

Child and adolescent health in humanitarian settings: operational guide



Coordinate

Assess and
prioritize

Respond

Monitor
and evaluate

A holistic approach for programme managers



**World Health
Organization**

REGIONAL OFFICE FOR THE **Eastern Mediterranean**



Child and adolescent health in humanitarian settings: operational guide

A holistic approach for programme managers



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REGIONAL OFFICE FOR THE Eastern Mediterranean

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The Eastern Mediterranean Region is experiencing health emergencies on an unprecedented scale. More than half the countries in the Region face significant challenges in delivering basic health care. Children and adolescents are more seriously affected than most other population groups. Protecting them effectively requires a focus not only on service provision, but also on the programmatic aspects of basic child and adolescent care. WHO is working to support countries in developing and adopting the comprehensive response that is needed.

The *Child and adolescent health in humanitarian settings operational guide* is part of that work. It aims to ensure that the needs and concerns of children and adolescents are duly considered in emergency preparedness and response efforts. Based on current technical guidance on child and adolescent health, and aligned with existing humanitarian frameworks, the operational guide sets out a straightforward, systematic and action-oriented approach to protecting and caring for children and adolescents during humanitarian crises. Its four interrelated programmatic actions ensure the continuity and sustainability of interventions and cover the broad spectrum of emergency settings, with scope for adaptation to different country circumstances. The guide can be used to support operational planning, upscale staff capacity, and advocate for prioritizing child and adolescent services in contexts where many priorities compete for policy-makers' attention. Its target audience includes health programmers and partners at all levels striving to strategically place child health services within humanitarian settings, aiming for a coordinated response based on reality on the ground.

The guide has been carefully designed to address the needs of countries in the Region, as identified through a systematic literature review and a rapid online survey. The content was developed by the Child and Adolescent Health team in coordination with the Health Emergencies Department in the WHO Regional Office, with significant input from other WHO technical units and a wide range of external stakeholders. It was then refined through extensive consultation and field testing, and a workbook has also been created to facilitate implementation of the guide.

I would like to extend my sincere thanks to all the WHO Member States, UN agencies and international nongovernmental organizations who contributed to the development of this guide. Special thanks are due to Dr Hamish Graham of the Royal Children's Hospital and University of Melbourne, Australia, and his team for their significant input.

I look forward to supporting Member States in the WHO Eastern Mediterranean Region in implementing this guide and delivering systematic and sustained improvement in child and adolescent health.

Acronyms and abbreviations

CAH – child and adolescent health

IASC – Inter-Agency Standing Committee

IFRC – International Federation of Red Cross and Red Crescent Societies

IMNCI – integrated management of neonatal and childhood illness

OHCHR – United Nations Office of the High Commissioner for Human Rights

RMNCHA – reproductive, maternal, newborn, child and adolescent health

UN – United Nations

UNFPA – United Nations Population Fund

UNHCR – UNHCR, the UN Refugee Agency

UNICEF – United Nations Children's Fund

UNOCHA – United Nations Office for the Coordination of Humanitarian Action

WASH – water, sanitation and hygiene

WFP – World Food Programme

WHO – World Health Organization

Introduction to the guide

The *Child and adolescent health in humanitarian settings: operational guide* provides programmatic guidance to support the health care and protection of children during humanitarian emergencies. It is a programmatic guide, not a clinical guide. Its focus is on equipping programme staff with the tools they need to confidently plan, implement, manage and evaluate child and adolescent health (CAH) activities in humanitarian emergencies, including preparedness, response and recovery.

The operational guide covers the full spectrum of child health from birth to adolescence (life-cycle approach) and all humanitarian emergencies, including natural disasters, armed conflict and political instability (all-hazards approach). Its primary purpose is to ensure that all children are fully included in humanitarian action.

The guide is a synthesis of existing standards and guidance material; it is not a new guideline or programme (Fig. 1). It presents these resources in a simple, systematic way, together with links to tools and other resources to support action.

The guide complements existing humanitarian frameworks (1), and child and adolescent health strategies (2), including the World Health Organization's (WHO's) regional implementation framework for newborn, child and adolescent health, (2019–2023) (3). It is a companion to existing guides on newborn, and sexual and reproductive health in humanitarian emergencies (4–6).

Who is the operational guide intended for?

Programme managers and health decision-makers in many related fields can have an enormous influence on child and adolescent health outcomes through well-informed decision-making.



Fig. 1 This operational guide is a synthesis of existing guidance information

The operational guide provides practical guidance for health managers and leaders who are involved in designing, implementing, managing, monitoring and evaluating child and adolescent health activities in humanitarian emergency settings. This includes staff in local and national governments, United Nations (UN) agencies, nongovernmental organizations, and academic and funding institutions.

While the guide's main target audience is programme managers and health decision-makers, it will also be relevant to staff in other sectors (e.g. social services), and especially to staff leading broader humanitarian/emergency and development activities. The guide will also be useful for local, national and regional advocacy on child and adolescent health in humanitarian emergency settings – including to support funding proposals.

Getting started with the guide

The operational guide is designed to be practical, simple and action-oriented. It describes the essential programmatic actions necessary to protect and care for children and adolescents during humanitarian crises. All the actions depend on the local context and users must consider how to apply or adapt recommendations to fit local needs and circumstances.

The guide is structured around four key programmatic actions: coordinate; assess and prioritize; respond; and monitor, evaluate and review (Fig. 2). These actions are part of a continuous cycle of activities. Each area of action is closely connected with other areas, and activities within each area will often occur at the same time.

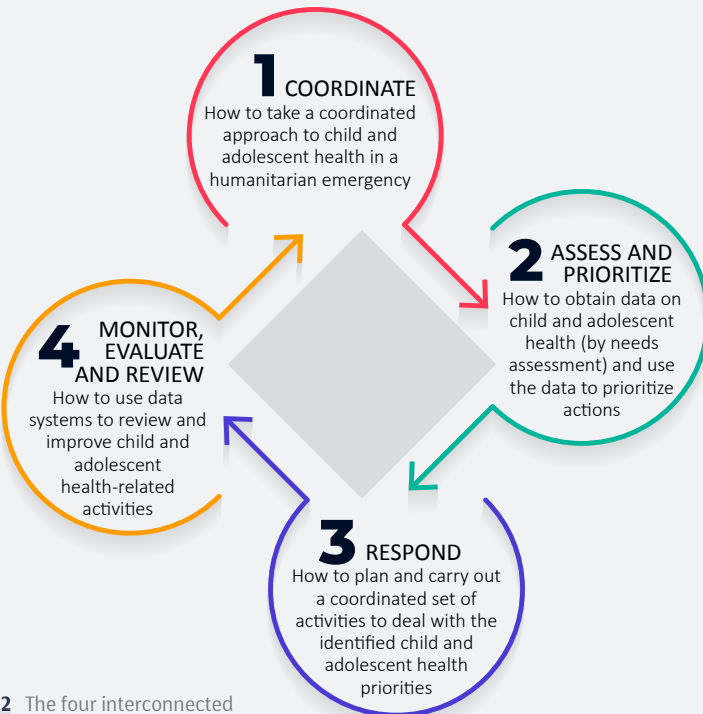


Fig. 2 The four interconnected programmatic action areas of the operational guide

1. Coordinate – My team understands humanitarian structures, has a clear role within the health cluster and actively contributes to the child and adolescent (CAH) working group.

N.B.: A CAH working group meets across agencies and clusters to ensure minimum CAH standards and facilitate transition to comprehensive CAH standards for all programmes related to child and adolescent health. See section 1.3 for more details.

0 – not at all	1 – partly true	2 – mostly true	3 – very true
We don't really understand humanitarian structures or our role within the cluster system.	We understand a little about clusters and humanitarian systems, but we do not really know where we fit in.	We are somewhat involved in the health cluster, but not actively part of a CAH working group.	We have a clear role within the health cluster, and actively contribute to the CAH working group.

2. Assess and prioritize – My team fully understands the situation of children and adolescents in our region, and has clearly prioritized specific focus areas for our context at this time.

0 – not at all	1 – partly true	2 – mostly true	3 – very true
We are not aware of the initial rapid assessment and are not up-to-date with situational reporting.	We have seen some parts of the initial rapid assessment, but need more information before we can set priorities.	We are aware of some assessments but have not worked with others to set priorities.	We have assessed the situation (needs, resources, capacity), and have set priorities in collaboration with other stakeholders.

3. Respond – My team understands the full range of CAH health activities, and actively works with other sectors to address the priority needs at this time.

0 – not at all	1 – partly true	2 – mostly true	3 – very true
We do not know what activities are important for children of different ages, or how to get these activities started.	We are starting to think about what activities are important for children of different ages, and how to deliver them.	We have some idea about what activities are important for children of different ages, and have started working on how to deliver them.	We have considered the range of CAH activities and determined what needs to be done now, and how to do it.

4. **Monitor and evaluate** – My team participates actively in health sector monitoring and evaluation activities, including supporting the CAH monitoring and evaluation plan and strengthening health information systems.

0 – not at all	1 – partly true	2 – mostly true	3 – very true
We are not aware of existing monitoring and evaluation plans and activities, and have little knowledge of health information or data systems.	We are aware of some monitoring and evaluation activities, but we do not know where we fit in or what we should be doing.	We understand and contribute to some monitoring and evaluation activities, but we do not have a clear role within the health sector’s monitoring and evaluation plan.	We understand and actively contribute to the health cluster’s monitoring and evaluation plan and activities, and aim to strengthen existing data systems.

Work through the sections of each action area addressing key actions

Start working through each section addressing the key actions to the best of your ability.

Don't worry if there are some things that are impossible to address. Work on the things you can change. Build on what you are already doing well. Celebrate your small successes and encourage others. Make notes of areas you need to tackle more fully in the future.

Work through the action areas repeatedly

Work through the sections of the action areas of the operational guide repeatedly, each time trying to address more of the key actions.

The operational guide can be used during preparedness, response and recovery phases of humanitarian action. How you use the guide will depend on the emergency and context, but the following process is suggested.

- Work through the entire guide in preparation for an emergency.
- Quickly work through the guide in the first month of an emergency; then systematically revisit all the sections over the next 3–6 months.
- Systematically review all of the guide every 6 months during a protracted emergency and into the recovery period.
- Use the self-assessment progress tracker (Annex 1) to track your improvement.

Box 1 gives some more tips on using the operational guide.

Limitations

The operational guide will not solve all your challenges in coordinating, planning, delivering and evaluating CAH activities in humanitarian emergency settings.

Box 1 Getting the most from the operational guide

Here are a few tips to get the most out of the operational guide.

- Become familiar with the overall guide, but feel free to use the parts that are most relevant and useful to you. Don't worry about doing everything.
- Adapt the guide to your context and people.
- Use the guide to orient new staff in your organization, and train and upskill existing staff – building understanding of their roles within the wider context.
- Use the guide when you are working with partners to help develop a common language and understanding.
- Consult the guide when developing your own strategies, standards and guidelines; you may find a lot of useful material to use or adapt.
- Use the guide as an advocacy tool to raise awareness and support for child and adolescent health in humanitarian settings.
- Use the guide as a quick reference to other tools and resources.

In creating the operational guide, we recognize some limitations.

- The guide provides general, action-oriented guidance. It will always require some adaptation to be appropriate in your context.
- The guide relies on existing authoritative guidance documents. Sometimes, this guidance is incomplete or missing (e.g. adolescent health and other non-traditional areas for humanitarian health action).
- The guide focuses on broad actions and does not give detailed guidance. Sometimes, you will want to consult the source documents for more detail.
- The guide include selective information and resources. The omission of particular resources does not imply that they are not useful; we have simply aimed to prioritize resources.

It is hoped that you will find the operational guide useful, and that you will be able to adapt the information successfully to your local context. See Box 1 for additional tips on using the guide.

Feedback on the guide

We encourage users to provide feedback on this working version of the *Child and adolescent health in humanitarian settings: operational guide*. Please see details in Annex 8 to access online form to provide feedback directly.

Humanitarian emergencies and humanitarian action

Humanitarian emergencies are varied and complex. They immediately threaten the health and safety of children and young people, and can have long-lasting effects on their development and well-being. Every context is different, and emergency situations evolve rapidly. Humanitarian action must be flexible and responsive.

This section describes the general principles of and approaches to humanitarian emergencies and humanitarian action.

Terminology

Humanitarian emergencies may also be called humanitarian crises, complex emergencies and humanitarian disasters. They may simply be referred to as crises, emergencies or disasters. While each of these terms has a particular definition, in this document we use the following phrases interchangeably: humanitarian emergencies, emergencies and emergency settings.

Humanitarian emergencies

Humanitarian emergencies can arise from natural disasters (e.g. floods, earthquakes and famine), armed conflict, political instability and other social upheavals – often in combination (Box 2). Humanitarian emergencies commonly result in large-scale displacement of people, severe food shortages, and destruction of economic, political and social institutions. These events often make existing social and economic instability worse. Humanitarian emergencies cause high morbidity and mortality due to the direct effects of injury and illness and indirectly through disruption of health and social systems.

Box 2 Humanitarian emergencies in the Eastern Mediterranean Region (2017–2018) (7,8)

Afghanistan. This protracted and complex crisis is an example of simultaneous rebuilding and emergency response requirements.

Iraq. The escalating conflict in Iraq has left 11 million people in need of assistance, with over 3 million people displaced, including 1.4 million children.

Lebanon. More than 1 million refugees from the Syrian Arab Republic now live in Lebanon, illustrating that humanitarian emergencies do not stop at borders.

Libya. Civil conflict and displacement from other countries (e.g. Syrian Arab Republic, Sudan) currently puts 1.5 million people in need of assistance, including many unaccompanied children.

Somalia. Drought, against a background of civil instability and conflict, has put Somalia on the brink of its third famine in 25 years.

Sudan. Conflict is decreasing, but more refugees from South Sudan are arriving, undernutrition is at a crisis point in Darfur and diarrhoeal outbreaks continue.

Syrian Arab Republic. The Syrian refugee crisis is the largest since the Second World War – 6 million internally displaced people, 5 million refugees in other countries, including more than 2 million children.

Yemen. Ongoing conflict and barriers to humanitarian assistance have resulted in a cholera outbreak and about 500 000 children with severe undernutrition.

Humanitarian emergencies are traditionally described in four phases:

1. Pre-crisis (before the emergency occurs);
2. Crisis (when the emergency occurs and peaks);
3. Stabilization (when immediate emergency concerns decrease);
4. Recovery (after resolution of the emergency).

In most humanitarian emergencies, these phases overlap substantially (Fig. 3), especially in protracted emergencies. The operational guide will be relevant for planning, implementing and monitoring activities during all phases; however your exact priorities and actions will vary.

Humanitarian action

Humanitarian action aims to save lives, alleviate suffering and maintain human dignity during and after crises. Humanitarian action takes place through all the phases of a crisis (pre-crisis, crisis, stabilization and recovery), and is also described in phases – preparedness, response and recovery (these often occur simultaneously).

1. **Preparedness** requires government, humanitarian agencies, communities and individuals to have the knowledge and capacity, and the institutional relationships with others, to prepare for and be able to respond effectively to emergencies.
2. **Response** involves immediate and longer-term relief efforts, including rapid assessment, strategic response planning, resource mobilization, implementation of response interventions and monitoring, and review and evaluation.
3. **Recovery** (early and long-term) involves rebuilding and rehabilitation. Planning for recovery should start very early during the emergency with the goal of “building back better” (10).

The operational guide will be relevant for planning and implementing activities during all phases of humanitarian action, but your exact priorities and actions will vary.

Principles and standards

Humanitarian action is guided by the humanitarian principles of *humanity, impartiality, neutrality* and *independence*. These are grounded in human rights and international law (11,12), specifically:

- the right to live with dignity
- the right to receive humanitarian assistance
- the right to protection and security.

Children have additional rights, described in the Convention on the Rights of the Child (13,14). The Core Humanitarian Standard is a consensus document from leading humanitarian actors (15). It is a voluntary code setting out nine principles to help humanitarian actors improve the quality and effectiveness of humanitarian action (Fig. 4).

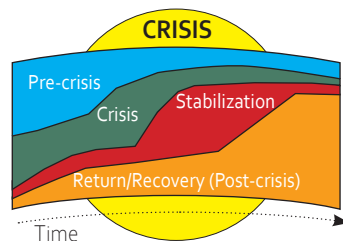


Fig. 3 Humanitarian emergency phases (9)



Fig. 4 Core humanitarian standard (15)

The *Sphere handbook: humanitarian charter and minimum standards in humanitarian response* (1) is the main humanitarian guidance document. It was created by a broad group of humanitarian actors and is accepted by most humanitarian agencies. The handbook includes the Humanitarian Charter, which outlines the ethical and legal foundations of humanitarian action, and the Minimum Standards in Humanitarian Response. The Sphere standards have been adopted by the UN and other agencies (6). These standards are the main source for the key actions and indicators given in the operational guide.

Child and adolescent health

Childhood is a period of enormous biological and social development – from birth to maturation (Fig. 5). The needs and capacities of a 4-year-old child will be very different from that of a 17-year-old adolescent, or a newborn baby.

To address child health in humanitarian emergencies adequately, we must understand the impact of humanitarian emergencies on children in each of these stages of development and the different responses needed. We must also understand that individual children mature at different rates, and sociocultural expectations and roles of children at different stages vary greatly in different contexts.

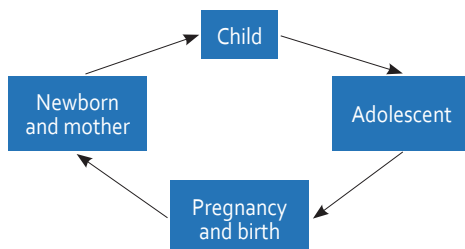


Fig. 5 Reproductive, maternal, newborn, child and adolescent health continuum (16)

To capture the different needs and capacities of children as they grow, the operational guide refers to children within five age groups:

- Newborns (neonates): first 28 days of life
- Young children: under 5 years
- Older children: 5–9 years
- Younger adolescents: 10–14 years
- Older adolescents: 15–19 years.

The operational guide contains guidance that concerns all children, from newborns through to late adolescence, and other guidance that is more relevant to a particular age group. If guidance is directed to “children”, then it should be understood to apply to all children, including adolescents, infants and newborns.

It is important to note that the operational guide is limited by the availability of existing evidence and guidelines. Traditionally, most humanitarian emergency guidelines, interventions, research and policies have focused on young children. This means that there are many areas for which there is little evidence or guidance available – especially for older children and adolescents.

It is hoped that this operational guide will stimulate more attention to the needs of older children and adolescents in humanitarian emergencies, and that future editions of the guide will more fully address the needs of all age groups of children.

Child and adolescent health in the Eastern Mediterranean Region

Table 1 shows the leading causes of death and disability by age group in the Eastern Mediterranean Region. Chronic conditions contribute substantially to morbidity and mortality (e.g. congenital anomalies, iron-deficiency anaemia, asthma and mental health conditions). Humanitarian emergencies have worsened the health and well-being of people of the Region, increasing the overall numbers of deaths from all causes, especially war-related violence.

Country-specific data can be found in the annual humanitarian needs overview for each country of the United Nations Office for the Coordination of Humanitarian Action (UNOCHA) (17).

