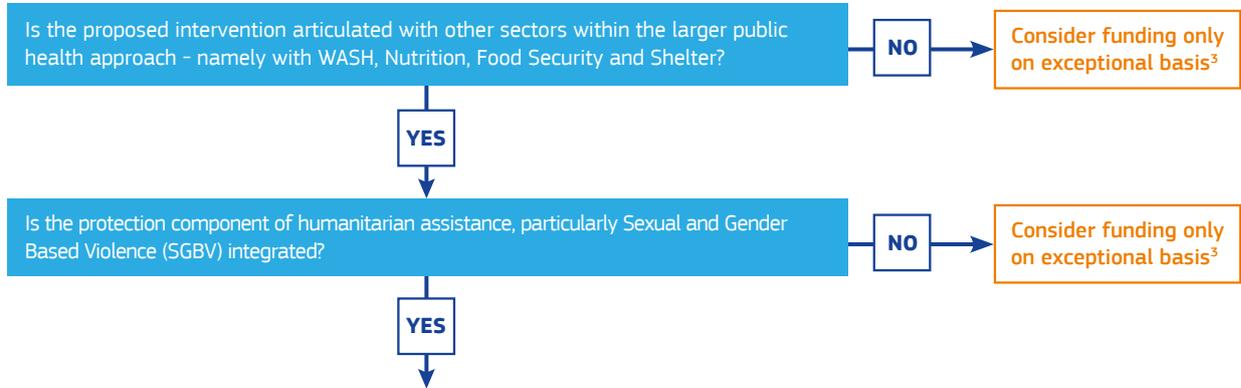
2 - For example a specific and detailed context related justification.



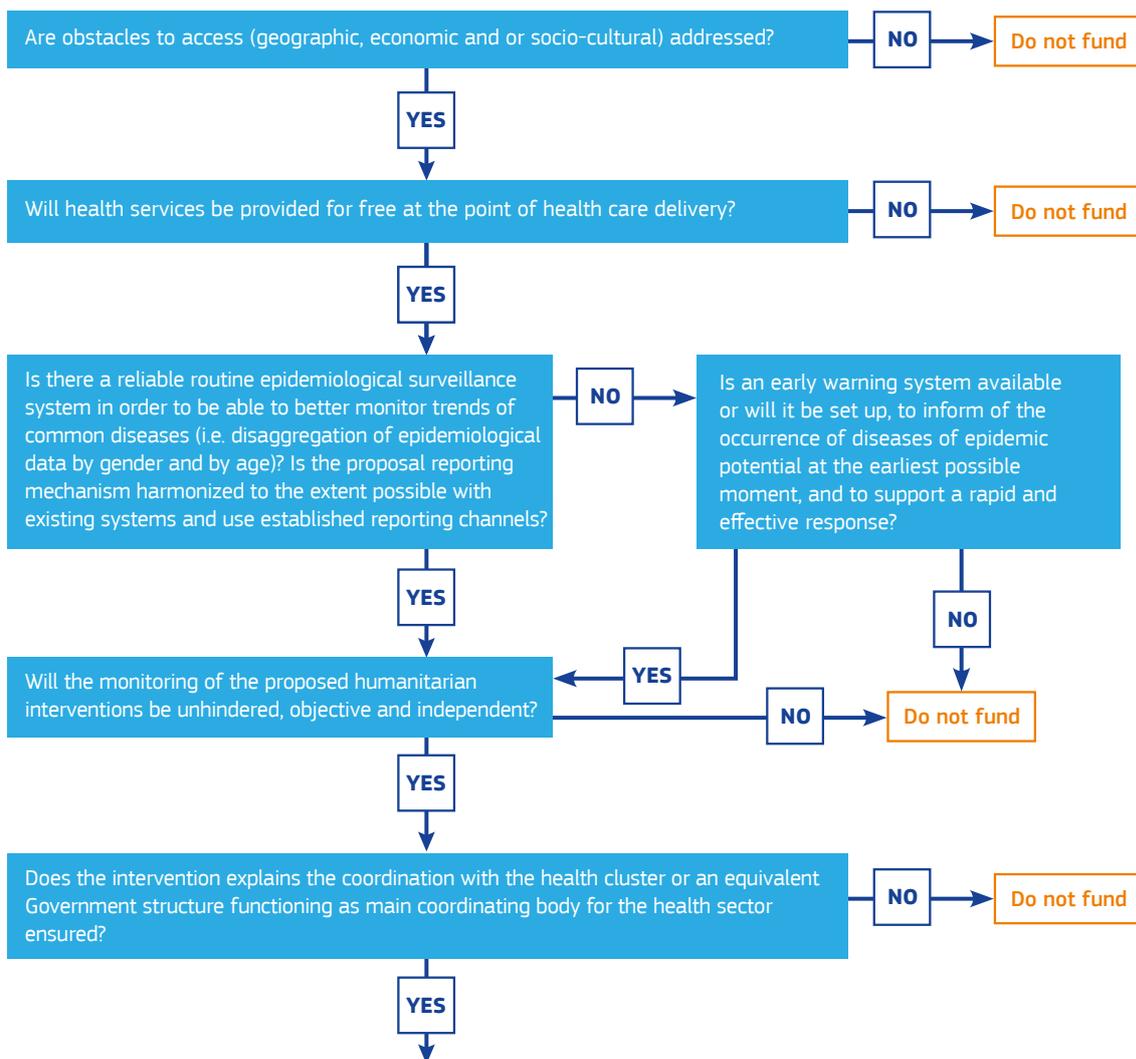
### 4) Does Proposal Have Beneficiary Participation?