Table 1 Leading causes of death and disability in the WHO Eastern Mediterranean Region

Age group	Leading causes of death (18)	Leading causes of DALYs lost (19)
Newborns (< 28 days)	1. Preterm complications 2. Birth asphyxia/trauma 3. Neonatal sepsis 4. Lower respiratory infection 5. Congenital heart anomalies	1. Preterm complications 2. Birth asphyxia/trauma 3. Neonatal sepsis 4. Lower respiratory infection 5. Congenital heart anomalies
Young child (1–59 months)	1. Lower respiratory infection 2. Diarrhoeal disease 3. Sexually transmitted infections (excluding HIV) 4. Preterm complications 5. Congenital heart anomalies	1. Lower respiratory infection 2. Diarrhoeal disease 3. Preterm complications 4. Congenital heart anomalies 5. Protein-energy malnutrition
Older child (5–9 years) Female	1. Collective violence and legal intervention 2. Lower respiratory infection 3. Road injury 4. Congenital anomalies 5. Diarrhoeal diseases	1. Collective violence and legal intervention 2. Iron-deficiency anaemia 3. Road injury 4. Drowning 5. Lower respiratory infection
Older child (5–9 years) Male	1. Collective violence and legal intervention 2. Road injury 3. Lower respiratory infection 4. Congenital anomalies 5. Drowning	
Younger adolescent (10–14 years) Female	1. Collective violence and legal intervention 2. Road injuries 3. Congenital anomalies 4. Lower respiratory infection 5. Tuberculosis	1. Iron-deficiency anaemia 2. Collective violence and legal intervention 3. Migraine 4. Anxiety disorders 5. Asthma
Younger adolescent (10–14 years) Male	1. Collective violence and legal intervention 2. Road injuries 3. Lower respiratory infection 4. Drowning 5. Congenital anomalies	1. Iron-deficiency anaemia 2. Collective violence and legal intervention 3. Conduct disorder 4. Other unintentional injury 5. Asthma
Older adolescent (15–19 years) Female	1. Collective violence and legal intervention 2. Maternal causes 3. Road injuries 4. Tuberculosis 5. Self-harm	1. Iron-deficiency anaemia 2. Collective violence and legal intervention 3. Migraine 4. Major depressive disorder 5. Anxiety disorders

Older adolescent (15–19 years) Male	<ol style="list-style-type: none"> 1. Collective violence and legal intervention 2. Road injuries 3. Inter-personal violence 4. Drowning 5. Self-harm 	<ol style="list-style-type: none"> 1. Collective violence and legal intervention 2. Other unintentional injury 3. Motor vehicle road injury 4. Major depressive disorder 5. Iron-deficiency anaemia
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DALY: disability-adjusted life year.

DALYs measure healthy years of life lost (i.e. death and disability).

Children and adolescents in humanitarian emergencies

Globally, one in four children (aged <15 years) lives in countries affected by humanitarian emergencies – even more in the Eastern Mediterranean Region. For many children and adolescents, the shocks of the emergency come on top of existing challenges.

Emergencies affect children and adolescents in many ways.

- Direct effects may include physical injuries and acute infectious disease from trauma and exposure to hazards, and psychological injury from exposure to trauma and abuse.
- Indirect effects may include physical and psychological injury and illness due to the breakdown of health services, food insecurity, separation from family members, homes and schools, and other forms of deprivation.

Children's limited life experience can limit their ability to understand or deal with the challenges of emergencies. Children, particularly young children, are dependent on others for their basic needs and safety, and caregivers may neglect these needs in the face of more urgent demands.

"Many of these children are already vulnerable – living in poverty, deprived of adequate nutrition, out of school, at risk of exploitation. Such complex and protracted emergencies aggravate the risks these children face and exacerbate their needs. They also threaten their societies – potentially reversing hard-won development gains around the world."

*Former UNICEF Executive Director,
Anthony Lake (7)*

Basic childhood activities, such as play, socializing with peers and learning, are often disrupted. Children and adolescents may take on additional responsibilities, for example, as breadwinners, or caregivers for younger children.

Some children and adolescents are particularly at risk of the harmful effects of emergencies (Box 3). Some people will experience emergencies differently to others (e.g. girls versus boys, urban children versus rural children).

For children and adolescents, emergencies threaten not only life and health, but also their physical, psychological, emotional and social development. Disruption to childhood development can have long-lasting effects.

However, children and adolescents are also uniquely resilient and adaptable with a remarkable capacity to survive and thrive. Supporting children's and adolescents' health and well-being during emergencies is a worthwhile investment for individuals, communities, and society.

Box 3 Child population groups at high risk

- Young children
- Girls
- Undocumented migrants, unaccompanied and separated children
- Children and adolescents from ethnic or religious minority populations
- Children and adolescents with disabilities or chronic health conditions
- Child and adolescent caregivers or primary income earners
- Children and adolescents in armed forces (and former combatants) or in the justice system
- Children and adolescents in forced or exploitative labour, including sex work
- Child and adolescent survivors of physical, sexual and emotional abuse

Resources and tools

Resources

- Health Cluster guide: a practical guide for country-level implementation of the Health Cluster. Geneva: World Health Organization; 2009 (https://apps.who.int/iris/bitstream/handle/10665/70128/WHO_HAC_MAN_2009.7_eng.pdf?sequence=1).
- Initiative. Compact for young people in humanitarian action [website]. Agenda for Humanity; 2016 (<https://www.agendaforhumanity.org/initiatives/3829>).
- Restoring humanity: synthesis of the consultation process for the World Humanitarian Summit [website]. World Humanitarian Summit Secretariat; 2015 (<http://synthesisreport.worldhumanitariansummit.org/>).
- UNICEF humanitarian action for children 2017 [website]. New York: United Nations Children's Fund; 2017 (<https://www.unicef.org/hac2017/>).
- Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation. Geneva: World Health Organization; 2017 (https://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/).
- Health for the world's adolescents. A second chance in the second decade. Geneva: World Health Organization; 2014 (<https://apps.who.int/adolescent/second-decade/>).
- ReliefWeb. Countries [website] (<https://reliefweb.int/countries>).
- One humanity: shared responsibility. Report of the Secretary-General for the World Humanitarian Summit. New York: United Nations General Assembly; 2016 (A/70/709) (<http://sgreport.worldhumanitariansummit.org/>).
- IHME. Eastern Mediterranean region Danger Ahead: the burden of diseases, injuries, and risk factors in the Eastern Mediterranean Region, 1990-2015. Int J Public Health. 2018. <http://www.healthdata.org/emr>

Tools

- The Sphere handbook: humanitarian charter and minimum standards in humanitarian response. Geneva: Sphere Association; 2018 (<https://spherestandards.org/wp-content/uploads/Sphere-Handbook-2018-EN.pdf>).
- Core Humanitarian Standard on Quality and Accountability. Geneva: HAP International, People in Aid and the Sphere Project; 2014 (<https://corehumanitarianstandard.org/language-versions>). Available in 27 languages.





Coordinate

1 Coordinate

Humanitarian emergencies are varied and complex. Therefore, effective coordination is essential, but challenging. Different situations and different humanitarian actors can mean there are differences in approaches and perceived priorities. However, any humanitarian response must be coordinated and system-wide to ensure assistance is provided quickly and efficiently to those in need.

This section helps you set up and participate effectively in coordination structures in humanitarian emergencies. It will help you to:

- participate in humanitarian structures
- identify key humanitarian actors
- establish a reproductive, maternal, newborn, child and adolescent health or a child and adolescent health (RMNCAH/CAH) working group and group lead
- communicate clearly
- advocate strongly.

Coordination actions are the foundation of all other activities described in the operational guide. Use the self-assessment progress tracker (Annex 1) to assess where you and your team (or organization) currently are and track your progress over time.

“Humanitarian coordination involves bringing together humanitarian actors to ensure a coherent and principled response to emergencies. The aim is to assist people when they most need relief and protection. Humanitarian coordination seeks to improve the effectiveness of humanitarian response by ensuring greater predictability, accountability, and partnership.” (20)

1.1 Participate in humanitarian structures

To integrate child and adolescent health into humanitarian action effectively, governments and organizations must be able to navigate humanitarian structures.

1.1.1 UN agencies and cluster approach

To improve coordination and cooperation in humanitarian emergencies, the UN and humanitarian organizations have formalized some aspects of humanitarian action.

Global level

At the global level, the Inter-Agency Standing Committee (IASC) coordinates humanitarian action and is headed by the Emergency Relief Coordinator. IASC is composed of UN agencies and international nongovernmental organizations. It is responsible for coordinating key agencies, assigning responsibilities and sharing resources and information. IASC designates responsibility for particular aspects of humanitarian action to particular agencies using a cluster approach (Fig. 6).

National level

At the national level, clusters may be formally activated during major humanitarian emergencies if the existing government structures are not capable of responding adequately (see Annex 2). The in-country cluster lead may be different to the global lead agencies shown in Fig. 6. Ideally, the clusters should be led by, or at least in close cooperation with, national authorities. Clusters should complement existing response mechanisms. UNOCHA or the national government typically has responsibility for oversight of all the clusters.

Experience shows that humanitarian emergencies attract a wide range of actors. To be effective at a country level, clusters must do more than just provide a platform for information sharing – they must also maintain an ability to make coordinated decisions about resources, activities and strategic direction.

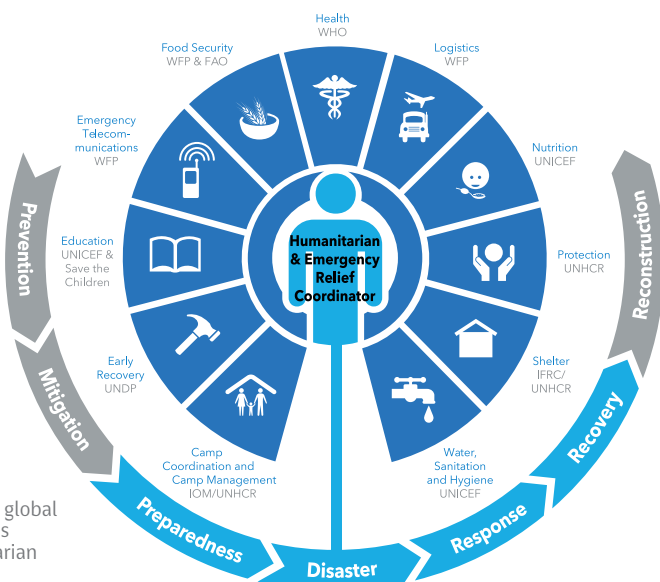


Fig. 6 Clusters and global lead agencies for humanitarian action (21)

¹ Inter-Agency Standing Committee (<https://interagencystandingcommittee.org/>).

The health cluster lead is usually a government department or UN agency, often in a coalition. However, governance structures may not always be clear, particularly in the early stages of an emergency.

Section 1.3 recommends establishing a child and adolescent working group within the health cluster to provide a clear voice on the health needs of newborns, children and adolescents and appropriate responses. If a health cluster is not formally activated, the CAH working group can still fulfil these roles, and should preferably be led by the ministry of health.



Key actions – humanitarian structures

Adapted from the Sphere Health Standards (1)

- ☐ Identify what organization leads the health cluster at your level (e.g. national or subnational). Contact them to find out about coordination activities and communication channels. Communicate areas that you are working in or may be able to help coordinate.
- ☐ If existing mechanisms are weak or non-existent, support authorities to create a coordination mechanism for humanitarian action. Ideally, representatives of the ministry of health should lead health sector/cluster coordination. When the health ministry lacks the capacity or willingness to provide leadership in the response, an alternate agency with the necessary capacity must be identified (usually OCHA) to take the lead in health sector/cluster coordination.
- ☐ The health sector/cluster should hold regular health coordination meetings for local and external partners at central, subnational and field levels within the health sector, and between health and other sectors and appropriate cross-cutting theme groups. All health-related organizations should participate in these meetings and contribute to the coordination of activities.
- ☐ The health sector/cluster should regularly produce and disseminate updates and health sector bulletins. All health-related organizations should contribute to and help disseminate these messages.



Key indicators

- ☐ Your organization is connected with the health sector/cluster in your region, actively communicates with partners and contributes to health (and other) sector/cluster updates.

1.2 Identify key humanitarian actors

Many different actors are involved in humanitarian action (Box 4). The most important actors are the affected communities and individuals.

The roles, presence and activities of various actors vary depending on the country context and the type of emergency. Child and adolescent health is central to the work of many humanitarian actors, particularly: government ministries of health, local or international nongovernmental organizations, UN agencies (Box 4).

Box 4 Key humanitarian actors (selected examples only)

Local community

- Health facilities (including private and “traditional” carers who are not part of the health system), schools and their leaders
- Religious, business and other civil society groups and leaders

Government

- Ministries of health (national/state level), other ministries, district health directors
- Military, police and emergency services, child protection services and others

Local nongovernmental organizations

- Many examples

Interagency

- Inter-Agency Standing Committee (IASC) – <https://interagencystandingcommittee.org/>
- Inter-Agency Working Group on reproductive health in crises (IAWG) – <http://iawg.net/>
- International Council of Voluntary Agencies (ICVA) – <https://www.icvanetwork.org/>
- International military and peace-keeping forces
- Steering Committee for Humanitarian Response (SCHR) – <https://www.schr.info/>

United Nations

- Department of Peace Operations (<https://peacekeeping.un.org/en/departement-of-peace-operations>)
- Food and Agriculture Organization of the United Nations (FAO) – <http://www.fao.org/home/en/>
- International Organization for Migration (IOM) – <https://www.iom.int/>
- United Nations Office of the High Commissioner for Human Rights (OHCHR) – <https://www.ohchr.org/EN/Pages/Home.aspx>
- United Nations Development Programme (UNDP) – <https://www.undp.org/content/undp/en/home/>
- United Nations Population Fund (UNFPA) – <https://www.unfpa.org/>
- United Nations Programme for Human Settlements (UN-Habitat) – <https://unhabitat.org/>
- UNHCR, the UN Refugee Agency – <https://www.unhcr.org/>
- United Nations Children’s Fund (UNICEF) – <https://www.unicef.org/>
- United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) – <https://www.unocha.org/>
- United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) – <https://www.unrwa.org/>
- World Food Programme (WFP) – <https://www.wfp.org/>
- World Health Organization (WHO) – <https://www.who.int/>

International nongovernmental organizations

- CARE International – <https://www.care-international.org/>
- Caritas – <https://www.caritas.org/>
- Catholic Relief Services – <https://www.crs.org/>
- International Committee of the Red Cross (ICRC) – <https://www.icrc.org/en>; National Red Cross societies
- International Federation of Red Cross and Red Crescent Societies (IFRC) – <https://media.ifrc.org/ifrc/>
- International Medical Corps – <https://internationalmedicalcorps.org/>
- International Rescue Committee (IRC) – <https://www.rescue.org/>
- Islamic Relief Worldwide – <https://www.islamic-relief.org/>
- Médecins Sans Frontiers (MSF)/Doctors Without Borders – <https://www.msf.org/>
- Organisation of Islamic Cooperation – <https://www.oic-oci.org/>
- Oxfam – <https://www.oxfam.org/en>
- Save the Children – <https://www.savethechildren.net/>
- World Vision – <https://www.wvi.org/>
- And many others

1.2.1 Roles and responsibilities

Different actors will bring different resources and skills, have different roles, and bear responsibility for different aspects of action.

- UN agencies typically have a coordination role in major humanitarian emergencies, primarily contributing coordination and technical expertise.
- Governments bear the main responsibility for the protection of their population; they typically coordinate and implement humanitarian action, contributing funds, staff and local technical expertise.
- Local community members, nongovernmental organizations and institutions are typically the main providers of humanitarian action, contributing staff and local expertise.
- International nongovernmental organizations are typically involved in the implementation, and sometimes coordination, of particular areas of humanitarian action, contributing staff and technical expertise.

1.2.2 Accountability to affected populations

Each actor has unique and valuable contributions to make and can greatly help alleviate suffering during humanitarian crises. However, actors who disregard humanitarian principles and international law can impede humanitarian action and cause more human suffering. Political, military, economic and other interests should never undermine humanitarian principles or international law. Use the core humanitarian standards (15, see Fig. 4) to hold yourselves (and others) accountable.

Above all, humanitarian actors must be accountable to affected populations (Box 5). Accountability to affected populations includes **taking account** (enabling people to have input in decisions, especially groups at very high risk of the harmful effects of emergencies), **giving account** (providing information on what you are doing and why), and **being held to account** (allowing communities to assess the quality of your response).

"In preparing for and responding to an emergency, international humanitarian actors are expected to cooperate with national authorities and support national capacity wherever it is feasible and appropriate to do so."

Inter-Agency Standing Committee (21)

Box 5 IASC commitments on accountability to affected populations (22)

Leaders of humanitarian organization will commit to the following:

Leadership/governance: Demonstrate their commitment to accountability to affected populations by ensuring feedback and accountability mechanisms are integrated into country strategies, programme proposals, monitoring and evaluations, recruitment, staff inductions, training and performance management, partnership agreements, and accountability is highlighted in reporting.

Transparency: Provide accessible and timely information to affected populations on organizational procedures, structures and processes that affect them to ensure that they can make informed decisions and choices; and facilitate dialogue between an organization and its affected populations on information provision.

Feedback and complaints: Actively seek the views of affected populations to improve policy and practice in programming, and ensure that feedback and complaint mechanisms are streamlined, appropriate and robust enough to deal with (communicate, receive, process, respond to and learn from) complaints about breaches in policy and stakeholder dissatisfaction.

Participation: Enable affected populations to play an active role in the decision-making processes that affect them through the establishment of clear guidelines and practices to engage them appropriately and ensure that the most marginalized and affected groups are represented and have influence.

Design, monitoring and evaluation: Design, monitor and evaluate the goals and objectives of programmes with the involvement of affected populations, and pass back what has been learnt to the organization on an ongoing basis and report on the results of the process.



Key actions – humanitarian actors

- ☐ Identify and reach out to partners within your area of action and work to establish common systems and avoid duplication.
- ☐ Integrate the Core Humanitarian Standards into your operations and use these to hold yourselves (and others) accountable.



Key indicators – humanitarian actors

- ☐ We have identified and connected with the health sector lead agency and partners in our area of work, and are committed to working together.

1.3 Establish a child and adolescent health working group

Many different clusters and agencies have responsibility for, and involvement in, child and adolescent health during humanitarian emergencies. An interagency RMNCAH/CAH working group² is essential to

² This working group may or may not include reproductive and maternal health (i.e. RMNCAH working group). It may be called a different name. For consistency, RMNCAH/CAH working group is used throughout the operational guide.

ensure that all partners work effectively and cooperatively to integrate child and adolescent activities into humanitarian action.

Ideally, the RMNCAH/CAH working group should be positioned under the health cluster. As the leaders of the health sector/cluster, WHO and the ministry of health are ultimately accountable for CAH activities and they should nominate an agency(ies) to lead the RMNCAH/CAH working group. (If this does not happen, raise it at a health cluster meeting.)

The RMNCAH/CAH working group can be led by any government body, local or international nongovernmental organization or UN agency that has the capacity to effectively lead the CAH response in collaboration with the ministry of health. The working group should include members from other sectors/clusters (e.g. nutrition, protection, WASH and education) as many issues that relate to newborn, child and adolescent health are cross-cutting. If a similar group already exists, build on this.

It will also be useful to establish subnational RMNCAH/CAH working groups to coordinate activities and provide feedback locally. These should be linked to local health authorities and the national RMNCAH/CAH working group.



Key actions – working group

Adapted from the Sphere Health Standards (1)

- ☐ Identify an agency(ies) to lead the RMNCAH/CAH working group. If the WHO/health ministry does not nominate a lead for CAH response, raise this at a health cluster/sector meeting.
- ☐ Establish an RMNCAH/CAH working group at your level (e.g. national, subnational, district) operating within the health sector/cluster.
 - Determine the composition of the RMNCAH/CAH working group. Include civil society members and young people.
 - Develop terms of reference for your RMNCAH/CAH working group, and roles for the group lead and participating agencies. (See Annex 3 for suggested terms of reference).
 - Develop a plan for working group meetings, communication and coordination with the wider community of humanitarian responders.
- ☐ The RMNCAH/CAH working group should liaise with stakeholders to clarify roles and integrate CAH priorities into the humanitarian response plan.
- ☐ The RMNCAH/CAH working group should actively engage partners outside the health cluster/sector, meet regularly and contribute to health (and other) cluster/sector updates.



Key indicators - working group

- ☐ At the onset of an emergency response, a national RMNCAH/CAH working group has been established (under the health cluster) with a nominated group lead and clear terms of reference. Subnational RMNCAH/CAH working groups have been established where needed.
- ☐ The RMNCAH/CAH working groups meet regularly and communicate their activities with other agencies, clusters/sectors and the community.
- ☐ CAH issues are fully included in humanitarian response plans.

1.4 Communicate clearly

Communication between organizations and with affected communities is vital at every stage of humanitarian emergencies – but it is difficult to do well. Effective communication strategies require an understanding of the situation, the people affected, current response efforts and the communication channels available, especially social media and mobile messaging platforms.

Children and young people of different ages have different capacities to communicate and will require different types of information. While it is important to communicate to their parents, it is also important to consider children's needs and capacities when developing communication strategies.

UNICEF's Communication for Humanitarian Action Toolkit (CHAT) provides some useful tools (23, Box 6) and other agencies have provided guidance on risk communication, behaviour change and social media in emergencies (see resources and tools at the end of this section).



Key actions - communication

Adapted from the CHAT handbook (23)

- ☐ Communicate urgent messages to the affected population now. Do not delay.
- ☐ Develop a communication strategy for your organization/team and for the RMNCAH/CAH working group (See CHAT strategy tool)
 - Assess the current situation to identify communication priorities, target populations and existing communication channels. (See CHAT survey tool)
 - Involve children and young people. Consider how they will perceive your messages. Consider what media and communication channels they use. Explore how you can get their input.
- ☐ The RMNCAH/CAH working group(s) should coordinate CAH-related health messages between agencies and sectors.



Key indicators - communication

- ☐ The RMNCAH/CAH working group, and individual organizations, have developed a communication strategy and are working together to implement it.

Box 6 Communication for humanitarian action toolkit (CHAT) principles (23)

CHAT principles

1. **Be prepared and communicate now.** Ideally, plan communication strategies as part of preparedness. Communicate urgent messages immediately, do not delay (See CHAT strategy tool)
2. **Work with partners and coordinate communication activities.** This includes: sharing what you know (about, for example, the crisis, the affected population and response efforts), deciding on communication priorities and formulating shared messages and communication strategies (who, what, when, where and how).
3. **Engage with communities.** Build trust. In emergencies, communities want and need information and this information can be life-saving. Communities are also the best source of information and they are the experts in communicating messages in their context.
4. **Build an evidence base through formative research.** Formative research can help identify which people are most in need, what information they require, and how to most effectively reach and engage them through the available communication options (See CHAT survey tool).
5. **Promote awareness and action.** Messages should be simple, clear and action-oriented. Action messages may include instructions to follow, a behaviour to adopt and precautions to take, or may identify where a service can be obtained.
6. **Wherever possible, test your approach.** The appropriateness of particular communication messages and materials depends greatly on language, culture and context. If possible, pre-test all messages before public release.
7. **Assess your impact.** Evaluate whether your messages reached the right people and had the result you hoped for. Use this to improve future messaging.

Communication channels

- **Interpersonal:** face-to-face, meetings, counselling, peer communication
- **Participatory:** street theatre, participatory videos, dance and so on
- **Print material:** newspapers, posters, leaflets, flyers, newsletters
- **Radio and television:** community, national and international, across all genres from drama to news
- **Digital/Internet-based:** crisis mapping, citizen media, blogs, social media and networking, data collecting
- **Mobile phone-based:** SMS warnings and information relays, SMS-based data gathering mechanisms

1.5 Advocate strongly

To successfully implement many of the key actions in the operational guide decision-makers need to be convinced of the benefits of the actions. This includes decision-makers in government, nongovernmental organizations and UN agencies, community leaders and health managers at every level (local up to national and global levels).

You can be an effective change agent by advocating for the health needs of children and adolescents to decision-makers. Advocacy can take many forms, and may occur both within organizations and between organizations. Children, adolescents and their parents are powerful advocates, so involve them in advocacy efforts as much as possible.



Key actions – advocacy

- ☐ The RMNCAH/CAH working group takes the lead in advocating for child and adolescent health to health and humanitarian authorities (see Annex 3).
- ☐ All health leaders and agencies working in child and adolescent health work together to advocate for the needs of children and adolescents, which should include the following areas.
 - Human rights: child rights; how humanitarian and protection principles relate to children and adolescents.
 - Data: disaggregate data by age and disability; include key CAH indicators in data collection activities; report to stakeholders and the community.
 - Prioritization: highlight CAH priority areas that need more support.
 - Funding: seek donors to support longer term (e.g. multiyear), multisectoral programming for sustainable learning and programmatic improvement.
 - Community: raise awareness of CAH issues among parents, teachers, community and religious leaders (especially about sensitive topics such as violence, child abuse, sexual health).
 - Participation: promote the involvement of children, adolescents and parents in all aspects of programme planning, implementation and evaluation.



Key indicators – communication

- ☐ The RMNCAH/CAH working group, and individual organizations, work together to advocate for the health needs of children and adolescents.

Resources and tools: coordinate

Resources

- Reference module for cluster coordination at country level. Geneva: Inter-Agency Standing Committee; 2015 (https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/cluster_coordination_reference_module_2015_final.pdf).
- IASC reference module for cluster coordination at the country level. Geneva: Inter-Agency Standing Committee; 2015 (<https://www.who.int/health-cluster/about/cluster-system/cluster-coordination-reference-module-2015.pdf>).
- IASC Operational guidance for cluster lead agencies on working with national authorities. Geneva: Inter-Agency Standing Committee; 2011 (https://www.who.int/hac/network/interagency/news/iasc_working_with_national_authorities/en/).
- Core Humanitarian Standard on Quality and Accountability. Geneva: HAP International, People in Aid and the Sphere Project; 2014 (<https://corehumanitarianstandard.org/language-versions>).
- Health Cluster guide: a practical guide for country-level implementation of the Health Cluster. Geneva: World Health Organization; 2009 (https://apps.who.int/iris/bitstream/handle/10665/70128/WHO_HAC_MAN_2009.7_eng.pdf?sequence=1).

Tools

- Humanitarian ID (<https://humanitarian.id/>) is a personalized identification (ID) for humanitarian workers, which provides access to Humanitarian ID contact lists. The same ID can be used to log

into Humanitarian Response and ReliefWeb. Introducing Humanitarian ID, video explainer: https://www.youtube.com/watch?v=6odKwkaq_Sw&feature=youtu.be

- Humanitarian Response (<https://www.humanitarianresponse.info/>) is the central website for humanitarian information management tools and services, enabling information exchange among operational responders during either a protracted or sudden-onset emergency. Provided by UN OCHA. Humanitarian Response.info platform, video explainer: https://www.youtube.com/watch?time_continue=g&v=OAZNjYtabuM
- ReliefWeb (<http://reliefweb.int/>) is the leading humanitarian information source on global crises and disasters, providing reliable and timely information to enable humanitarian workers to make informed decisions. The site includes reports, maps, infographics and videos. Provided by UN OCHA.
- Humanitarian Data Exchange (HDX) (<https://data.humdata.org/>) is an open platform for sharing humanitarian data. HDX aims to make humanitarian data easy to find and use for analysis. Provided by UN OCHA. Making the invisible visible, video explainer: <https://www.youtube.com/watch?v=7QX5Ji5glg&feature=youtu.be>
- NGO Coordination Resource Centre (<https://ngocoordination.org/en>) is nongovernmental organizations' one-stop shop for humanitarian emergencies. Provided by the International Council of Voluntary Agencies.
- Accountability to affected populations. Tools to assist in implementing the IASC AAP commitments. Geneva: Inter-Agency Standing Committee; 2012 (https://interagencystandingcommittee.org/system/files/legacy_files/TOOLS%20to%20assist%20in%20implementing%20the%20IASC%20AAP%20Commitments.pdf).
- Operational guidance on accountability to affected populations (AAP). Health Cluster; August 2017 (<https://www.who.int/health-cluster/resources/publications/AAP-tool.pdf>).
- Communicating risk in public health emergencies: a WHO guideline for emergency risk communication (ERC) policy and practice. Geneva: World Health Organization; 2017 (<https://apps.who.int/iris/bitstream/handle/10665/259807/9789241550208-eng.pdf;jsessionid=52CDE2DEE72038D4E8F5E0EF1687BA6C?sequence=2>).
- Communication for Humanitarian Action Toolkit. New York: United Nations Children's Fund; 2015 (http://www.unicefinemergencies.com/downloads/eresource/docs/Communication%20for%20Development/6-C4D-CHAT_Proof-2.pdf). Contains strategy tool, survey tool and a lot of additional useful information.
- Behaviour change communication in emergencies: a toolkit. Kathmandu: United Nations Children's Fund Regional Office for South Asia; 2006 (https://www.unicef.org/cbsc/files/BCC_Emergencies_full.pdf).
- How to use social media to better engage people affected by crises. A brief guide for those using social media in humanitarian organizations. Geneva: International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies and United Nations Office for the Coordination of Humanitarian Affairs; 2017 (<https://www.icrc.org/en/document/social-media-to-engage-with-affected-people>).





Assess and prioritize

Assess and prioritize

2

2 Assess and prioritize

Humanitarian emergencies are complex and chaotic. Careful, coordinated assessment of the situation and ongoing monitoring of the response and changing needs is critical to effective humanitarian action (Fig. 7).

This section helps you take a coordinated and structured approach to understanding the situation of the affected population, including service availability, and using these data to decide on priorities. It will help you to:

- include child and adolescent health in initial health needs assessment
- assess existing resources and capacity
- prioritize CAH interventions.

This section deals mainly with initial assessment tools; these tools (and other tools) will be discussed again in the monitor, evaluate and review section (action area 4). Actions in this section build on the coordination structures (action area 1) and lead directly into how to respond (action area 3). Use the self-assessment progress tracker (Annex 1) to assess where you and your team (or organization) currently are, and track your progress over time.

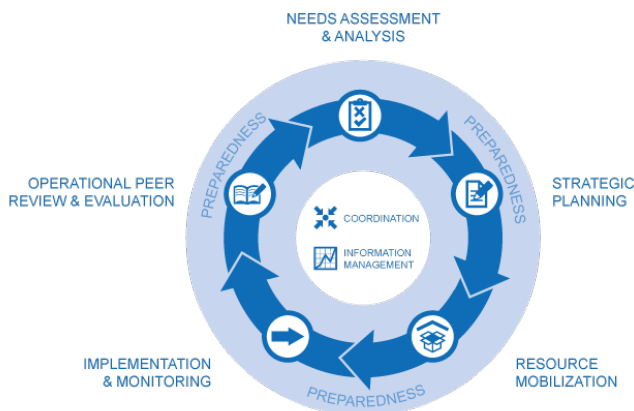


Fig. 7 Humanitarian programme cycle (24)

2.1 Include child and adolescent health in initial health assessment

Key agencies should initiate a coordinated needs assessment at the start of a humanitarian emergency to provide an understanding of the crisis, including how it may continue to develop, and identify gaps in response and any operational constraints (Fig. 7). This assessment should consider both the *crisis impact* (scope and scale of the crisis, how people are affected) and the *operational environment* (capacities, humanitarian access) (Fig. 8).

The IASC operational guidance for coordinated assessments in humanitarian crises (25) describes four phases of the initial assessment (Fig. 9). OCHA typically leads the first two phases, using the multi-sector initial rapid assessment (MIRA) tool (26) (including the rapid health assessment). The later phases require a more tailored plan and are typically coordinated within particular sectors/clusters (Box 7).

The health cluster will lead the rapid health assessment and contribute to other parts of the multi-sector initial rapid assessment (MIRA) tool. The rapid health assessment will address:

- health status and risks,
- health resources and service availability
- health system performance (including coverage, quality, access and utilization).

The RMNCAH/CAH working group, and individual agencies, should actively participate to ensure that children and adolescents are counted and assessed accurately. This starts with disaggregating data by age (newborns, < 5 years, 5–9 years, 10–14 years and 15–19 years). In many cases, there will be specific CAH vulnerabilities and risks (Box 8), capacities and actions that need to be addressed within a needs assessment.

As much as possible, integrate child and adolescent needs assessment activities within the broader needs assessment activities. Commonly used data collection tools are described in Table 2.

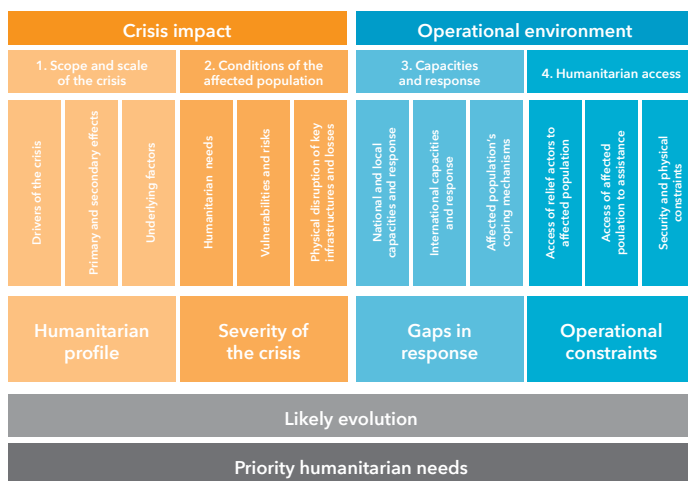


Fig. 8 Components of a needs assessment (26)

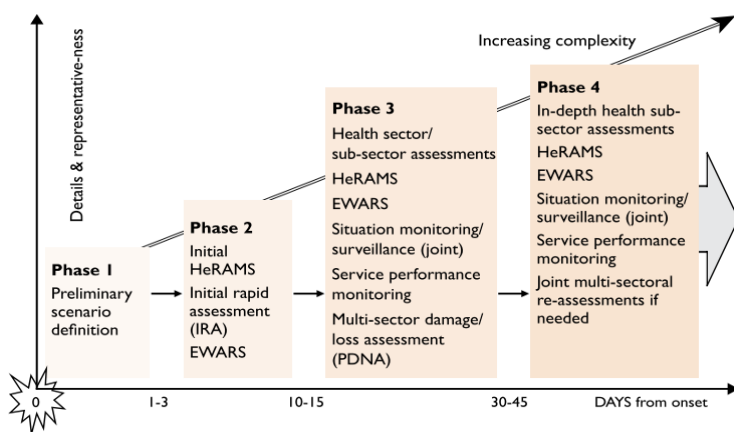


Fig. 9 Coordinated assessment and phases (HeRAM: Health Resources Availability Monitoring System, EWARS: Early Warning, Alert and Response System, PDNA: post disaster needs assessments) (25)

Box 7 Ten principles for conducting needs assessments (25)

- Wherever possible, assessments are led by national governments and promote ownership by national and local authorities.
- Plan for assessments as part of emergency preparedness.
- Build each assessment on existing data, assessing CAH information from existing quantitative and qualitative data, e.g. pre-crisis national demographic surveys and reports from previous emergency responses.
- Ensure links between assessment and monitoring.
- Collect exactly the data required for decision-making.
- Involve all stakeholders in assessment design and implementation. Consider the use of technology, including social media, to reach young people.
- Address priority issues and groups, including gender, age, disability, unaccompanied minors, ethnic minorities and other groups at high risk.
- Use sound information management strategies.
- Include an analysis of context.
- Do assessments with future recovery and development activities in mind.

Box 8 Children at high risk in emergencies and specific issues to consider

Children at high risk

- Young children
- Girls
- Undocumented migrants, unaccompanied and separated children
- Children and adolescents from ethnic or religious minority populations
- Children and adolescents with disability or chronic health conditions
- Child and adolescent caregivers or primary income earners
- Children and adolescents in the armed forces (and ex-combatants) or justice system
- Children and adolescents in forced or exploitative labour, including sex work
- Child and adolescent survivors of physical, sexual and emotional abuse

Issues to consider

- Violence, trauma: particularly common in armed conflict, displaced populations and natural disasters
- Food insecurity, undernutrition: particularly common in famine, armed conflict and displaced populations
- Disease outbreaks: particularly common in displaced populations and refugee camps, and in the case of destruction of water and sanitation infrastructure or low immunization coverage
- Uncontrolled endemic disease: particularly common in displaced populations, and in the case of destruction of social and health infrastructure
- Mental health and psychological well-being: particularly common in armed conflict and protracted emergencies
- Gender: effect of the emergency on girls and boys
- Age: effect of the emergency on older and younger children and adolescents

Table 2 Data collection tools commonly used in humanitarian emergencies

Data collection method	Comments
IASC Multi-sector initial rapid assessment (MIRA) tool (26)	MIRA is the coordinated approach to overall assessment of a crisis situation, and is led by OCHA. It includes the rapid health assessment which is led by the health cluster.
WHO Health Resources Availability Monitoring System (HeRAMS) (27)	HeRAMS is a tool for initial assessment and ongoing monitoring of human resources for health, and is used by the health cluster.
WHO service availability and readiness assessment (SARA) (28)	SARA is an alternative tool for cross-sectional assessment of health service availability and readiness.
WHO rapid risk assessment (29)	Rapid risk assessment guides the initial rapid assessment of acute public health events.
WHO Early Warning and Response System (EWARS) (30)	EWARS is a system for early detection of crises. (See also action area 3 – Monitor, Evaluate, Review)
3W/4W/5W (31)	This tool assesses humanitarian response: who, what, when, where, and for whom.
WHO strategic tool for assessing risk (32)	The WHO strategic tool for assessing risk is mainly used for planning (preparedness).
SMART nutrition assessment (33)	SMART is a method for rapid assessment of nutrition in emergencies.

Key actions – needs assessment



Adapted from the Sphere Health Standards (1)

- ☐ Members of the RMNCAH/CAH working groups review the OCHA risk profile, all hazards response plans¹ and other relevant sources of information.
- ☐ Contribute to a systematic, objective and ongoing assessment of the context and stakeholders (intersectoral).
 - The RMNCAH/CAH working group coordinates input from agencies to ensure that CAH concerns are fully represented in the rapid health assessment (and all future assessments).
 - Advocate for disaggregation of data by sex and age (newborn, < 5 years, 5–9 years, 10–14 years and 15–19 years).
 - Use pre-existing data as much as possible (e.g. service coverage, and morbidity and mortality). Coordinate with others to avoid burdening communities with multiple assessments, and unnecessary duplication.
- ☐ The RMNCAH/CAH working groups contribute to assessing the safety and security of affected, displaced and host populations to identify threats of violence and any forms of coercion, denial of subsistence or denial of basic human rights – with a focus on children and young people.
 - Consider using the *Child protection rapid assessment toolkit* (34) to assess child and adolescent risks, vulnerabilities and needs.

¹ Check with your country coordinators and online (<https://reliefweb.int/>).

- ☐ Consider how gender roles, norms and stereotypes affect children's and adolescents' experience of and response to a crisis. Consider how to approach this in your programmes and activities.
- ☐ Share assessment findings widely (including with affected populations). Use multiple communication channels (e.g. face-to-face, email, social media and radio).



Key indicators – needs assessment

- ☐ The health sector lead agency has conducted an initial rapid assessment, with active involvement of the RMNCAH/CAH working group.

2.2 Assess existing resources and capacity

The rapid assessment will provide a general indication of the needs and capacity to respond. The health cluster, and RMNCAH/CAH working group, should expand on this with a more thorough assessment of health service resources and capacity.