### 5) Is Proposal Integrated?

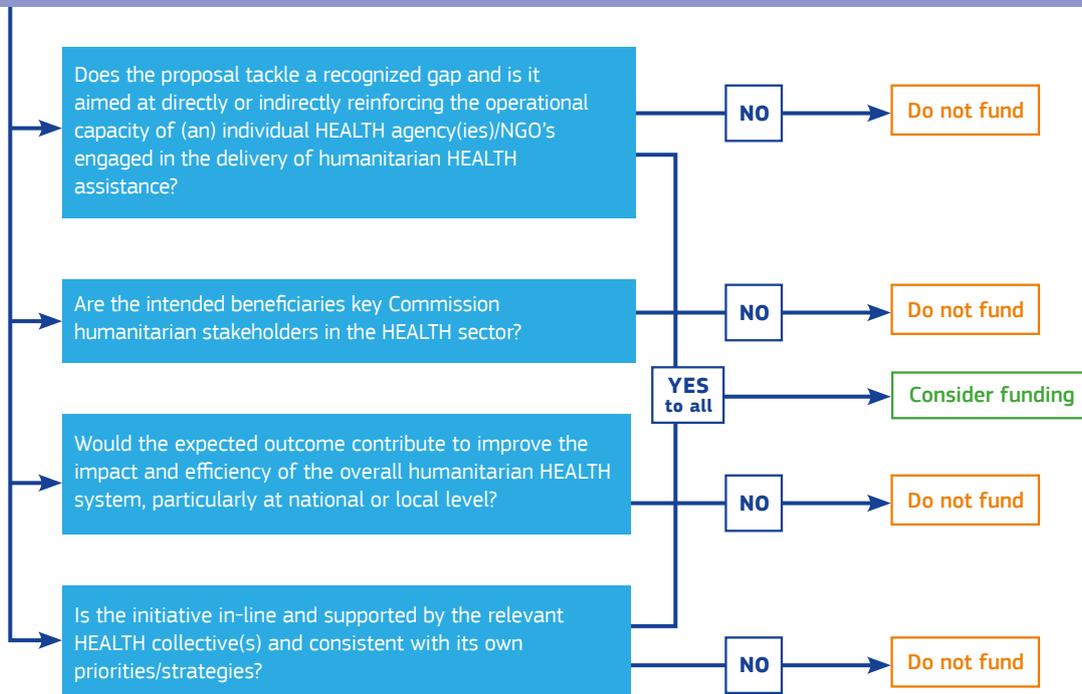


### 6) Is there a Monitoring and Evaluation Component?



<sup>3</sup> - Only if for emergency life-saving assistance for which there is no alternative.

## 7) An INSTITUTIONAL HEALTH CAPACITY BUILDING intervention in benefit of Commission humanitarian implementing partners.