Key actions – health service assessment

Adapted from the Sphere Health Standards (1)

- ☐ The RMNCAH/CAH working group coordinates additional assessment of CAH needs and response capacity in collaboration with the health cluster lead, and the health cluster information management working group.
- ☐ Review existing policies and protocols related to CAH care.
 - Avoid reinventing programmes and protocols that already exist, or developing new recommendations that may conflict with current standards. If existing policies are lacking, involve the government in creating new policies.
 - If communication between government and international or local nongovernmental organizations is challenging, invite UN organizations (e.g. WHO) to facilitate dialogue and ensure that national policies align with international standards.
- ☐ Review existing CAH clinical guidelines to ensure that they are up to date and appropriate. Review health promotion and communication tools and health care worker training materials. If new guidelines or tools need to be created, work collaboratively with government, UN agencies, and international and local nongovernmental organizations.
- ☐ Map existing health facilities, assess their current status, including functional capacity, CAH service availability and damage – use the Health Resources Availability Monitoring System (HeRAMS) (27), Service Availability and Readiness Assessment (SARA) (28), 3W/4W (31) or tools for use in the field (4). Include private and “traditional” care providers. Where possible, assess access to and use of health services and identify possible threats (e.g. security and transport). Where available, use pre-existing service coverage data (e.g. measles immunization and antenatal care coverage).

- ☐ Review existing staffing levels using national standards and classifications of job functions, if available, adapting to the emergency setting. Document the number and type of skilled health care providers at health facilities and where they work (e.g. within the facility, outreach and mobile clinic). Use simple questionnaires to assess health care provider competency in essential CAH health services, and identify training needs and opportunities.
- ☐ Review the existing national essential medicines and medical device list early in the response. Clarify procurement and distribution procedures and possible challenges. Help staff address urgent issues with supplies (See section 3.4).
- ☐ The RMNCAH/CAH working group should assist the health cluster lead to collate the information on health facilities and create a service map showing existing service availability, strengths and weaknesses (Box 9). Use the service map to coordinate service planning and priority-setting with partner organizations, and ensure it is regularly revised. Share the service map with decision-makers, partners and the community.



Key indicators – health service assessment

- ☐ The RMNCAH/CAH working group has prepared a plan (with the health cluster lead) to conduct additional assessments of CAH needs and response capacity. The plan includes a timeline of activities and designates responsibility.
- ☐ The RMNCAH/CAH working group has helped the health cluster lead to create and disseminate a service map.

Box 9 Service map of existing service availability

Important elements to include in a service map

- Geographical locations. Existing health care networks.
- Distances from affected communities (including mobile and outreach services). Distances between peripheral health facilities and larger hospitals.
- Transport options between locations, and potential access issues (e.g. security risks, safety issues and cultural factors).
- Communications systems (e.g. telephone and Internet).
- Health services provided (preventive and curative). Medicines and medical supplies. Costs.
- Staff-to-patient ratios (e.g. doctors and nurses per 10 000 population).

2.3 Prioritize child and adolescent health interventions

Humanitarian emergencies typically increase the health needs of populations while at the same time disrupting the capacity of existing services to respond. Humanitarian responders must quickly identify the biggest health needs (including populations at very high risk), and decide actions to prioritize¹.

Prioritization aims to bring the greatest benefit to the greatest number of people (Box 10). In practice, this means confronting the biggest causes of death and disability with the most cost-effective tools and providing extra attention to populations at high risk. This requires balancing the desire to provide more services against the desire to reach more people with the available resources and workforce. It also requires consideration of the practical feasibility of interventions in particular contexts.

The RMNCAH/CAH working group should assist the lead health agency to prioritize services (maternal and child health will always need to be a high priority). See Annex 4 for a list of priority health issues and interventions for consideration. Action area 3 (Respond) describes each action in more detail.

Box 10 Principles for prioritizing actions

1. The goal of prioritization is to prevent the greatest suffering and loss of life. Priority actions will vary between contexts (e.g. displacement versus famine) and will change over time.
2. Certain child populations are at high risk of suffering and loss of life, and will therefore require particular attention (e.g. young children, girls, children with disabilities¹).
3. Prioritization requires balancing (i) the desire to provide more services with (ii) the desire to reach more people using available resources.

¹ Child populations at high risk are outlined Box 8, Section 2.1.



Key actions - prioritization

Adapted from the Sphere Health Standards (1)

- ☐ The health cluster lead should coordinate the systematic prioritization of health services and activities. Child health will always be a high priority, but the RMNCAH/CAH working group (and individual organizations) should advocate strongly for newborn, child and adolescent issues.
- ☐ In cooperation with the health cluster lead, the RMNCAH working group(s) reviews findings from the needs assessment and pre-crisis morbidity and mortality data to identify the main health threats. Review findings from the service availability assessment to decide what is feasible. Review priorities from the all hazards risk assessment (or other similar preparedness plans). Ensure that child and adolescent health is reflected in humanitarian needs overview and humanitarian response plans.
- ☐ Analyse which interventions will have maximum impact to reduce morbidity and mortality². Prioritize:

¹ These interventions may include preventative and curative health interventions, as well as a range of broader public health and social activities (e.g. water and sanitation and food security).

² See Annex 4 for a list of essential health interventions to consider.

- the most likely and largest causes of excess morbidity and mortality,
 - the population groups most affected,
 - the most effective interventions in reducing morbidity and mortality, and
 - the most feasible interventions.
- ☐ Take care to assess needs and capacities of those in hard-to-reach locations and at-risk groups (e.g. people with disabilities, young children and adolescents¹), and develop strategies to include them in the humanitarian response.
 - ☐ Identify barriers that impede access to prioritized CAH health services and look for practical solutions to tackle them.
 - ☐ Repeat the prioritization exercise as the response evolves, to assess and deal with any changes in health needs. Frequency should be decided jointly with the ministry of health, or lead agency, and all health partners.



Key indicators

- ☐ The RMNCAH/CAH working group and health cluster lead have produced a document explaining the identified CAH priorities, and disseminate it to health actors.

Resources and tools: assess and prioritize

Resources

- Guideline. Coordinated assessments in humanitarian crises. Geneva: Inter-Agency Standing Committee; 2012 (https://interagencystandingcommittee.org/system/files/legacy_files/operational_guidance_for_coordinated_assessments_in_humanitarian_crises.pdf).
- Health Cluster guide: a practical guide for country-level implementation of the Health Cluster. Geneva: World Health Organization; 2009 (https://apps.who.int/iris/bitstream/handle/10665/70128/WHO_HAC_MAN_2009.7_eng.pdf?sequence=1).

Tools

- Humanitarian Health Action. Global Health Cluster tools – including HeRAMS, initial rapid assessment tool kit and the UNHCR health information system (https://www.who.int/hac/global_health_cluster/guide/tools/en/).
- Tool. Multi-sector initial rapid assessment (MIRA). Geneva: Inter-Agency Standing Committee; 2015 (<https://emergency.unhcr.org/entry/198217/multicenter-sector-initial-rapid-needs-assessment-mira>).
- Multi indicator cluster surveys (MICS) [website]. UNICEF (<http://mics.unicef.org/>).
- Rapid risk assessment of acute public health events. Geneva: World Health Organization; 2012 (https://apps.who.int/iris/bitstream/handle/10665/70810/WHO_HSE_GAR_ARO_2012.1_eng.pdf?sequence=1).
- Humanitarian Health Action. Health Resources Availability Monitoring System (HeRAMS) [website]. World Health Organization (<https://www.who.int/hac/herams/en/>).
- Strategic Tool for Assessing Risk. A comprehensive toolkit for public health risk assessment. Geneva: World Health Organization (in press).

¹ See Box 8 Section 2.1 for groups at very high risk.

- 3W/4W/5W – who, what, where, when, for whom. United Nations Office for the Coordination of Humanitarian Affairs (OCHA) (<https://www.ochaopt.org/dbs/4w>).
- Service Availability and Readiness Assessment (SARA). Geneva: World Health Organization; 2015 (https://www.who.int/healthinfo/systems/sara_introduction/en/).
- Child protection rapid assessment toolkit. Geneva: Global Protection Cluster, Child Protection Working Group; 2012 (http://www.globalprotectioncluster.org/_assets/files/tools_and_guidance/info_data_management/CPRA_English-EN.pdf).
- dhis2. District Health Information Software, version 2 is free health information system software (<https://www.dhis2.org/>).
- Emergencies. EWARS: a simple, robust system to detect disease outbreaks [website]. Geneva: World Health Organization (<https://www.who.int/emergencies/kits/ewars/en/>).
- Health Information System (HIS) Toolkit. Geneva: UNHCR, the UN Refugee Agency; 2010 (<https://www.unhcr.org/protection/health/4a3374408/health-information-system-toolkit.html>). Health Information System (HIS) reference manual (<https://www.unhcr.org/4a3114006.html>).
- SMART methodology manual 2.0. SMART (Standardized Monitoring and Assessment of Relief and Transitions) (https://smartmethodology.org/survey-planning-tools/smart-methodology/smart-methodology-manual/?doing_wp_cron=1580992077.4052801132202148437500).
- Newborn health in humanitarian settings: field guide. New York: United Nations Children's Fund, and Save the Children; 2018 (<https://www.healthynewbornnetwork.org/hnn-content/uploads/NewBornHealthBook-Production2017-V4b-WEB.pdf>). See annexes of the field guide for newborn assessment tools.





Respond

3

Respond

3 Respond

3

Humanitarian emergencies severely disrupt and weaken health systems. Children and adolescents are disproportionately affected by the loss of essential health promotion, prevention and treatment activities. A strong and equitable health system can reduce the impact of an emergency and promote early recovery.

This section helps you work with partners to plan and implement CAH-related activities. It will help you to:

- Establish service delivery structures
- Decide on an essential services package
- Strengthen the health care workforce
- Obtain essential medicines and medical supplies
- Obtain financing.

This section is relevant to the preparedness, response and recovery phases. The specific actions will be informed by assess and prioritize (action area 2) and will require good coordination (action area 1) and ongoing monitoring and evaluation (action area 4). Use the self-assessment progress tracker (Annex 1) to assess where you and your team (or organization) currently are, and track your progress over time.

3.1 Establish service delivery structures

Humanitarian emergencies raise major challenges to CAH health service delivery (Box 11). Many of these challenges affect everyone in some way. But many challenges will disproportionately affect children of different ages or different capacities. These include loss of: birthing services for newborns and adolescent mothers; integrated management of neonatal and childhood illness (IMNCI) for young children, supply chains for those with chronic conditions, and safe streets for older children and adolescents.

Health service delivery structures often require major changes in order to effectively and efficiently respond to the new, different and rapidly changing health needs of the population (and children and adolescents in particular) in the evolving situation. This may include different scopes of practice and new services (e.g. outreach) as well as modification of existing methods of health service delivery (Box 12).

Box 11 Challenges to the delivery of child and adolescent health services

Service disruption and facility destruction

Break down of essential health promotion and prevention services (e.g. immunization, nutrition advice, breastfeeding support and vector control) and treatment activities (e.g. IMNCI and integrated community case management). Disruption of supply chains. Loss of health care providers and reduced affordability of essential services. Reduced access to essential services (water and power), sanitation and hygiene, and food. Damaged roads, difficult transport.

Population movements

Mobile populations. Crowded living environments. Loss of livelihoods. Rapid population increase in semi-urban areas (many displaced people will move into urban areas, rather than into refugee camps).

Competing priorities

New health issues (e.g. injury and epidemic disease) and displaced populations overwhelming existing health structures and programmes and causing neglect of other essential services.

Lack of safety

Threats to the security and safety of affected populations and health care workers and hence impaired access to and delivery of essential health services. Impaired access because of restrictions on mobility (e.g. curfews).

Key actions – health service structure



Adapted from the Sphere Health Standards (1)

- ☐ The health cluster/sector lead coordinates the implementation of priority health services, in collaboration with government departments and other health partners. The RMNCAH/CAH working group has an important role in advocating for CAH priorities and ensuring that the interests of all children and adolescents are protected.
- ☐ Review the levels of service delivery identified by the needs assessment (Box 12) and consider how the prioritized health services and activities can be most effectively delivered in your context. Adapt and improve the existing system.
- ☐ Engage the community to design health services relevant to their needs and with access acceptable to the affected population. Involve young people and women in decisions about CAH health services. Incorporate accountability processes (section 1.2.2).
- ☐ Identify threats to and opportunities for reaching the population affected (Box 11). Consider the different needs and capacities of urban versus rural populations¹ and children at high risk (Box 8). Develop strategies to include them.

¹ Increasingly, most people affected by emergencies are in urban settings with unique risks (e.g. large populations, many services and much of the infrastructure affected by the crisis) and opportunities (e.g. existing infrastructure, hospitals and health services, technology and communication).

Box 12 Levels of health service delivery

These are the general features of the different levels of health service delivery and the potential role they can play during emergencies. This is only a guide – the exact structure of health service delivery and the roles of those providing services will vary between places and over time.

1. Household and community

Care is provided to children, adolescents and families in the community, including camps and informal settlements for displaced people. Care providers may include community health workers, traditional birth attendants, outreach workers, or other trained health workers. Providers should be linked to nearby primary care facilities for referral and other support. Providers typically provide a narrow selection of health promotion and preventative services (e.g. safe birth kits and advice, nutrition advice and contraception), and basic treatment (e.g. first aid and community case management). Outreach workers and teams often have a particularly important role during humanitarian emergencies.

2. Clinics/primary care facilities

Care is provided to children, adolescents and families at small health facilities, including mobile clinics and temporary camp clinics. Care providers may include nurses, midwives, health assistants and sometimes doctors. They typically provide a range of outpatient services (e.g. IMNCI, vaccinations, nutrition services and treatment of common conditions) and link to hospitals for referral and support.

3. Hospitals/secondary and tertiary health facilities

Care is provided to children, adolescents and families at established hospitals, including camp hospitals and therapeutic feeding centres. Care providers include the full range of medical, nursing and allied health professions, varying by size of facility. They typically provide a range of inpatient and outpatient services, linking to other hospitals and primary care facilities; they often run outreach services.

- ☐ Consider additional services to reach populations in need. Establish temporary health outposts within, or very close to, affected communities. Provide mobile services. Deploy community workers to visit pregnant women, children and families in their homes. Provide clean delivery kits and essential newborn kits to promote safe delivery when access to a health facility is not possible.
- ☐ Strengthen, or establish, referral pathways to ensure that pregnant women, children and adolescents have access to essential services.
 - Establish or strengthen a protocol for triage at health facilities to ensure those with emergency presentations receive immediate treatment and stabilization care during transport when referred. Use WHO emergency triage, assessment and treatment (35).
 - Address referrals between levels of care and services. Include referrals between sectors (e.g. nutrition, education and child protection).
- ☐ Assess risk of violence against health facilities, workers and patients. Create a prevention and response plan. Make health facilities weapon-free. Use locally recognized symbols to identify health facilities (e.g. red cross or red crescent).
- ☐ Provide health care that guarantees patients' rights to dignity, privacy, confidentiality, safety and informed consent. Give special consideration to

those who may need assistance (e.g. children, people with certain impairments, people with certain mental illnesses and unaccompanied minors).

- ☐ Use or adapt standardized protocols for health care, case management and rational drug use. Use national standards, if available, or refer to international guidelines (see WHO and **Médecins Sans Frontières** guidelines in resources and tools).
- ☐ Provide safe health care and services. Use appropriate infection prevention and control measures. Employ appropriate use (rational drug use) and safe management of medicines, laboratories and technology.
- ☐ Manage and bury dead people in a safe, dignified and culturally appropriate manner, based on good public health practice (36).



Key indicators – health service structures

- ☐ The RMNCAH/CAH working group and partners have worked with the health cluster lead to review service delivery capacity and develop a plan.
- ☐ Availability of health facilities
 - One community health unit per 1000 population
 - One health facility per 10 000 population
 - Five health facilities with basic emergency obstetric and newborn care per 500 000 population
 - One health facility with comprehensive emergency obstetric and newborn care per 500 000 population
 - Ten inpatient beds per 10 000 population.
- ☐ Proportion of health care facilities using triage and referral systems.
- ☐ Proportion of the population within 5 km of a health facility.

3.2 Decide on an essential services package

A service package lists the services offered at each level of service delivery (community, primary care and hospital), and links to minimum requirements for staffing, medications and medical supplies.

While many countries have an existing services package, for emergency situations it is often necessary to define an essential services package. An essential services package should address the needs of children of different ages (Box 13)¹. It should be based on the priorities identified and the realities of service delivery constraints. The package should be defined as part of preparedness, put in place during response and expanded into a more comprehensive services package during recovery.

This section highlights important CAH considerations for an essential services package, in the following fields:

- acute conditions (general)
- chronic conditions (general)
- child safety and protection

¹ See also the priority CAH actions in Annex 3.

Box 13 Priority areas for children of different ages in humanitarian emergencies

Newborns (4). Biggest risks of death and morbidity are prematurity, sepsis (infection) and birth asphyxia, as well as small for gestational age and tetanus. Priority services must address safe birth, essential newborn care, care for small and sick newborns and prompt recognition and treatment of infection.

Young children (< 5 years). Biggest risks are respiratory infection, diarrhoea, measles and undernutrition, as well as meningitis (and other outbreaks). Priority services must address prevention and treatment of common infections (including immunization), nutritional deficiencies and child safety.

Older children (5–9 years). Biggest risks are infection, injury (including drowning, burns and traffic incidents) as well as mental health issues and nutrition. Priority services must address prevention and treatment of common infections and illness, chronic conditions, child safety and psychological well-being.

Younger adolescents (10–14 years). Biggest risks are injury, infection, mental health issues. Priority services must address safety and violence, sexual and reproductive health, treatment of common infections, chronic conditions and psychological well-being.

Older adolescents (15–19 years). Biggest risks are injury, infection, mental health issues and substance abuse, and pregnancy and childbirth. Priority services must address safety and violence, sexual and reproductive health, treatment for common infections, chronic conditions and psychological well-being.

NOTE: Many children's services end at the age of 13 or 14 years, and adult-oriented services typically do not have a developmental perspective. Where age criteria for health services are unclear, using the older age limit is recommended.

- disease outbreaks and immunization
- nutrition and food security
- child development and education
- disability
- psychosocial distress and mental health
- sexual and reproductive health
- WASH.

For each field the important concepts and ideas that should be familiar to everyone working with children and adolescents in humanitarian emergencies are briefly described. Specific key actions and key indicators derived from existing standards are also given. Your interpretation and application of these actions and indicators will depend on your particular context and the priorities that you have identified. Depending on your role, some actions will be more directly relevant to you than others.

3.2.1 Acute conditions (general)

Acute infections and injury are the leading causes of death in all age groups during humanitarian emergencies, and many have long-lasting effects (e.g. birth asphyxia, meningitis and trauma). This section focuses on common acute infections and neonatal conditions; other specific acute conditions are covered in later sections.

- Acute infections. Most deaths in humanitarian emergencies can be attributed to four conditions: diarrhoea, respiratory infections, measles and malaria.
- Reducing deaths from infection requires a coordinated, intersectoral response addressing health care access, supplies, communication, WASH, waste management, shelter and overcrowding, nutrition and food supply, outbreak detection and response, and vector control.
- Newborns (< 28 days of life) are at particularly high risk of death during emergencies because of poor antenatal care, maternal illness and/or undernutrition, and lack of safe birth options. Mothers may have poor access to maternity and obstetric care due to insecurity and displacement, destruction of existing facilities, or break down of usual services. Adolescent mothers and their babies are at particular risk.
- The main causes of neonatal death are: prematurity, infection and intrapartum complications (e.g. birth asphyxia).
- Most complications can be prevented or addressed by simple measures including: clean delivery and cord care, keeping the baby warm, skin-to-skin contact, supporting breastfeeding and monitoring for danger signs (i.e. complications that may result in death such as bleeding and hypertension).