## Annex B: List of Acronyms

<b>ABC</b>	Categorisation of medicines by spend, A being highest
<b>ACT</b>	Artemisinin Combination Therapy
<b>AEFI</b>	Adverse Events Following Immunisation
<b>AFD</b>	French Agency for Development
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ANC</b>	Ante-Natal Care
<b>ANC1</b>	Ante-Natal Care First Trimester
<b>AOP</b>	Aspect Oriented Programming
<b>AR</b>	Attributable Risk
<b>ARI</b>	Acute Respiratory Infection
<b>ART</b>	Anti-retroviral therapy
<b>ARV</b>	Anti-retroviral
<b>AU</b>	African Union
<b>BCG</b>	Bacillus Calmette-Guéria tuberculosis vaccine
<b>BEMOC</b>	Basic Emergency Obstetric and newborn Care
<b>BMS</b>	Breast Milk Substitute
<b>BoR</b>	Bed occupation Rate
<b>BPHS</b>	Basic Package of Health Services
<b>C2D</b>	Contrat Désendettement-Développement (Debt Reduction and Development Contract)
<b>CBR</b>	Community-based rehabilitation
<b>CCHF</b>	Crimean-Congo haemorrhagic fever
<b>CEMOC</b>	Comprehensive Emergency Obstetric and newborn Care
<b>CFR</b>	Case Fatality Rate
<b>CHW</b>	Community Health Worker
<b>CMAM</b>	Community-based Management of Acute Malnutrition
<b>CSB</b>	Corn Soy Blend
<b>CSF</b>	Cerebrospinal fluid
<b>CT</b>	Computed Tomography
<b>CTC</b>	Community-based Therapeutic Care
<b>CTU</b>	Cholera Treatment Unit
<b>CTX</b>	Cotrimoxazole
<b>DEET</b>	N,N-Diethyl-meta-toluamide
<b>DEN1-4</b>	Dengue viruses
<b>DFID</b>	Department for International Development
<b>DG ECHO</b>	Directorate General for Humanitarian Aid and Civil Protection
<b>DHF</b>	Dengue haemorrhagic fever
<b>DPT</b>	Diphtheria, pertussis, tetanus
<b>DPT1</b>	1st DPT vaccine
<b>DPT3</b>	3rd DPT vaccine
<b>DRC</b>	Democratic Republic of Congo
<b>DRR</b>	Disaster Risk Reduction
<b>EC</b>	European Commission
<b>EDL</b>	Essential Drugs List
<b>EPI</b>	Expanded Programme on Immunisation
<b>EU</b>	European Union
<b>EWARN</b>	Early Warning and Response Network
<b>EWARS</b>	Early Warning and Response System
<b>FED</b>	European Development Fund
<b>FP</b>	Family Planning
<b>FPA</b>	Framework Partnership Agreement
<b>GAVI</b>	Global Alliance for Vaccination and Immunisation
<b>GBV</b>	Gender Based Violence