Key actions – acute conditions (general)

Adapted from the Sphere Health Standards and the newborn health in humanitarian settings field guide (1,4)

- ☐ The RMNCAH/CAH working group (and organizations) develop and implement general prevention measures in coordination with relevant sectors. Priority areas are: safe water and hygiene, vector-borne infections, vaccine-preventable diseases, public safety, safe delivery and recognition of illness in young children.
 - Develop public health education messages to encourage people to seek care early for fever, cough, diarrhoea and obstetric and newborn complications (Section 1.4). Encourage antenatal, skilled birth and postnatal care.
- ☐ Provide health care at all first-level health facilities (clinics/primary care) based on standard case management protocols. Use local protocols or international standards (e.g. see resources and tools at the end of this section), particularly IMNCI and basic emergency obstetric and newborn care. Provide skilled staff and essential supplies.
- ☐ Provide health care at hospitals (secondary/tertiary care) based on standard case management protocols. Use local protocols or international standards. Include comprehensive emergency obstetric and newborn care, emergency surgical care and general paediatric care. Provide skilled staff and essential supplies.
- ☐ Implement triage, diagnostic and case management protocols for early treatment of conditions such as pneumonia, malaria, diarrhoea, measles, meningitis, undernutrition, dengue, and obstetric and newborn complications. Train staff on treatment protocols.
- ☐ Provide referral care for management of severe illness. Establish communication and transportation systems (covering community, primary care and hospitals) to manage common obstetric, newborn and child emergencies.



Key indicators – acute conditions (general)

- ☐ The RMNCAH/CAH working group and partners have defined acute care priorities for newborns, children and adolescents. The RMNCAH/CAH working group and partners have advocated for these priorities within the health cluster and have successfully integrated them into the health cluster plan.

3.2.2 Chronic conditions (general)

Chronic conditions of childhood are common. These conditions contribute substantially to the burden of disease and disability in all age groups, particularly older children and adolescents. This section covers common chronic health conditions. Mental health, other specific chronic health conditions and disability are covered later.

- Chronic conditions affect individuals, families and the community. Effective support for those living with chronic conditions can substantially increase the ability of communities to cope with and respond to crises.
- Chronic conditions are defined as health conditions that last an extended period (> 3 months), cause considerable impact on the lives of the child and their family, and require particular health care services (37).
- Common chronic health conditions affecting children and adolescents include:
 - Neurological: cerebral palsy, epilepsy
 - Respiratory: asthma, cystic fibrosis, bronchiectasis, chronic lung disease
 - Cardiac: congenital heart disease, rheumatic heart disease
 - Musculoskeletal: amputation, traumatic injury
 - Endocrine: diabetes, hypothyroidism
 - Nutritional: obesity/overnutrition, undernutrition
 - Haematological/malignancy: sickle-cell disease, thalassemia, leukaemia, lymphoma
 - Developmental: intellectual disability, autism spectrum disorders, attention deficit hyperactivity disorder, specific learning disorders
 - Infectious: HIV/AIDS, tuberculosis, scabies
 - Sensory: blindness, deafness
 - Psychological: anxiety, depression, trauma-response/post-traumatic stress disorder
 - Congenital syndromes: Down syndrome, Turner syndrome, fragile X syndrome.
- Humanitarian emergencies often destroy structures for the care of, and support for, children and adolescents with chronic conditions. Chronic conditions require different health system approaches from acute conditions, including close partnership between health providers, patients and families, and the broader community who provide support (Annex 4). Humanitarian emergencies can be an opportunity to improve chronic care systems by making use of resources provided during emergencies to establish a long-term system.



Key actions – chronic conditions (general)

Adapted from the Sphere Health Standards (1)

- ☐ The RMCAH/CAH working group and members cooperate with partners to ensure access to care for children and adolescents with chronic health conditions.
 - Include children and adolescents living with chronic health conditions, and their families, in planning. Promote independence and self-management, recognizing that children and adolescents and their families as the experts in care.
 - Assess and document the prevalence of chronic health conditions and disability and share the data with agencies responding to the disaster. Include the prevalence of chronic health conditions and disability in needs assessment and monitoring and evaluation.
 - Identify individuals with chronic health conditions who were receiving treatment before the emergency and ensure that they continue to do so. Avoid sudden discontinuation of treatment.
 - Ensure that people with acute complications and exacerbations of chronic health conditions that pose a threat to their life and individuals in pain receive treatment.
 - In situations where treatments for chronic conditions are unavailable, establish clear standard operating procedures for a referral.
 - Ensure that essential diagnostic equipment, core laboratory tests and medication for the routine, ongoing management of chronic conditions are available through the primary health care system. This medication must be specified on the essential medicines list.



Key indicators – chronic conditions

- ☐ The RMNCAH/CAH working group has identified priority chronic care needs, essential medicines and medical supplies, and communicated these to providers, in collaboration with the health cluster.
- ☐ Health facilities have adequate medication for people who were receiving treatment for chronic conditions before the emergency to continue receiving this medicine.

3.2.3 Child safety and protection

Child protection is core business for all those who work with children and adolescents during humanitarian emergencies.

- **Unintentional injuries.** Globally, these injuries account for over 30% of deaths in young adolescents aged 10–14 years and almost 50% in older adolescents aged 15–19 years. In humanitarian settings, the risk of children and adolescents being unintentionally injured (e.g. falls, drownings, burns and road traffic injuries) is increased by rapid environmental changes, such as overcrowding, displacement, reconstruction, and disruption to fuel supplies, housing and sanitation.

- **Conflict.** Three quarters of the people killed in recent conflicts around the world have been women and children. Explosive remnants of war, landmines, and crossfire cause a considerable number of injuries to children and adolescents, both unintentionally and intentionally. Limited access to health care may delay treatment for illnesses and injuries leading to a greater chance of long-term or permanent injury.
- **Violence.** Violence and child abuse may increase after a disaster, both within families and outside the home. During conflicts, children and adolescents may suffer extreme violence such as killing, maiming, torture and abduction. Apart from the acute and chronic physical effects of violence, it often has long-term psychosocial impacts on survivors.
- **Sexual and gender-based violence.** Sexual violence, often concealed, occurs in all emergency contexts. The consequences of sexual violence include physical injuries and death, unwanted pregnancy, sexually transmitted infections, mental health issues, distress, and social and economic exclusion. In addition, harmful practices such as early marriage or female genital mutilation can increase after a humanitarian disaster.
- **Other protection concerns.** During a humanitarian crisis, children and adolescents are more likely to join labour forces – voluntarily and involuntarily. They are particularly vulnerable to unsafe working environments, exploitation and trafficking. Children and adolescents may be recruited into armed forces, where the risks of abuse, drug addiction, violence and injury are extremely high. Law and order may break down during humanitarian emergencies, and adolescents in the justice system are at particular risk of maltreatment.



Key actions – child safety and protection

Adapted from the child protection standards of the Child Protection Working Group (38)

- ☐ The RMNCAH/CAH working group should cooperate with the protection cluster lead to ensure child safety actions are integrated into the humanitarian response of every sector. Use emergencies as an opportunity to strengthen child protection systems for the long term, and raise awareness of child protection issues and sociocultural responses.
- ☐ Contribute to protection cluster activities and encourage CAH partners to develop appropriate child safety and protection policies and procedures:
 - Develop an advocacy plan that respects diversity, inclusion, privacy and children's agency. Advocate with governments, donors, parties involved in the conflict, those planning and implementing programmes in other sectors, and other high-level actors and decision-makers.
 - Involve children and adolescents, particularly those with disabilities and other vulnerabilities, in developing and implementing responses.
 - Implement risk assessment, risk reduction and injury prevention in all humanitarian activities.
 - Map existing protection services. Develop the capacity of child protection workers and all health and humanitarian workers to prevent, detect and respond appropriately to child protection issues.
 - Establish case management services to identify and refer children at high risk to essential services, including medical support, interim care, psychosocial support, legal assistance, safety and security.

- Ensure organizations have codes of conduct, hold staff to high standards, deal appropriately with staff misconduct with children and adolescents, actively gather complaints and address allegations transparently.
 - Ensure services are gender-sensitive and culturally appropriate.
 - Create safe community spaces, playgrounds and recreation areas for children and adolescents. Strengthen/reactivate existing supportive community networks to prevent harm and promote well-being.
- ☐ Develop plans for how your agency will cooperate with partners to support the most at-risk children and adolescents.
- Sexual violence. Recognize that sexual violence is common. Seek to understand local perceptions and reactions. Disseminate sexual violence prevention messages. Educate health and allied staff to look, recognize, and respond to sexual violence sensitively. Report information in line with national laws and international norms. Consider using the Inter-Agency Child Protection Information Management System (39) or the Gender-Based Violence Information Management System (40).
 - Armed forces. Assess involvement of children and adolescents in armed forces, community perceptions, and demobilization and reintegration activities. Support schools and other institutions protecting children. Share prevention, reporting and survivor care information.
 - Survivors. Develop age-appropriate survivor assistance that includes medical care, physical rehabilitation, psychosocial support, legal support, economic inclusion, and educational and social inclusion. Include non-stigmatizing support for those who need additional attention (e.g. those involved in armed forces, pregnant girls, sexually exploited children and adolescents, girls who are pregnant as a result of rape).
 - Child labour. Prioritize action on the worst forms of child labour, including forced/bonded labour, armed conflict, trafficking, sexual exploitation, illicit work, unsafe work. Involve affected families and other local stakeholders in responses.
 - Unaccompanied and separated children. Assume all children have a caring adult with whom they can be reunited, until tracing proves otherwise. Review existing legal systems and procedures for family tracing and reunification. Assess the scope, causes and risks of family separation. Take practical steps to prevent separation (e.g. reception registers, ID cards). Avoid unintentionally encouraging abandonment (e.g. advertising special assistance to unaccompanied and separated children).
 - Justice system. Strengthen child-friendly spaces in courts and police stations. Identify children in detention (especially arbitrary detention), and patterns of violations. Promote diversion activities to resolve issues without the trauma of the justice system.



Key indicators – child safety and protection

- ☐ The RMNCAH/CAH working group and partners have developed and adopted child safety and protection measures within their organizations.
- ☐ The RMNCAH/CAH working group works collaboratively with the protection cluster to support full integration of child safety into humanitarian action.

3.2.4 Disease outbreaks and immunization

Disease outbreaks are the greatest immediate threat to life during humanitarian emergencies, making immunization and other preventative measures a critical priority for all age groups.

- Measles is a major cause of death, particularly in situations of displacement, crowding and undernutrition. While most deaths occur in young children (under 5 years), a significant proportion of deaths occur in older age groups and full immunization coverage is essential for population protection.
- Other important vaccine-preventable infections include: cholera, meningitis, yellow fever, polio, tetanus, diphtheria and pneumococcal infections.
- All sectors must cooperate to assess risks, monitor for and detect outbreaks, and mount a multisector response (including immunization, water and sanitation, communication and supply chain).

Key actions – outbreaks and immunization

Adapted from the Sphere Health Standards (1). See Standards for details

Disease outbreaks: The RMNCAH/CAH working group and partners:

- ☐ Assist the health cluster to prepare an outbreak investigation and response plan, in collaboration with other clusters.
- ☐ Implement appropriate vector-control methods for malaria, dengue and other vector-borne diseases depending on local epidemiology.
- ☐ Implement disease-specific prevention measures, e.g. mass vaccination against measles as indicated.
- ☐ Establish a disease early warning surveillance and response system based on a comprehensive risk assessment of communicable diseases, as part of the broader health information system. See action area 4 on monitoring, evaluation and review.
- ☐ Train health care staff and community health workers to detect and report potential outbreaks.
- ☐ Provide populations with simple information about symptoms of epidemic-prone diseases, as well as about where to go for help.
- ☐ Ensure that protocols for the investigation and control of common outbreaks, including appropriate treatment protocols, are available and distributed to relevant staff.
- ☐ Ensure that reserve stocks of essential medicines and supplies are available for priority diseases or can be procured rapidly from a pre-identified source.
- ☐ Identify sites for isolation and treatment of infectious patients in advance, e.g. cholera treatment centres.
- ☐ Identify a laboratory, whether local, regional, national or in another country, that can confirm outbreaks.
- ☐ Ensure that sampling materials and transport media are available on site for the infectious agents most likely to cause a sudden outbreak.
- ☐ Describe the outbreak according to time, place and person, so as to identify high-risk individuals and adapt control measures

Immunization

- ☐ Estimate measles vaccination coverage of children aged 9 months to 15 years at the outset of the disaster response to determine the risk of outbreaks.
 - When measles vaccination coverage is < 90% or unknown, conduct a mass measles vaccination campaign for children aged 6 months to 15 years, including the administration of vitamin A to children aged 6–59 months.
 - Ensure that all infants vaccinated between 6 and 9 months of age receive another dose of measles vaccine on reaching 9 months.
 - For mobile or displaced populations, establish an ongoing system to ensure that at least 95% of newcomers to a camp or community aged between 6 months and 15 years receive vaccination against measles.
- ☐ Address potential challenges to the cold chain and vaccine supplies.
- ☐ Consider reactive or pre-emptive vaccination for certain communicable diseases against imminent or ongoing outbreaks. These communicable diseases are cholera, measles, meningitis, yellow fever and polio.
- ☐ Re-establish the national immunization programme (Expanded Programme on Immunization) as soon as conditions permit in order to routinely immunize children against measles and other vaccine-preventable diseases included in the national schedule.
- ☐ Screen children attending health services for vaccination status. Administer any needed vaccinations.



Key indicators – outbreaks and immunization

- ☐ The RMNCAH/CAH working group and partners have contributed to the creation and dissemination of the multisector outbreak response plan.
- ☐ The RMNCAH/CAH working group and partners support the re-establishment of the national immunization programme.
- ☐ Percentage of reported outbreaks investigated within 48 hours of alert.
 - 90%.
- ☐ Percentage of target populations that successfully received the interventions, following a vaccination campaign:
 - Measles – 95% of children aged 6 months to 15 years
 - Vitamin A – 95% of children aged 6–59 months.
- ☐ Case fatality rate of measles
 - Aim for < 5% in conflict settings.
- ☐ The national immunization programme has been re-established.
 - 100% enrolment of infants in national immunization programmes.
 - 90% of children aged 12 months have had three doses of the diphtheria, pertussis and tetanus vaccine.
 - 90% of primary health care facilities offer basic services within the immunization programme at least 20 days a month.

3.2.5 Nutrition and food security

In emergencies, increased illness and irregular access to nutritious foods, adequate shelter, water, hygiene and sanitation dramatically increases the incidence of acute undernutrition. Rates of undernutrition and related mortality can increase sharply during a humanitarian crisis.

- Globally, more than a third of all deaths in children under 5 years are attributable to undernutrition, either as a direct cause of death or through the weakening of the body's resistance to illness. A young child with severe acute malnutrition is nine times more likely to die than a well-nourished child.
- Undernutrition is a particular threat to child survival during an emergency. Population displacement, break down of food supply chains, disruption to local crops and food production, and issues with cooking fuel and energy sources, privacy and sanitation can all lead to an inadequate availability of food.
- Breastfed children are at least six times more likely to survive in the early months, so support, promotion and protection of breastfeeding are fundamental to preventing undernutrition and death in infants in emergencies.
- Undernutrition survivors can experience long-term consequences on their cognitive, social, motor skill, physical and emotional development.
- For children and adolescents, micronutrient deficiency increases the risk of death from infectious disease and impaired physical and mental development. Maternal micronutrient deficiency during pregnancy and breastfeeding also increases the risk of poor health and development in children. Provision of fortified foods and micronutrient supplements is an integral component of the response to tackle micronutrient deficiency.



Key actions – nutrition and food security

Adapted from the Sphere Health Standards (1). See Standards for full actions and details

General

- ☐ The RMNCAH/CAH working group and partners support the nutrition cluster lead to assess, plan and implement preventative and curative programmes addressing priority nutrition needs.
 - Assess the nutrition and food security status of local communities to identify those most affected and to define the most appropriate response.
 - Analyse available cooking methods, including the type of stove and fuel used. Identify related risks that threaten safety and leave people vulnerable to harm, particularly women and girls.
 - Consult with local communities and across sectors to identify local needs and groups with the greatest nutritional support needs.
 - Evaluate national and local capacity to lead and support the response.

Severe acute malnutrition

- ☐ Establish clearly defined and agreed malnutrition strategies, including criteria for the set up and closure of inpatient and outpatient interventions. Include inpatient care, outpatient care, referral and community components.

- ☐ Maximize access to and coverage of severe acute malnutrition interventions through community engagement from the beginning of the response.
- ☐ Emphasize protecting, supporting and promoting breastfeeding, complementary feeding and hygiene. Admit breastfeeding mothers of acutely malnourished children under 6 months to inpatient facilities to provide supplemental feeding for the child.
- ☐ Provide nutritional and medical care according to nationally and internationally recognized guidelines for community management of acute malnutrition for the management of severe acute malnutrition.

Micronutrient deficiencies

- ☐ Determine the most common micronutrient deficiencies. Train health staff on how to identify and treat micronutrient deficiencies.
- ☐ Provide micronutrient supplements as necessary: consider vitamin A, iron and folic acid, and iodine in children aged 6–59 months, and daily supplements to pregnant and breastfeeding women.

Infant and young child feeding in emergencies

- ☐ Establish policies and programming for infant and young child feeding in emergencies and a coordination authority.
- ☐ Mitigate and manage potential risks associated with inappropriate donations of breastmilk substitutes (formula milk) and associated equipment.
- ☐ Prioritize pregnant and breastfeeding women for access to food, cash or vouchers, and other supportive interventions. Enable access to skilled breastfeeding counselling for pregnant and breastfeeding mothers.
- ☐ Support timely, safe, adequate and appropriate complementary feeding.
- ☐ Provide feeding support to particularly vulnerable infants and young children (with HIV, separated and unaccompanied, low birth weight, with disabilities, under 2 years of age not breastfeeding, and acutely malnourished).



Key indicators – nutrition and food security

- ☐ The RMNCAH/CAH working group and partners have supported the nutrition cluster lead to assess, plan and implement preventative and curative programmes.
- ☐ Number of systematic and objective food security needs assessments conducted within the first week of an emergency response.
 - At least one, with clear recommendations
- ☐ Percentage of targeted households that report that provision of food assistance corresponds to their requirements.
 - Establish baseline and move towards improvement
- ☐ Standard assessment and analysis methodologies adopted.
 - Single standard methodology adopted for each nutrition response
 - All reports contain clear recommendations to meet prioritized needs
- ☐ Population proximity to dry ration supplementary feeding sites.

- > 90% of target population can access dry ration feeding within a day
- > 90% of target population can access on-site programmes within an hour
- ☐ Feeding programme outcomes (died, recovered and defaulted).
 - Died: < 3%. Recovered: > 75%. Defaulted: < 15%
- ☐ National/organizational policies address infant and young child feeding in emergencies.
 - During preparedness or within 4 weeks of the start of the emergency.
 - Lead agency designated within 72 hours of the start of the emergency.
- ☐ Prevalence of undernutrition in children under 5 years disaggregated by sex and age (from 24 months on, also disaggregated by disability)
 - Use WHO classification system (global acute malnutrition < 15%) (41)

3.2.6 Child development and education

Nurturing care is essential for child development (Fig. 10). Early childhood development should be integrated into all humanitarian activities¹.

- Humanitarian emergencies can threaten all the components of nurturing care because they can lead to, for example, unsafe environments, lack of nutrition, and caregivers who are absent or unable to attend to and stimulate young children. This leads to toxic stress, which disrupts the developing brain's architecture.
- Conversely, efforts to improve infant attachment, sense of security and early stimulation can be enormously protective for children in crisis.
- Responsive caregiving is particularly important during emergencies, and parents need support to prioritize young children's development alongside other critical competing priorities.

Education is particularly important throughout early childhood and adolescence. We know that communities value and prioritize education during emergencies, recognizing its life-sustaining and life-saving role.

- Education and early learning opportunities are critical to the development and well-being of children and adolescents, especially during humanitarian emergencies. Education provides physical, psychosocial and cognitive protection.
- Education can enable early identification of children at risk (e.g. child head of household, impoverished children and undernourished children) and those with additional needs.
- Education can protect children and adolescents from dangers and exploitation (e.g. sexual or economic exploitation, early marriage, and involvement in armed forces and crime).
- Education provides children and adolescents with problem-solving and critical-thinking skills, which enable them to make more informed decisions and better understand political messages and conflicting information.

¹ Particular aspects of nurturing care are covered in other sections (e.g. child safety and protection, nutrition and food security). See UNICEF's *Early childhood development in emergencies: integrated programme guide* (42) for more details.



Fig. 10 Nurturing care framework (43)

- Educational venues can provide a place to deliver essential support such as food and nutritional supplements, WASH education and resources, health education and health services (e.g. immunization, deworming and menstrual care).
- Education can promote inclusion and equality if it provides equitable access for groups at high risk.
- Education can provide an important routine to support well-being and recovery.



Key actions – child development and education

- ☐ The RMNCAH/CAH working group and partners work with the education and other sectors to integrate nurturing care for all children (from early childhood care to post-secondary education) into humanitarian action. (See Annex 5 and Annex 6 for more on early child development and education in emergency situations.)
- Share health promotion messages. Share information on health challenges and health service delivery (e.g. access barriers, unreached populations and emerging health issues). Strengthen referral pathways for children and adolescents with additional health needs.



Key indicators – child development and education

- ☐ The RMNCAH/CAH working group and lead education cluster agency have regular meetings to strengthen coordination of activities.

3.2.7 Disability

Disability is as an umbrella term for impairments, limitations to activities and restrictions on participation.

Humanitarian agencies can, and should, provide humanitarian action that is inclusive of and appropriate to children and adolescents with disabilities. Chronic health conditions were addressed in section 3.2.2. This section on disability focuses on the structural aspects of disability-inclusive humanitarian action.

- Children and adolescents with disabilities are often forgotten by service planners and implementers, resulting in services that are inaccessible to them and inappropriate to their needs. A disability-inclusive approach must be part of all stages of humanitarian planning, delivery, and monitoring and evaluation.
- Children and adolescents with disabilities are at particular risk when their coping strategies and usual supports are weakened. For example, loss of assistive devices (e.g. hearing aid, glasses and mobility aids), medications or medical supplies (e.g. sanitary items, feeding tubes and catheters), loss of caregiver or support person(s), poor access to medical services, and loss of financial or other social supports.
- Children and adolescents with disabilities may be unable to access mainstream humanitarian services or food distribution (either directly due to their impairment or due to associated social stigma and negative attitudes).
- Children and adolescents with disabilities are particularly at risk of physical, sexual, emotional and verbal abuse and neglect.

“Disability is the interaction between individuals with a health condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports).” (44)

“Children with disabilities ... belong at the centre of efforts to build inclusive and equitable societies – not only as beneficiaries, but as agents of change. After all, who is in a better position to comprehend their needs and evaluate the response” (45)



Key actions – disability

Adapted from the Sphere Health Standards (1)

- ☐ The RMNCAH/CAH working group and partners promote disability-inclusive approaches in all activities (see Annex 7).
 - Use a disability-inclusive approach to humanitarian response.
 - Ensure information is accessible to persons with disabilities, particularly those with visual, hearing or language impairments.
 - Make mainstream services accessible through planning and design (health, WASH and nutrition services, and schools).
- ☐ Include children and adolescents with disabilities, and their families, in planning. Promote independence and self-management, recognizing that children and adolescents and their families are the experts in care.
- ☐ Ensure that assistive devices (e.g. walking aids) are available for people with mobility or communication difficulties.
- ☐ Challenge discriminatory attitudes and promote equity by partnering with disability organizations at the community, local and national level.



Key indicators – disability

- ☐ All health care providers and partner agencies have adopted policies on disability-inclusive action, and are translating these into concrete actions.

3.2.8 Psychological distress and mental health

- Humanitarian emergencies expose children and adolescents (and their carers) to a wide range of psychosocial traumas, including displacement, housing instability, resource and food insecurity, death, family separation, physical injuries and illness, armed violence, abuse, neglect and exploitation. The lack of credible or accurate information for those affected by an emergency exacerbates confusion and insecurity.
- Emergencies weaken protective familial and community supports for children and adolescents, increasing the risks of a wide range of psychosocial problems, and exacerbate pre-existing problems.
- Children and adolescents of different ages are all at risk. They may express their distress in a variety of ways, including developmental regression, anxiety, sleep problems, emotional changes, risk-taking, substance misuse, impaired concentration, and changes in behaviour in and out of school.
- Alcohol and other drugs can become an important problem, particularly among those involved with armed forces.
- Many children and adolescents have experienced substantial loss and need support through grief and bereavement.
- Some children and adolescents are more at risk, especially those who have lost their usual supports, or who are survivors of violence. Emergency situations can unmask, trigger or exacerbate serious mental health problems, such as depression, anxiety, or post-traumatic stress disorder.

The core principles of emergency mental health and psychosocial interventions are (46):

1. Promote respect for human rights and equity
2. Promote community (adolescent) participation
3. Do no harm
4. Build on available resources and capacities
5. Integrate activities and programming into wider systems (e.g. health programmes and education programmes)
6. Develop a multilayered response



Key actions – psychosocial and mental health

Adapted from the Child protection standards of the Child Protection Working Group (38)

- ☐ The RMNCAH/CAH working group and partners work with child protection, education and other sectors to promote good mental health and well-being.
- ☐ Ensure the availability of basic clinical mental health care for priority conditions (including depression, anxiety, post-traumatic stress disorder) at every health facility.
- ☐ Provide psychological interventions for people with prolonged distress and disabling emotional problems.
- ☐ Protect the rights of people with severe mental health problems in the community, hospitals and institutions (e.g. schools and the workplace).
- ☐ Minimize harm related to alcohol and drugs through health promotion, confronting stigma, and non-punitive health care and support for those affected.
- ☐ Ensure psychosocial support is available for national workers involved in the emergency response.
- ☐ Strengthen pre-existing community networks to provide psychosocial support to children and adolescents and their families; for example, by providing information on how to cope with stress and carrying out activities for children.
- ☐ Support activities for children and adolescents in the community, such as recreational activities, sports, cultural activities and life skills, to help recreate a routine and help them to build their resilience.
- ☐ Provide support to caregivers to improve care for their children, to deal with their own distress and to link them to basic services.



Key indicators – psychosocial and mental health

- ☐ The RMNCAH/CAH working group and partners have identified mental health priorities for children, adolescents, and their carers and families, in collaboration with the health cluster.
- ☐ Basic mental health services are available at every facility.

3.2.9 Sexual and reproductive health

Sexual and reproductive health issues affect children of all ages, and good care can have a considerable effect both immediately and in the longer term.

- Adolescents need culturally sensitive information and resources to protect their sexual and reproductive health.
- Children and adolescents are particularly at risk of sexual exploitation, rape and gender-based violence, including child and forced marriage, and genital mutilation. Survivors need adolescent-friendly medical, psychological, social and legal care.
- The well-being of young parents directly affects the health of their offspring.
- Poor nutrition and risk-taking behaviours, including drug and alcohol abuse, can complicate these health issues.
- Pregnant adolescents are at increased risk of morbidity and mortality from complications during pregnancy and childbirth, including obstructed labour, preterm labour and spontaneous abortion.
- Half of new HIV infections occur in young people aged 15–24 years, and a third of new cases of curable sexually transmitted infections affect people younger than 25 years.
- Five million adolescents between the ages of 15 and 18 years have unsafe abortions each year causing 70 000 abortion-related deaths. The unmet need for contraceptives among adolescents is more than twice that of married women.

During a crisis, children and adolescents are at higher risk of:

- Early pregnancy
- Unmet need for contraception and unwanted pregnancy
- HIV/AIDS and other sexually transmitted infections
- Unsafe abortion
- Sexual and gender-based violence (in all forms)
- Difficulties with the management of menstrual hygiene.



Key actions – sexual and reproductive health

Adapted from the Minimum Initial Service Package (MISP) for Reproductive Health and Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (47,48)

General

- ☐ The RMNCAH/CAH working group and partners collaborate to assess, plan and implement services based on identified priorities. Encourage adolescent participation in any multisectoral prevention task force.
- ☐ Establish basic services at the outset of a crisis and progress towards more comprehensive services. (See MISP for lists of basic and comprehensive services.)
- ☐ Provide community information, education and communication directed toward adolescents. Involve adolescents, parents and community leaders in the development of an information, education and communication strategy.
- ☐ Train staff in and provide adolescent-friendly care for all listed services.

- ☐ Collaborate across humanitarian clusters and community groups to establish education and referral services.
- ☐ Source and procure contraceptive supplies and ensure availability to meet demand.
- ☐ Train community workers to provide community-based family planning services, including counselling and health education.

Address gender-based violence in adolescence

- ☐ Coordinate and ensure health sector prevention of sexual violence.
- ☐ Prevent and tackle other forms of gender-based violence, including domestic violence, forced and/or early marriage, female genital mutilation, and trafficking.
- ☐ Provide medical, psychological, social and legal care for survivors of gender-based violence and sexual violence.
- ☐ Work with the protection cluster and subcluster for gender-based violence to identify a multisectoral referral network for young survivors of gender-based violence.
- ☐ Raise awareness in the community about the problem of gender-based violence and sexual violence, strategies for prevention and care available for survivors.
- ☐ Engage community health workers to link young survivors of sexual violence to health services.
- ☐ Sensitize uniformed men about gender-based violence and its consequences.
- ☐ Establish peer support groups.

Establish maternal and newborn care services that address the needs of adolescents

- ☐ Establish a round-the-clock referral system for obstetric emergencies.
- ☐ Provide midwife delivery supplies, including newborn resuscitation supplies.
- ☐ Provide clean delivery packages.
- ☐ Provide adolescent-friendly services at health facilities, involving male partners where appropriate.
- ☐ Coordinate with the health cluster and other sectors to identify pregnant adolescents in the community and link them to health services.
- ☐ Engage community health workers to link young mothers to health services.
- ☐ Encourage facility-based delivery for all adolescent mothers.
- ☐ Integrate mental health and psychosocial support services for adolescent mothers.

Address sexually transmitted infections in adolescents, including HIV prevention and treatment

- ☐ Provide access to free condoms. Provide discreet access to free condoms at adolescent-oriented distribution points.
- ☐ Ensure adherence to standard precautions and safe blood transfusions.

- ☐ Establish comprehensive prevention and treatment services for sexually transmitted infections, including surveillance systems or sexually transmitted infections.
 - Provide care, support and treatment for people living with HIV. Make HIV treatment available for people already taking antiretroviral medicines including for prevention of mother-to-child transmission of HIV.
 - Train adolescents on community-based distribution of condoms. Provide education on the prevention of and testing for sexually transmitted infections and HIV and the treatment services available. Provide referrals for services.
 - Establish programmes, including peer education, for adolescents most at risk of acquiring and transmitting HIV.

Key indicators – sexual and reproductive health



- ☐ The RMCAH/CAH working group and partners have created and communicated a plan to address sexual and reproductive health issues across the lifespan.
- ☐ Gender-based violence programmes have been established, and referral pathways for children and adolescents are available and appropriate.
- ☐ All services, including obstetric and maternity services, are adolescent friendly.

3.2.10 Water, sanitation and hygiene

- Outbreaks of diarrhoeal diseases, including dysentery and cholera, are common in emergencies. Faecal–oral diseases may account for more than 40% of deaths in the acute phase of an emergency, and more than 80% of deaths in children under 2 years. In some emergencies and post-emergency situations, diarrhoea can be responsible for most deaths.
- Overcrowded WASH facilities can be a considerable threat to children's safety because this situation may lead to, for example, riots, demonstrations, violent behaviour and child abuse. In addition, families may adopt risky strategies to obtain water, sanitation facilities, or soap and buckets.
- WASH implementation may enable children and adolescents, especially girls, to attend school. WASH programmes can free children and adolescents from the hard work of water collection and hygiene maintenance (this includes enabling girls to manage menstrual hygiene with dignity).
- Children need different excreta disposal facilities depending on age. If nappies (diapers) are distributed, waste management is an issue; however, non-disposable nappies present the problem of washing. Providing potties (pot toilets) for children may be useful if children are afraid of falling into a pit latrine or when they might not want to use a toilet because of fear of the dark or snakes and other animals, or because of the smell and dirtiness.
- Young women and girls are often responsible for managing the water needs of the family and maintaining domestic hygiene. Their safe access is an essential consideration when designing refugee shelter and WASH facilities (latrines, water sources and lighting). Considerations include placement (relative to living quarters) of sanitation (or water source), shared or collective sanitation facilities versus individual, and amenities (lighting, locks and other design elements). Safe, hygienic and private options for menstrual hygiene management should be provided.
- People with disabilities or chronic health conditions should also be considered and their needs for WASH access evaluated and provided.

The main objective of WASH programmes in humanitarian settings is to reduce the risk of faecal–oral diseases and exposure to vectors that can carry disease. This is achieved through the:

- promotion of good hygiene practices
- provision of safe drinking water
- reduction of environmental health risks
- provision of conditions that allow people to live with health, dignity, comfort and security.

Key actions – WASH



Adapted from the Sphere WASH standards (1). See Sphere Standards for detail

General

- ☐ The RMNCAH/CAH working group and partners collaborate with the WASH cluster leads to support holistic WASH programmes.
- ☐ Implement WHO's WASH facility improvement tool for health facilities (49).
- ☐ Consult local communities and stakeholders (including adolescents, children with disabilities, women and hard-to-reach groups or those at high risk) to identify the key WASH risks, needs and coping mechanisms. Seek ongoing feedback.
- ☐ Determine the main public health threats to the affected population, for example, excreta management, vectors, handwashing and infrastructure. Assess current behaviours and practices in the affected population. Train communities to monitor and provide feedback on WASH disease incidence and risk behaviours.
- ☐ Hygiene promotion. Communicate with families about children's WASH needs:
 - Wash hands with soap after faecal contact and before preparing food, eating food or feeding children.
 - Treat drinking water with an appropriate household water treatment method before giving to children.
 - Freshly prepare children's food, or reheat to boiling before feeding.
 - Protect children from ingesting soil and animal faeces.
- ☐ Hygiene. Consult with the community to understand the hygiene items they require (e.g. soap, menstrual hygiene products, incontinence products, nappies, potties and water containers). Develop appropriate menstrual hygiene and incontinence solutions (e.g. toilets, bathing areas, laundry facilities, disposal options and water supply).
- ☐ Water supply. Define the most appropriate structures and systems for short- and long-term management of the water systems and infrastructure.
- ☐ Excreta management. Determine the most appropriate excreta management options. Consult all stakeholders about the siting and design of shared toilets. Design and construct toilets to minimize safety threats, especially for women, children, older people or people with disabilities.
 - Segregate all shared toilets by sex and age, considering cultural norms and the potential for violence, harassment or stigmatization.

- Ensure that toilets used by women and girls have facilities to let them manage menstrual hygiene, including a menstrual waste disposal option.
 - Facilities at schools, temporary learning spaces, child-friendly spaces and women's and girls' safe spaces need to be planned, designed and constructed with those specific users in mind.
- ☐ Solid waste. Work with communities to manage solid waste systems and ensure a clean environment to live, learn and work.
 - ☐ Vector control. Work to protect communities, families and individuals from a range of relevant vector-borne disease.



Key indicators – WASH

- ☐ The RMNCAH/CAH working group and partners have contributed to the WASH sector plan, and regularly meet to support programme implementation.
- ☐ Percentage of the affected population that has hygiene items suitable for their priority needs
 - 100%
- ☐ Percentage of the affected population (households) using soap and water (or an alternative) for hand washing
 - 100%; 250 g soap per person per month.
- ☐ Percentage of women and girls, and people with incontinence, that express satisfaction with the consultation regarding the design of menstrual hygiene management systems, including toilets and disposal options
 - 100%
- ☐ Number of litres of water per person per day accessible for drinking, and domestic and personal hygiene.
 - 15 L per person per day (based on cultural and social norms, the context and phase of response, and in coordination with national authorities and/or cluster members).
- ☐ Percentage of affected households that possess at least two clean narrow-necked and covered water containers for drinking water at all times (100%)
- ☐ Percentage availability of appropriate, accessible and safe toilets.
- ☐ Percentage of health facilities appropriately disposing of hazardous waste.

3.3 Strengthen the health care workforce

During emergencies, local health care workers carry a triple burden of recovering from personal injury and loss, helping their family and friends, and providing care to the broader population. Loss of skilled health care workers during emergencies is a challenge. Furthermore, health needs are often not only greater during emergencies but different from before and therefore different skill sets and expertise may be needed to manage them.



Key actions – health workforce

Adapted from the Sphere Health Standards (1)

- ☐ The RMNCAH/CAH working group and partners work with the health cluster lead to evaluate the current health workforce capacity and needs, and establish a plan for response.
- ☐ Review existing staffing levels using national standards and classifications of job functions adapted to the emergency setting (see section 2.2 Needs assessment). Consider how to best use existing staff, including task-shifting or expanding scope of practice to allow lower skilled health care workers to perform additional duties.
- ☐ Coordinate staff recruitment, training and deployment with government and other health agencies, including the private sector. Recruit sufficient staff to match needs ensuring a mix of skills, and appropriate gender and ethnic ratios. Consider both paid and volunteer roles.
- ☐ Integrate local health workers into the emergency response. Support local staff by providing flexible working conditions during crisis situations, and training to handle new roles and changing health priorities.
- ☐ Develop incentive and salary strategies that minimize pay inequities and uneven distribution of health workers between ministry of health and other health providers. Consider non-monetary incentives. Avoid recruiting people away from underserved regions.
- ☐ Identify priority facilities and skills to target retraining and recruitment activities. Train staff based on an assessment of their performance and skills.
 - Use national standards or international guidelines. Incorporate approved RMNCAH messages, humanitarian action information, new/revised service delivery protocols, and codes of conduct (e.g. Core Humanitarian Standards).
 - Use practical, task-oriented training methods, ideally in their usual work environment, to promote effective learning and application, for example, on-the-job training and supportive supervision.
 - Integrate training activities within existing programmes as much as possible (e.g. IMNCL). Coordinate training sessions with the ministry of health and other agencies.
 - Provide ongoing and refresher training to maintain the skills of health care workers, as the usual continuing education system may be lost.
- ☐ Ensure health workers, including community health workers, operate in a safe working environment. Provide: occupational health training and protection (e.g. hepatitis B and tetanus immunization for clinical workers); infection prevention and control training; and adequate infection prevention and control equipment and protective equipment to carry out duties.
- ☐ Share health workforce data on availability and readiness with the ministry of health at national and subnational levels.
- ☐ Train staff on responding to the needs of children at high risk and adolescents. Improve capacity of staff and services to provide confidential and respectful services to all children and young people.



Key indicators – health workforce

- ☐ The RMNCAH/CAH working group and partners have supported the health cluster to evaluate the current health workforce capacity and needs, and established a plan for response.
- ☐ Availability of health workers
 - 1–2 community health workers per 1000 population
 - 23 qualified health workers per 10 000 population.

3.4 Obtain essential medicines and medical supplies

Evaluate existing supply chains and order lists before rushing to obtain more. Pre-existing supply chains may be disrupted, and changing health needs may require different or additional supplies. However, poorly considered orders can lead to preventable overstocking (and understocking), and waste valuable resources. Work with the logistics cluster¹ to address coordination and information management of the logistics response. The WFP is the lead agency of this cluster.