<b>GFATM</b>	Global Fund to fight AIDS, Tuberculosis and Malaria
<b>GMP</b>	Good Manufacturing Practices
<b>GPARC</b>	Global Plan for Artemisinin Resistance Containment
<b>GPIRM</b>	Global Plan for Insecticide Resistance Management
<b>HBC</b>	Home-based care
<b>HC</b>	Health Centre
<b>HCF</b>	Health Care Facilities
<b>HCW</b>	Health Care Worker
<b>HF</b>	Health Facilities
<b>HIC</b>	Humanitarian Information Centre
<b>HIS</b>	Humanitarian Information Service
<b>HPC</b>	Humanitarian Procurement Centre
<b>HR</b>	Human resources
<b>HRH</b>	Human Resources for Health
<b>IASC</b>	Inter-Agency Steering Committee
<b>IDP</b>	Internally Displaced Person
<b>IDSR</b>	Integrated Disease Surveillance and Response
<b>IEC</b>	Information, Education and Communication
<b>IFIs</b>	International Financial Institutions
<b>IM</b>	Intra-muscular
<b>IMF</b>	International Monetary Fund
<b>INAC</b>	Initial Needs Assessment Checklist
<b>INGO</b>	International Non-Governmental Organisation
<b>IPC</b>	Integrated food security Phase Classification
<b>IPTp</b>	Intermittent Preventative Treatment of pregnant women
<b>IRS</b>	Indoor Residual Spraying
<b>ITM</b>	Insecticidal Treated Materials
<b>IV</b>	Intravenous
<b>LLIN</b>	Long Lasting Insecticidal Nets
<b>LRRD</b>	Linking Relief, Rehabilitation and Development
<b>M+E</b>	Monitoring and Evaluation
<b>MAM</b>	Moderate Acute Malnutrition
<b>MCH</b>	Maternal and Child Health
<b>MCV1/2</b>	Measles Vaccination
<b>MDG</b>	Millennium Development Goals
<b>MDR</b>	Multi Drug Resistant tuberculosis
<b>MHPSS</b>	Mental health and psycho-social support
<b>MISP</b>	Minimum Initial Service Package
<b>MoH</b>	Ministry of Health
<b>MOU</b>	Memorandum of Understanding
<b>MRI</b>	Magnetic Resonance Imaging
<b>MRP</b>	Monitoring and Reporting Programme
<b>MSF</b>	Médecins Sans Frontières
<b>MSM</b>	Men who have sex with men
<b>MU</b>	Mobile Units
<b>MUAC</b>	Mid-Upper Arm Circumference
<b>NCD</b>	Non-communicable disease
<b>NFI</b>	Non Food Items
<b>NGO</b>	Non-Governmental Organisation
<b>NID</b>	National Immunization Days
<b>NTD</b>	Neglected tropical diseases
<b>OCV</b>	Oral Cholera Vaccine
<b>OI</b>	Opportunistic Infections
<b>ORS</b>	Oral Rehydration Salts

<b>OVC</b>	Orphans and other vulnerable children
<b>PARSSI</b>	Projet d'Appuis à la Redynamisation du Secteur de la Santé en Côte d'Ivoire (Project Supporting the Revitalisation of the Health Sector in Ivory Coast)
<b>PCR</b>	Polymerase Chain Reaction
<b>PEP</b>	Post Exposure Prophylaxis
<b>PEPFAR</b>	United States President's Emergency Plan for AIDS Relief
<b>PHC</b>	Primary Health Centre
<b>PLHIV</b>	People Living with HIV
<b>PMTCT</b>	Prevention of Mother To Child Transmission
<b>PNC</b>	Post-Natal Care
<b>PSP</b>	Ivory Coast National Pharmacy
<b>PTSD</b>	Post-Traumatic Stress Disorder
<b>PW</b>	Pregnant Women
<b>RBM</b>	Roll Back Malaria programme
<b>RDT</b>	Rapid Diagnostic Testing
<b>RH</b>	Reproductive Health
<b>RHA</b>	Regional Health Authority
<b>RSO</b>	Regional Support Office
<b>RUSF</b>	Ready to Use Supplementary Food
<b>SAGE</b>	World Health Organisation's Strategic Advisory Group of Experts on immunisation
<b>SAM</b>	Severe Acute Malnutrition
<b>SCF</b>	Save the Children Fund
<b>SFP</b>	Supplementary feeding programme
<b>SGBV</b>	Sexual and Gender-Based Violence
<b>SHC</b>	Secondary Health Centre
<b>SIA</b>	Supplementary Immunisation Activities
<b>SMS</b>	Short Message Service
<b>SOP</b>	Standard Operating Procedures
<b>SQUEAC</b>	Semi-Quantitative Evaluation of Access and Coverage
<b>SSA</b>	Sub-Saharan Africa
<b>SSV</b>	Survivors of Sexual Violence
<b>STD</b>	Sexually Transmitted Disease
<b>STI</b>	Sexually Transmitted Infection
<b>SWD</b>	Staff Working Document
<b>TA</b>	Technical Assistant
<b>TB</b>	Tuberculosis
<b>TFP</b>	Therapeutic Feeding Programme
<b>TIP</b>	Technical Issue Paper
<b>US</b>	Children under 5 years of age
<b>UN</b>	United Nations
<b>UNFPA</b>	United Nations Population Fund
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>UNICEF</b>	United Nations Children's Fund
<b>VCT</b>	Voluntary HIV Testing
<b>VEN</b>	analysis of vital, essential and non-essential items
<b>VHF</b>	Viral haemorrhagic fevers
<b>VPD</b>	Vaccine preventable diseases
<b>W/H</b>	Weight/Height
<b>WASH</b>	Water, Sanitation and Hygiene
<b>WB</b>	World Bank
<b>WHO</b>	World Health Organisation
<b>YF</b>	Yellow Fever
<b>(YF-)ICG</b>	International Coordination Group for Yellow Fever Vaccine

## Annex C: Glossary

**Attack rate:** proportion or percentage of the population at risk (or of the entire population) that experiences a new case of infection or disease during a given time period.