The UN can provide some emergency kits (Box 14). These kits are intended for new, acute crises with severe disruption to supplies. However, procurement and delivery takes about 3 months. In special circumstances, these kits can be modified to better suit your needs (discuss with the providing agency). Order kits or individual items through the UN country office or procurement partner².

Box 14 United Nations emergency supply kits

- Interagency Emergency Health Kit 2015 (10 000 people for 3 months)
- UNICEF Early Childhood Development Kit (50 children at the same time) and Recreation Kit (for 90 children simultaneously)
- UNICEF Midwifery Kit (50 normal deliveries)
- UNICEF Nutrition Kit (50 inpatients for 3 months)
- UNICEF Nutrition Kit (500 outpatients for 3 months)
- UNICEF Obstetric Surgical Kit (100 deliveries)
- UNICEF Post-exposure Prophylaxis (PEP) Kit
- UNICEF School Kit (40 students)
- UNFPA Interagency Reproductive Health Kit 2011 (10 000 or 30 000 or 150 000 people for 3 months) – and supplementary newborn kits
- UNFPA Basic Dignity Kit (one mother)
- WHO Cholera Kit (various kits for 100 patients at different facility levels)
- WHO Severe Acute Malnutrition with Medical Complications Kit (SAM/MC) (50 children)

1 Logistics cluster (<https://logcluster.org/>).

2 For more information, see UNICEF supply catalogue (<https://supply.unicef.org/>), or contact UNICEF: countrysupport@unicef.org, psid@unicef.org.



Key actions – medicines and medical supplies

Adapted from the Sphere Health Standards (1)

- ☐ The RMNCAH/CAH working group and partners should collaborate with the health cluster and health sector leads to assess needs, including future demand, and ensure that essential supplies for children and adolescents are prioritized.
- ☐ Evaluate existing supply chains and order lists before rushing to obtain more.
- ☐ Establish and use a standardized essential medicines and medical device list based on your essential services package and service delivery plan, and review of existing supply lists¹. Advocate for the inclusion of critical medicines and equipment; for example, for chronic conditions, sexual and reproductive health, pain relief, anaesthesia, and for people with disabilities (assistive devices).
- ☐ Ensure availability of safe, essential medical devices through an effective management system.
- ☐ Accept donations of medicine and medical equipment only if they follow internationally recognized guidelines.



Key indicators – medicines and supplies

- ☐ Total number of days key medicines were not available in the past 30 days, e.g. paracetamol, amoxicillin, oxytocin and sodium valproate.
- ☐ Total number of days basic equipment was not available or not functional in the past 30 days, e.g. blood sugar machine, pulse oximeter, thermometer, scales, soap, chlorhexidine, mid-upper arm circumference bands and stethoscope.

3.5 Obtain financing

Health agencies should aim to provide free essential services to affected communities. This usually requires additional funding, for training, material development, procurement of medicines and supplies, salaries and other service delivery costs.

The humanitarian funding process can be slow – from developing and submitting proposals to approval and provision of funds. Health actors and the RMNCAH/CAH working group must be proactive in identifying funding needs and potential donors as soon as possible. Use experienced grant writers whenever possible.

The UN Central Emergency Response Fund (CERF) was established in 2006 to receive and disburse funds for the UN's global emergency response (Fig. 11). See website for details on how to apply for funding (<https://cerf.un.org/>).

¹ See tools and resources at the end of this section for lists and medicines and medical devices.

CONTRIBUTIONS



Donors contribute to CERF before urgent needs arise.

IDENTIFYING HUMANITARIAN NEEDS



Aid workers identify the most urgent types of life-saving assistance that affected people need, such as shelter, food, clean water and medicine.



MANAGING FUNDS



CERF pools these donations into a single fund.

REQUESTING CERF FUNDING



UN agencies and their partners work together to prioritize life-saving relief activities. They request CERF funding through the top UN official in the country.



ALLOCATING FUNDS



Based on expert advice from aid workers on the ground, the Emergency Relief Coordinator distributes CERF funding.



SAVING LIVES



Relief organizations use the money for life-saving aid operations. They track spending and impact, and report back to CERF on people reached with CERF funding.

Fig. 11 UN Central Emergency Relief Fund (CERF)



Key actions – financing

Adapted from the Sphere Health Standards (1)

- ☐ The RMNCAH/CAH working group works with partners and the health cluster lead to proactively identify funding needs and potential donors.
- ☐ Health service providers are careful to protect affected people from catastrophic health expenditure. Aim to identify and mobilize financial resources that will enable the provision of free health care at the point of delivery to the affected people for the duration of the emergency. Consider both internal organizational funding and external funding opportunities.
- ☐ Health service providers aim to abolish or suspend user fees for the duration of the emergency.
- ☐ Organizations provide support to government health facilities to cover any financial gaps created by the abolition and/or suspension of user fees.



Key indicators – financing

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

Resources and tools: respond

General resources

- The Sphere handbook: humanitarian charter and minimum standards in humanitarian response. Geneva: Sphere Association; 2018 (<https://spherestandards.org/wp-content/uploads/Sphere-Handbook-2018-EN.pdf>). Sphere. Resources: training material in multiple languages (<https://spherestandards.org/resources/?category=training-pack&lang=all&years=all&postTag=all&pages=1>).
- Health Cluster guide: a practical guide for country-level implementation of the Health Cluster. Geneva: World Health Organization; 2009 (https://apps.who.int/iris/bitstream/handle/10665/70128/WHO_HAC_MAN_2009.7_eng.pdf?sequence=1).
- Core commitments for children in humanitarian action. New York: United Nations Children's Fund; 2010 (https://www.unicef.org/cholera/Chapter_1_intro/05_UNICEF_Core%20Commitments_for_Children_in_Humanitarian_Action.pdf).
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- Health-care in danger [website]. International Red Cross and Red Crescent Movement. Contains a range of resources to assist in preparedness and security of health care facilities (<http://healthcareindanger.org/>).
- Guide to health workforce development in post-conflict environments. Geneva: World Health Organization; 2005 (<https://www.who.int/publications-detail/guide-to-health-workforce-development-in-post-conflict-environments>).
- Global atlas of medical devices Geneva: World Health Organization; 2017 (https://www.who.int/medical_devices/publications/global_atlas_meddev2017/en/).
- IASC Task Team on Humanitarian Financing [website]. Inter-Agency Standing Committee. Brings together aid agencies to reduce obstacles to humanitarian funding (<https://interagencystandingcommittee.org/iasc-task-team-on-humanitarian-financing>).
- United Nations Central Emergency Response Fund (CERF) [website]. Receives contributions year-round to provide immediate funding for humanitarian action globally (<https://cerf.un.org/>).
- The Grand Bargain [website]. Inter-Agency Standing Committee. A high-level agreement between donors and humanitarian organizations to improve the effectiveness and efficiency of humanitarian action (<https://interagencystandingcommittee.org/grand-bargain>).

Tools

- Pocket book of hospital care for children, 2nd edition. Geneva: World Health Organization; 2013 (https://www.who.int/maternal_child_adolescent/documents/9241546700/en/).
- Manual for the health care of children in humanitarian emergencies. Geneva: World Health Organization; 2008 (https://www.who.int/maternal_child_adolescent/documents/9789241596879/en/).
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- WHO recommendations on adolescent health: guidelines approved by the WHO Guidelines Review Committee. Geneva: World Health Organization; 2017 (<https://apps.who.int/iris/bitstream/handle/10665/259628/WHO-MCA-17.09-eng.pdf?sequence=1>).
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- Management of dead bodies after disasters: a field manual for first responders, second edition. Washington (DC): Pan American Health Organization; 2016 (<https://www.who.int/hac/techguidance/management-of-dead-bodies/en/>).

Child and adolescent health areas

General acute and chronic conditions

- Newborn health in humanitarian settings: field guide. New York: United Nations Children's Fund, and Save the Children; 2018 (<https://www.healthynewbornnetwork.org/hnn-content/uploads/NewBornHealthBook-Production2017-V4b-WEB.pdf>).
- Documents on Integrated Management of Pregnancy & Childbirth (IMPAC). Maternal, newborn, child and adolescent health, World Health Organization (https://www.who.int/maternal_child_adolescent/documents/impac/en/).
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- I'm here: adolescent girls in emergencies. New York: Women's Refugee Commission; 2016 (<https://www.girlsnotbrides.org/resource-centre/im-adolescent-girls-emergencies/>).

Danger, violence and child protection

- Minimum standards for child protection in humanitarian action. New York: Alliance for Child Protection in Humanitarian Action; 2019 (https://alliancecpa.org/en/system/tdf/library/attachments/cpms_2019_final_en.pdf?file=1&type=node&id=35094).
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- Child Protection Resource Pack: how to plan, monitor and evaluate child protection programmes. New York: United Nations Children's Fund; 2015 (<https://www.unicef.org/protection/files/CPR-WEB.pdf>).
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- Caring for child survivors of sexual abuse: guidelines for health and psychosocial service providers in humanitarian settings. New York: International Rescue Committee; 2012 (https://www.unicef.org/protection/files/IRC_CCSGuide_FullGuide_lowres.pdf).
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- Guidelines for integrating gender-based violence interventions in humanitarian action. Geneva: Inter-Agency Standing Committee; 2015 (http://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf).

Disease outbreaks and immunization

- Communicable disease control in emergencies: a field manual. Geneva: World Health Organization; 2005 (https://apps.who.int/iris/bitstream/handle/10665/96340/9241546166_eng.pdf?sequence=1).
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- A manual for estimating the burden of common communicable diseases in settlements of refugee and internally displaced people. World Health Organization Regional Office for the Eastern Mediterranean/University of Edinburgh (in press).
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Nutrition and food security

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Child development and education

- International Network for Education in Emergencies (INEE) (<https://inee.org/>). INEE Minimum standards for education: preparedness, response, recovery. New York: INEE; 2010 (<https://inee.org/standards>) in many languages.
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Disability

- The state of the world's children 2013: children with disabilities. New York: United Nations Children's Fund; 2013 (<https://www.unicef.org/sowc2013/>).
- Disability checklist for emergency response. Yogyakarta: Handicap International; 2005 (<https://www.miusa.org/sites/default/files/documents/resource/HI-%202005-%20disability%20checklist%20for%20emergency%20response.pdf>).
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- Disability survey instruments for children and adolescents (see Annex 7).
- Model disability survey. Brief version. Geneva: World Health Organization; 2017 (<https://www.who.int/disabilities/data/mds/en/>).

Psychosocial distress and mental health

- mhGAP humanitarian intervention guide (mhGAP-HIG): clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: World Health Organization; 2015 (https://www.who.int/mental_health/publications/mhgap_hig/en/).
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Sexual and reproductive health

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WASH

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monitor and evaluate



4

4 Monitor and evaluate

Monitoring, evaluation and review are essential to effective humanitarian action (see Fig. 7).

This section helps you to use existing health information systems and data sources to evaluate and improve CAH response. It will help you to:

- Create a monitoring and evaluation plan
- Improve health information systems.

This section builds on the previous sections on coordination (action area 1) and assessment and prioritization (action area 2), and will specify how you evaluate the activities in the response (action area 3). Use the self-assessment progress tracker (Annex 1) to assess where you and your team (or organization) currently are, and track your progress over time.

4.1 Create a monitoring and evaluation plan

The RMNCAH/CAH working group should nominate a lead agency (or work with the health cluster monitoring and evaluation lead if already nominated) to develop an overall monitoring and evaluation plan, and coordinate assessment and reporting.

Integrate agency-level data as much as possible. Individual agencies and health facilities typically collect more detailed data for internal monitoring and evaluation and quality improvement. The use of some of these data for regional and national monitoring helps increase data completeness, encourages collaboration and highlights success stories.

Key actions – monitoring and evaluation plan



Adapted from the Sphere Health Standards (1)

- ☐ The RMNCAH/CAH working group and partners work with the health sector's lead agency to create a monitoring and evaluation plan for child and adolescent health. Coordinate with others to avoid burdening communities with multiple assessments. Joint assessments and findings should be shared with interested agencies, government and affected populations. Consider partnering with an academic institution.
- ☐ Review existing data collection, reporting and evaluation activities. Consider data from all levels of health services addressing:
 - health status and risks,
 - health resources and service availability,

- health system performance (coverage, quality, access and use).

Data may be collected through routine facility reporting, facility assessments, household surveys, or through dedicated surveillance systems.

- ☐ Decide on a set of key indicators (with standard definitions) to monitor the priority CAH activities. These should assess: health status and risks; health resources and service availability; and health system performance (including coverage, quality, access and use). Consider denominator figures (e.g. population and age disaggregation).
- ☐ Agree on reporting units (e.g. mobile clinics, field hospitals and health posts) and reporting pathways, and frequency of submission, analysis and report generation and dissemination.



Key indicators

- ☐ The health cluster/sector has created a monitoring and evaluation plan, which addresses the main CAH priorities. The plan specifies clear indicators.
- ☐ Early warning surveillance reports received from health facilities each week
 - 90% of facilities
- ☐ Regular production of an overall health information report by the lead health actor. Report will include analysis and interpretation of epidemiological data, and a report on the coverage and use of the health services. Report will address CAH priorities, including disaggregation of data by age.

4.2 Improve health information systems

Early warning systems are essential in order to respond promptly to emerging diseases and deteriorating conditions. Typically the early warning system will be in addition to regular surveillance mechanisms, and will track up to 10 priority conditions (e.g. cholera, dengue, Ebola virus disease, kala-azar, malaria, severe acute respiratory infection) by gathering specific information from selected facilities (sentinel sites)¹.

Routine health information systems and data flow are usually disrupted during emergencies and often require adaptation to reflect the emergency needs and capacities.

Share the data and promote the use of this information at local, district and national levels. If health managers do not have the time or analytical skills to review the data, consult the lead monitoring and evaluation agency for support. There is no point collecting data if it does not or is not used to inform action.

¹ The WHO Early Warning and Response System (EWARS) is available online or can be ordered in a box (EWARS in a box) (30).

Key actions – health information services



Adapted from the Sphere Health Standards (1)

- ☐ The RMNCAH/CAH working group cooperates with the health cluster lead (and the health cluster information management working group) to improve health information services for child and adolescent health and share information.
 - Agree on neonatal, child and adolescent health indicators to include in the health information system.
 - Adapt or develop a health information system that is suitable and appropriate for the context and the emergency.
 - Adapt or develop a disease early warning alert and response system to detect and respond to epidemic-prone communicable disease outbreaks.
 - The lead agency analyses and interprets health surveillance information and disseminates to all partners and stakeholders (including the community) in a regular and timely way.
 - Use surveillance information supplementary data, such as surveys and health facility assessments, promptly to guide decision-making for health programmes.
 - Take adequate precautions and clearly stipulate actions for the protection of data to guarantee the rights and safety of individuals, reporting units, and/or populations.



Key indicators

- ☐ The RMNCAH/CAH working group provides leadership to the health cluster to improve the health information system (including early warning systems), and regularly disseminates reports to other partners.
- ☐ Early warning surveillance reports received from health facilities each week
 - 90% of health facilities
- ☐ Regular production of an overall health information report by the lead health actor. This report addresses CAH priorities, and includes analysis and interpretation of epidemiological data disaggregated by age, as well as coverage and use of health services.

Resources and tools: monitoring and evaluation

Resources

- IASC operational guidance for coordinated assessments in humanitarian crises. Geneva: Inter-Agency Standing Committee; 2012 (https://interagencystandingcommittee.org/system/files/legacy_files/operational_guidance_for_coordinated_assessments_in_humanitarian_crises.pdf).
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Tools

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Annexes

Annex 1 – Self-assessment progress tracker

Use the self-assessment progress tracker to assess where you and your team (or organization) currently are, and track your progress over time. It is suggested you complete this tracker at baseline and repeat it periodically. For example:

- at baseline, i.e. before implementing the operational guide
- after 3 months of implementing the operational guide
- every 6 months during a protracted emergency and recovery period
- annually during stable (preparedness) periods.

Score each statement according to how truly it reflects your situation				
0 – not at all	1 – partly true	2 – mostly true	3 – very true	

	Date of assessment -				
		SCORE (0–3)			
EXAMPLE		0	1	2	3
Coordination My team understands humanitarian structures, has a clear role within the health cluster and actively contributes to the child and adolescent (CAH) working group.					
We understand the local and national humanitarian structures, and our role within them, particularly the health cluster.					
We know the other humanitarian actors in our local area and are working collaboratively with them, including government, nongovernmental organizations, UN, civil society and other groups					
We are part of an active RMNCAH/CAH working group that meets regularly and coordinates CAH activities, and is formally linked to the health cluster.					
We have a communication plan, and contribute to CAH communication through the RMNCAH/CAH working group and health cluster.					
We work with others to advocate for the needs of children and adolescents to decision-makers in government, UN agencies, nongovernmental organizations, other institutions and communities.					

	Date of assessment -				
		SCORE (0–3)			
EXAMPLE		0	1	2	3
Assess and prioritize My team fully understands the situation of children and adolescents in our region, and has clearly prioritized specific areas for our particular context at this time.					
We have supported the RMNCAH/CAH working group and health cluster to incorporate CAH fully into the initial needs assessment (including disaggregation of data by age) and report results to stakeholders. We understand the general needs and gaps and the capacity required to respond.					
We have supported the RMNCAH/CAH working group and health cluster to: (i) conduct additional CAH needs assessment as necessary; (ii) review and update CAH clinical guidelines, policies and medical lists; and (iii) map existing CAH capacities within the health service. We understand CAH needs and capacity required to respond.					
We have supported the RMNCAH/CAH working group and health cluster to: (i) review available data, and (ii) prioritize CAH activities. We understand the priority CAH activities and our role in addressing them in our local area.					
Respond My team understands the full breadth of CAH activities and actively works with other sectors to address the priority needs at this time.					
We have supported the RMNCAH/CAH working group and health cluster to develop a service delivery plan (based on identified needs and capacity) with the participation of the affected community, including structures for triage and referral. We provide safe and ethical health care using standardized guidelines.					
We have supported the RMNCAH/CAH working group and health cluster to develop an essential services package.					
Our service package addresses the needs of all children.					
Neonates/newborns (< 28 days)					
Young children (< 5 years)					
Older children (5–9 years)					
Younger adolescents (10–14 years)					
Older adolescents (15–19 years)					
Our service package adequately addresses all CAH areas and has clearly specified priorities.					

	Date of assessment -				
		SCORE (0–3)			
EXAMPLE		0	1	2	3
Acute conditions – prevention and treatment of common acute infections, injuries, and obstetric and neonatal conditions					
Chronic conditions – identification of and treatment for epilepsy, asthma, diabetes and other chronic conditions					
Child safety and protection – work with protection cluster to integrate child protection into all CAH activities and agencies ¹					
Disease outbreaks and immunization – emergency and ongoing immunization; early warning outbreak systems.					
Nutrition and food security – work with nutrition cluster; prevention and treatment of acute malnutrition; infant and young child feeding in emergencies ²					
Child development and education – work with education and other clusters to integrate nurturing care into all activities					
Disability – work with other clusters to integrate disability-inclusive approaches into all activities ³ .					
Psychosocial distress and mental health – promote good mental health; treat mental illnesses and substance misuse.					
Sexual and reproductive health – child and adolescent friendly services; Minimum Initial Service Package ⁴ (pregnancy and birth care, gender-based violence and sexually transmitted infections).					
WASH – work with WASH cluster for safe water, hygiene, and sanitation for children/adolescents; WASH in health facilities.					
We have supported the RMNCAH/CAH working group and health cluster to: (i) evaluate CAH workforce capacity and needs and (ii) prepare a CAH health workforce plan. We work with partners to coordinate recruitment and training, providing quality care in safe ⁵ environments.					
We have supported the RMNCAH/CAH working group and health cluster to: (i) assess current CAH medical supply needs and supply chains and (ii) standardize CAH medicines lists. We manage our medical supplies efficiently and responsibly (including donated items) and avoid stock-outs.					