**Communicable disease or infectious disease:** disease that is caused by the infection of the body with foreign pathogens.

**Comparative Advantage:** For the context of this paper, this refers to the relative ability of one actor to efficiently and effectively meet a defined set of needs, on the basis of their mandate and operational parameters, compared to another actor.

**Coverage:** proportion or percentage of individuals in need of (or targeted as intended beneficiaries of ) an intervention, who actually get it.

**Crude mortality rate, CMR:** mortality rate among all age groups and due to all causes.

**Disease (and other conditions):** symptoms of illness and/or impairment of normal healthy bodily and/or mental functions due to an infectious or non-infectious cause. Conditions is used here for key health related events that are not a disease, such as pregnancy, vaccination or trauma.

**Do no harm:** A response that does not create undue dependency on the relief system, expose beneficiaries to unjustified risk or cause excessively detrimental impact on the environment.

**Epidemic:** occurrence of cases of a disease that is usually absent from the community; alternatively, a situation in which the disease is usually present, but suddenly reaches incidence levels in excess of the expected range.

**Excess morbidity/mortality:** morbidity/mortality that would not have occurred if the crisis had not taken place. Can be quantified as excess incidence or using other indicators.

**Humanitarian Crisis:** A humanitarian crisis is an event or series of events which represents a critical threat to the health, safety, security or well-being of a community or other large group of people, usually over a wide area. A humanitarian crisis can have natural or manmade causes, can have a rapid or slow onset and can be of short or protracted duration.

**Incidence:** occurrence of new cases of infection or new cases of disease, depending on which event is being investigated. Incidence rate: number of incident (i.e. new) cases of infection or disease, per unit population at risk and unit time: for example, 'new cases of bloody diarrhoea per 1,000 children under 5 years per week'.

**Integrated (horizontal) intervention:** an intervention usually targeted at many diseases at once, and integrated within the existing health system.

**Maternal mortality ratio, MMR:** number of women dying due to pregnancy-related causes while pregnant or within 42 days of pregnancy termination, out of 100,000 live births in a given year.

**Mortality (morbidity) rate:** number of deaths (or cases of disease for morbidity) occurring in a given population at risk per unit time, over a given time period (e.g. deaths per 10,000 people per day). Also known as death rate.

**Neonatal mortality (or death, ratio or rate):** number of infants below 28 days old dying out of 1,000 live births in a given year (sometimes 'below 30 days' is used instead). Equivalent to the probability of dying in the first month of life.

**Non-communicable (or non-infectious) disease:** disease not caused by infections. May include both physical and mental diseases. Also include many chronic diseases (hypertension, diabetes).

**Outbreak:** equivalent to epidemic, but usually taken to refer to the very first cluster of epidemic cases, or to a small epidemic.

**Prevalence:** number of cases of infection or disease present in the population (or a specific sub-group). This includes incident (new) as well as existing cases.

**Preventive health or intervention:** an intervention whose main benefit consists of reducing the risk of infection, exposure or progression to disease or death before the individual contracts the infection or disease.

**Proportion:** quantity A over (i.e. divided by) quantity N, where A is a fraction of N (e.g. proportion of all people with malaria infection: A = malaria-infected people; N= all people).

**Rate:** the number of events occurring per unit time (e.g. number of landslides per year). In epidemiology, rates are usually expressed as events per unit time and per unit people, i.e. as incidence rates (e.g. new cases of disease per 1,000 people per month). Other common uses are mortality rates or birth rates (e.g. births per 1,000 people per year).

**Ratio:** quantity A over (i.e. divided by) quantity B, where A is not part of B (e.g. male to female ratio; people to latrines ratio).

**Recovery (Early Recovery):** Actions taken (at the earliest opportunity) to strengthen local capacity, work with local resources and restore services

**Resilience:** The ability of a system, community or society exposed to hazards to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions.

**Risk:** in epidemiology, a general term indicating the probability, for an individual or a community, that a given health event (infection, disease, death, etc.) will occur or is present.

**Risk assessment:** systematic assessment of disease risk.

**Risk factor:** factor that, when present, increases epidemiological risk of a given health event. E.g. exposure.

**Risk management:** planning and implementation of interventions designed to mitigate risk.

**SPHERE:** The Humanitarian Charter and Minimum standards in Humanitarian relief reflect the determination of agencies to improve both the effectiveness of their assistance and their accountability to their stakeholders.

**Surveillance:** systematic collection, analysis and interpretation of data on health events that is then used for defining and monitoring policy and interventions to mitigate them. In crises, surveillance efforts mostly concern epidemic-prone diseases.

**Under-5 mortality rate, U5MR:** in emergency epidemiology, this is understood as the mortality rate among children under 5 years (e.g. deaths among children under 5 years per 10,000 children under 5 years per day). In demography and more long-term development settings, this refers to the number of children under 5 years of age dying out of 1,000 live births in a given year, i.e. the probability of dying before age 5: this is also known as the child mortality ratio or rate, as commonly reported in UNICEF State of the World's Children publications.

**Undernutrition:** The term undernutrition covers i) wasting (low weight for height) and nutritional oedema (a form of severe acute undernutrition); ii) stunting (low height for age, an indicator of chronic undernutrition); iii) intrauterine growth restriction which leads to low birth weight; and iv) deficiencies of essential micronutrients. Here, the Commission may trigger nutrition support when emergency rates of mortality or acute undernutrition have been reached or exceeded, or are anticipated

**Vector:** organism (usually insects, more rarely snails or other small animals) that plays a role (usually crucial) in the transmission of an infectious pathogen from one individual to the next. Very often, pathogens can only survive and reproduce by infecting specific vectors (e.g. the female *Anopheles* spp. mosquito for malaria) and fulfilling part of their life cycle within them.

**Vertical intervention:** an intervention targeted specifically to one disease (or closely related group of diseases), and running in parallel to the routine health system.

**Vulnerability:** Vulnerability comprises the characteristics of population groups that make them more or less susceptible to experiencing, stress, harm or damage when exposed to particular hazards. Therefore those who are vulnerable to food insecurity may currently be able to maintain an acceptable food intake, but are at risk of becoming food insecure in the future if exposed to a shock.

## Annex D: References

- ECHO Technical Issue Papers on Health, WASH and Nutrition issues (12)
- ECHO position paper on fees
- ECHO HIV funding guidance
- ECHO Guidelines on Medicine Quality
- The Global Health Cluster guidance, and in particular the health services checklist.
- ODI paper 61 on Public Health in Emergencies (Gayer, Grais, Checchi, Foreman)
- OFDA Health in Emergencies handbook: field operational guide
- Medicine Quality Assurance QUAMED site
- IASC Health Cluster Guide
- IASC guidance on Mental Health and Psychosocial Support
- The global health cluster guidance, and in particular the health services checklist.
- ACAPS disaster summary sheets
- Website on healthy new-born and reference material 'Global Epidemiology of New-born Mortality'
- MISP
- Handbook of Malaria in Emergencies
- Lancet Series on Diarrhoea and Respiratory infection
- Lancet Series on Maternal and Child nutrition (second series)
- Lancet Series on Humanitarian Health
- Lancet article on trends on health in emergencies (Spiegel, Waldman, Checchi)
- Cochrane reviews
- PLOS reviews
- Refugee Health – MSF
- Clinical and Therapeutic guides – MSF
- SPHERE Handbook
- WHO Manual of Early Warning and Surveillance in Emergencies
- WHO Communicable Diseases in Emergencies Manual
- WHO Risk assessment and Interventions guides for specific emergencies
- WHO HERAMS Health Service checklist
- WHO HESPER perceived needs tool
- WHO/PAHO Safe Hospital Guidance
- WHO Analysing Disrupted Health Systems Manual
- WHO Factsheets- new-born and maternal mortality
- WHO Tuberculosis care and control in refugee and displaced populations manual
- WHO Cholera web page
- WHO Mental health web entry
- WHO Vaccination in Acute Humanitarian Emergencies Manual

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