¹ Including having child protection policies and procedures in your organization.

² Infant and young child feeding in emergencies.

³ Including having disability-inclusion policies and procedures in your organization.

⁴ Minimum Initial Service Package (MISP). New York: Inter-Agency Working Group on Reproductive Health in Crisis; 2011 (<https://iawg.net/resources/minimum-initial-service-package-misp-resources>).

⁵ Safe for children, families, and health care workers.

	Date of assessment -				
		SCORE (0–3)			
EXAMPLE		0	1	2	3
We have supported the RMNCAH/CAH working group and health cluster to: (i) identify funding needs and opportunities and (ii) proactively apply for funding from a range of sources. We provide free CAH services to children and adolescents and mobilize internal resources to the best of our ability.					
Monitor, evaluate and review My team participates actively in health sector monitoring and evaluation activities, including supporting the CAH monitoring and evaluation plan and strengthening health information systems.					
We have supported the RMNCAH/CAH working group and health cluster to develop a monitoring and evaluation plan for CAH, which involved: (i) reviewing existing data on activities and (ii) agreeing on key indicators and reporting processes. We continually evaluate needs, processes and outcomes and revise our activities accordingly.					
We have supported the RMNCAH/CAH working group and health cluster to build or strengthen a health information system (including early warning systems). We contribute to reporting to stakeholders, including communities.					

Annex 2 – Clusters at the global and national levels

Global level

The Global Cluster lead agencies are expected to provide support to strengthen field response, including:

- Technical surge capacity
- Trained experts to lead cluster coordination at the field level
- Increased stockpiles, some pre-positioned within regions
- Standardized technical tools, including for information management
- Agreement on common methods and formats for needs assessments monitoring and benchmarking
- Best practices and lessons learned from field-tests.

While all the global clusters are important for the health of children and adolescents, some clusters are particularly relevant (listed here with their lead agency).

- Global Health Cluster (WHO) – <https://www.who.int/health-cluster/en/>
- Global Protection Cluster (UNHCR) – <https://www.globalprotectioncluster.org/>; particularly the Child Protection AoR (UNICEF) – <https://cpaor.net/> and Gender-based violence AoR (UNFPA) – <https://gbvaor.net/>
- Global Education Cluster (UNICEF, Save the Children) – <https://www.educationcluster.net/>
- Global WASH Cluster (UNICEF) – <http://www.washcluster.net/>
- Global Nutrition Cluster (UNICEF) – <https://www.nutritioncluster.net/>
- Global Food Security Cluster (FAO, WFP) – <https://fsccluster.org/>
- Global Shelter Cluster (IFRC, UNHCR) – <https://www.sheltercluster.org/>

In addition to the clusters, certain agencies are responsible for important cross-cutting areas, including:


- Gender (OCHA, Relief International, International Medical Corps, UNICEF)
- HIV/AIDS (UNAIDS, IFRC)
- Mental health and psychosocial support (UNICEF, World Vision International).

Country level

Clusters are only activated by the IASC when existing structures are unable (or unwilling) to meet the needs of a particular humanitarian emergency. In-country clusters are intended to be a temporary coordination solution with handover to local authorities as soon as feasible.

The process for cluster activation involves various people and agencies.

1. The Emergency Relief Coordinator (ERC) (head of the IASC) recognizes a deteriorating humanitarian situation and appoints a humanitarian coordinator (HC). This is usually the highest level UN official in the country, called the Resident Coordinator (RC).
2. The HC forms a humanitarian country team (HCT), which is a strategic and operational decision-making body and involves particular UN agencies and nongovernmental organizations.
3. The HC/HCT assess the humanitarian coordination and response capacity and needs.
4. The HC liaises with the ERC to decide which clusters (if any) should be activated, and select appropriate cluster lead agencies.

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5. The ERC sends the proposal to the IASC principals and global clusters.
 6. The ERC informs the HC of the decision within 24 hours.

After formal cluster activation, cluster lead agencies have a responsibility to coordinate their cluster – often in partnership with other UN, government and nongovernmental organization agencies. Cluster lead agencies report back to the humanitarian coordinator/humanitarian country team as well as to national authorities and people affected by the crisis.

National clusters have six core functions:

1. to support service delivery;
2. to inform the strategic decision-making of the humanitarian coordinator/humanitarian country team by assessing needs, analysing gaps, finding solutions and formulating priorities;
3. to plan and implement cluster strategies (including indicators and funding);
4. to monitor and evaluate performance;
5. to build national capacity in preparedness and contingency planning; and
6. to support robust advocacy.

Annex 3 – Suggested terms of reference for the child and adolescent working group

Child and adolescent health issues are a priority during humanitarian emergencies, and responses need to be coordinated across health and other sectors. It is recommended to establish a child and adolescent health working group (integrated with reproductive, maternal and newborn health, if possible) to act as the key body within the health cluster that promotes child and adolescent health.

A RMNCAH/CAH working group should be established within the health cluster/sector at the national level during the response phase. The goal is to create an intersectoral, interagency coordinating body that promotes and coordinates CAH activities in emergency contexts.

It will also be useful to establish subnational and field-level RMNCAH/CAH working groups to communicate and pursue the same goals at other levels.

Suggested roles for the RMNCAH/CAH working group

- Advocate for the interests of all children (from birth through adolescence) in humanitarian action.
- Advocate for the integration of child protection, disability-inclusion, early childhood development and gender-sensitive activities in humanitarian action.
- Advocate for the inclusion of children, young people and parents in humanitarian activities (e.g. assessments, planning, implementation and evaluation).
- Ensure child and adolescent health is fully included in rapid assessments, follow-on assessments, early warning systems, health information systems, and other monitoring and evaluation activities.
- Ensure that child and adolescent health is fully considered in prioritization exercises (especially the interests of older children, adolescents, unaccompanied minors, children with disabilities and other groups at high risk).
- Facilitate communication between the health cluster, other agencies working in child and adolescent health, and the affected population (bidirectional information flow).
- Lead intersectoral collaboration related to CAH interests and promote the life-cycle approach to health and well-being, especially the neglected interests of older children and adolescents.
- Represent CAH interests, needs and opportunities at cluster meetings.
- Facilitate bimonthly meetings to help coordinate CAH responses and encourage ongoing communication between stakeholders.
- Provide guidance on resources (i.e. human, material and financial) needed to support CAH capacity within clusters and government ministries.

The RMNCAH/CAH working group can be led by any government body, local or international nongovernmental organization or UN agency that has the capacity to effectively lead the CAH response in collaboration with the ministry of health. It should include members from other sectors. If a similar group already exists, build on this.

The RMNCAH/CAH working group should be established and function transparently. Meetings should be held in public facilities to promote visibility and commitment. Government representatives should be involved and, if possible, have a role in chairing meetings. Community members, including young people, should be included. The working group should establish procedures for communication within the group and with external bodies and the community. The working group should hold itself and its members accountable for their stated deliverables.

Annex 4 – Essential child and adolescent health interventions to consider

Box A4.1 Recommended interventions for newborns and children¹

Key health matters to be tackled

- Newborns: preterm, low birth weight, sepsis and intrapartum complications
- Children: malaria, pneumonia, diarrhoea, measles, malnutrition, and mental health and well-being

Health interventions

Newborns

- Preventive care: thermal care, protection and promotion of immediate and exclusive breastfeeding, prevention and care of low birth weight newborns, chlorhexidine for umbilical cord care, vaccination, dexamethasone for preterm labour, tocolytics, hygiene, prevention of mother to child transmission of HIV
- Treatment: kangaroo care, antibiotics, newborn resuscitation and intensive care, intrapartum care, emergency obstetric care, oxygen, antiretroviral treatment

Children

- Preventive care: long-lasting insecticide-treated bed nets and indoor residual spraying of insecticides, measles vaccination, infant and young child feeding interventions, adequate complementary feeding, psychosocial health
- Treatment: antibiotics, artemisinin-based combination therapy, oral rehydration salts, zinc, vitamin A, ready-to-use therapeutic foods, mental health support
- Delivery models: transit site clinics, community-based care such as integrated community case management and community-based management of acute malnutrition, home-based care
- Campaigns: mass measles vaccinations, distribution of insecticide-treated bed nets, child health days, mass malaria care, chemotherapy (e.g. for worms, schistosomiasis)

Non-health interventions

- Water, sanitation and hygiene
- Nutritional status screening of infants and growth monitoring
- Communication and education on child and maternal nutrition in emergencies
- Micronutrient distribution for children 6–59 months
- Early childhood development
- Child-friendly spaces
- Basic education
- Child protection
- Psychosocial support
- Birth certificates and registration
- Early stimulation
- Cause of death surveillance

¹ Zeid S, Gilmore K, Khosla R, Papowitz H, Engel D, Dakkak H, et al. Women's, children's, and adolescents' health in humanitarian and other crises. *BMJ* 2015;351:h4346. doi: 10.1136/bmj.h4346

Health system enablers

Resilience

- Age and sex disaggregated data to assess populations in need and reached
- Integration of risk assessment and analysis into resilient systems and services
- Development of the capacity of health systems to have flexible and adaptable financing and service delivery, trained and available staff, priority drugs available when needed, reliable information systems, and leadership and governance that take into account emergency risk
- Newborn cause of death notification and audit
- Inclusion of children in the design, planning and implementation of health policies and programmes from preparedness to the onset of an emergency
- Re-establishment of or repairs to health care infrastructure, support of referral system
- Strengthening of routinely used laboratories and disease surveillance systems

Innovation

- Pneumococcal vaccine, rotavirus, *Haemophilus influenzae* type B vaccine, dispersible tablets, single-dose vaccines, single-dose antibiotics, vaccines that don't need to be kept cold, remote monitoring and teaching, m-health
 - Micronutrient powder
 - Newborns: prefilled, single-use injection device filled with gentamicin, cycloheximide for cord care, Doppler technology, gestational age estimate methods, aspartate aminotransferase for preterm labour at home, simplified antibiotic therapy for sepsis in young infants
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Box A4.2 Recommended interventions for adolescents¹

Key health matters to be tackled

- Early pregnancy, HIV/AIDS and other sexually transmitted infections, unsafe abortion, sexual and gender-based violence (including child forced marriage and female genital mutilation), menstrual hygiene, nutritional deficiencies, traumas

Health interventions

- Preventive care: contraception, condoms, emergency contraception, prevention of sexual and gender-based violence, mental health, sexuality education, life skills, maternal health care including family planning counselling, voluntary counselling and testing for HIV, iron and folic acid supplements
- Treatment: treatment of traumas and orthopaedic surgery, emergency obstetric and neonatal care services, contraception, nutrition, comprehensive abortion care, clinical care for survivors of sexual violence, treatment of sexually transmitted infections, emergency skilled birth attendance, postnatal care including for postpartum depression, antiretroviral treatment
- Delivery models: flexible and integrated adolescent-friendly health services, temporary clinics that are community-based and mobile, provision of comprehensive sexual and reproductive health services for adolescents at a single site, home-based care, education and outreach through non-health facilities, safe spaces, adaptation of minimum initial services package and assessment for adolescents
- Kits: menstrual hygiene kits (dignity kits), post-rape kits, sexually transmitted infection kits, contraception kits

Non-health interventions


- Targeted support for schooling options (safe passage, financial support to families) and vocational training
- Access to life skills and comprehensive sexuality education in and out of schools
- Protection of girls from child marriage
- Systems for adolescent participation in decision-making (especially for girls) at community, provincial and national levels
- Strengthened links between programmes and referral pathways and coordination between sectors, including protection, education and livelihoods, for a holistic, multisectoral response
- Safe spaces, especially for girls

Health system enablers

Resilience

- Data disaggregated by age, sex and disability
- Qualified and dedicated adolescent sexual and reproductive health staff, including clinical staff (community health workers, nurses, midwives, doctors, paramedics, national and international volunteers)
- Surveillance of priority illnesses including malnutrition and mortality

¹ Zeid S, Gilmore K, Khosla R, Papowitz H, Engel D, Dakkak H, et al. Women's, children's, and adolescents' health in humanitarian and other crises. *BMJ* 2015;351:h4346. doi: 10.1136/bmj.h4346

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- Inclusion of adolescents in the design, planning and implementation of adolescent health interventions from the onset of an emergency, as well as in monitoring and evaluating projects
 - Involvement of the community and parents

Innovation

- Use of social media to promote access to quality health information and information sharing
 - Flexible outreach strategies, including transportation budgets that consider the difficulty of reaching adolescents in insecure environments and otherwise hard-to-reach areas
 - Focus on adolescent potential for, and actual contributions to, community resilience, response and recovery as part of sustainable development
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Annex 5 – Integrating early childhood development into humanitarian action

Here are some key actions related to the integration of early childhood development into humanitarian activities (adapted from UNICEF's *Early childhood development: integrated programme guide*¹).

Health

- ☐ Promote safe parenthood for mothers and fathers and ensure that pregnant woman and their families are aware of how to access skilled health care.
- ☐ Identify signs of maternal and paternal depression and provide mental health support and referrals as needed. Advocate for health worker outreach to families of newborns.
- ☐ Provide parent/caregiver support programmes. Counsel mothers and fathers of newborn children immediately after the birth of the child to increase parenting skills.
- ☐ Guarantee referrals to other services. Ensure health services are available in community-based care centres, crèches, preschools and other formal spaces where young children gather to learn and play.
- ☐ Provide early childhood development learning materials. Provide stimulation and play materials for young children in health clinics and facilities.
- ☐ Provide child-friendly facilities especially in emergency situations.

Nutrition

- ☐ Breastfeeding and positive interaction (within the first hour of birth).
- ☐ Complementary feeding. After 6 months of age, infants should start eating semisolid and solid foods as breastfeeding continues.
- ☐ Household registration. Households with children under 2 years should be registered and linked to food security programmes.
- ☐ Training and counselling materials. Integrate into all nutrition materials simple messages with key facts about the impact of early childhood development activities.
- ☐ Provide simple messages and parents/caregiver-baby groups at outreach therapeutic programmes and supplementary feeding programme sites.
- ☐ Nutrition and early-learning programmes. Provide young children attending day care and early-learning programmes with a nutritious mid-day meal.

WASH

- ☐ Ensure that WASH facilities are available at early childhood development centres, child-friendly spaces, preschools and schools.
- ☐ Water sources should be at child level along with separate latrines that are safe and the appropriate size for young children.
- ☐ Ensure availability of hygiene kits, baby kits and water kits in early childhood development centres, preschool settings and schools.

1. Early childhood development in emergencies: integrated programme guide. New York: United Nations Children's Fund; 2014 (https://www.unicef.org/earlychildhood/files/Programme_Guide_ECDiE.pdf).


- ☐ Pregnant mothers and caregivers with young children should be given priority access to water facilities.
- ☐ Promote baby-wash and skin-to-skin contact.
- ☐ Keep child spaces clean and safe.
- ☐ Parents and caregivers should be provided with information and skills for treating and storing drinking water within the household.
- ☐ Ensure availability of hand washing points and soap (or alternative material).
- ☐ Systematically integrate early childhood developmental messages to reinforce hygiene such as connection between hygiene, nutrition and brain development.

HIV and AIDS

- ☐ Collaborate with health care providers and early childhood development specialists to track patients who need access to services for prevention of mother-to-child transmission of HIV and antiretroviral therapy, and refer them to health facilities, nutrition support and infant feeding and stimulation counselling.
- ☐ Promote links between ECD practitioners and existing programmes for orphans and children at high risk and children affected by AIDS.
- ☐ Provide links between HIV and AIDS services and community-based ECD centres. Early childhood development centres and child-friendly spaces offer meeting places for support groups for caregivers or children affected by HIV and AIDS; non-formal education; training in parenting skills; and life-skills training for older children.
- ☐ Provide support for families of HIV-positive children. Where possible, respond to the economic needs of the most impoverished families affected by HIV and AIDS through links to available social protection initiatives.
- ☐ Support in-service training for early childhood development care providers. Ensure that caregivers are responsive to the specific needs of HIV-positive and HIV-exposed children, particularly regarding psychosocial, nutritional and health needs.

Education

- ☐ Ensure that young children have access to early learning spaces where their development needs are met.
- ☐ Teachers and volunteers should support children's development and respond to their students' emotional needs as they face the uncertainties of crisis.
- ☐ Caregivers, teachers and volunteers should be screened, recruited and trained as defined by codes of conduct.
- ☐ Learning should be child friendly and participatory, and should include activities for cognitive, language, and social and emotional development.
- ☐ Early learning programmes provide an ideal opportunity for links with other services to ensure children's overall health and development.
- ☐ Involvement of primary caregivers in formal and informal spaces established for young children is important.
- ☐ Conflict and disaster risk reduction messages should be integrated into preparedness, emergency, and early recovery and resilience activities.

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- ☐ In order to most effectively influence and encourage communities to foster and maintain peace, education must begin in early childhood, when brain architecture is developing most rapidly.

Protection

- ☐ Establish mechanisms for birth registration to ensure that all newborns and previously unregistered young children are registered.
- ☐ Ensure that caregivers and young children are provided with information on where and how to access missing documentation in order to gain access to services that support young children's developmental needs.
- ☐ Child-friendly spaces provide young children with protective environment that promotes their physical and emotional well-being, and provides them with equal access to services.
- ☐ Provide technical guidance to other sectors to ensure that young children are free of inhibitive barriers that restrict their access to basic social services and humanitarian assistance.
- ☐ Encourage parents to create home environments free of protection risks.
- ☐ Promote community support and protection mechanisms.
- ☐ Avoid institutional care for orphans and other young children; only implement such care as a last resort. These institutions typically cannot provide an environment that supports young children's overall development.
- ☐ Ensure early childhood development is taken into consideration in all emergency assessments.

Annex 6 – Inter-Agency Network for Education in Emergencies: minimum standards for education ¹

Minimum Standards for Education: Preparedness, Response, Recovery

Inter-Agency Network for Education in Emergencies
Réseau Inter-agences pour la Éducation en Situations de Émergence
شبكة الوكالات المتعددة للتعلم في حالات الطوارئ

INEE

Foundational Standards			
Community Participation Standards: Participation and Resources – Coordination Standard: Coordination – Analysis Standards: Assessment, Response Strategy, Monitoring and Evaluation			
Access and Learning Environment	Teaching and Learning	Teachers and Other Education Personnel	Education Policy
Standard 1: Equal Access – All individuals have access to quality and relevant education opportunities. Standard 2: Protection and Well-being – Learning environments are secure and safe, and promote the protection and the psychosocial well-being of learners, teachers and other education personnel. Standard 3: Facilities and Services – Education facilities promote the safety and well-being of learners, teachers and other education personnel and are linked to health, nutrition, psychosocial and protection services.	Standard 1: Curricula – Culturally, socially and linguistically relevant curricula are used to provide formal and non-formal education, appropriate to the particular context and needs of learners. Standard 2: Training, Professional Development and Support – Teachers and other education personnel receive periodic, relevant and structured training according to needs and circumstances. Standard 3: Instruction and Learning Processes – Instruction and learning processes are learner-centred, participatory and inclusive. Standard 4: Assessment of Learning Outcomes – Appropriate methods are used to evaluate and validate learning outcomes.	Standard 1: Recruitment and Selection – A sufficient number of appropriately qualified teachers and other education personnel are recruited through a participatory and transparent process, based on selection criteria reflecting diversity and equity. Standard 2: Conditions of Work – Teachers and other education personnel have clearly defined conditions of work and are appropriately compensated. Standard 3: Support and Supervision – Support and supervision mechanisms for teachers and other education personnel function effectively.	Standard 1: Law and Policy Formulation – Education authorities prioritise continuity and recovery of quality education, including free and inclusive access to schooling. Standard 2: Planning and Implementation – Education activities take into account international and national educational policies, laws, standards and plans and the learning needs of affected populations.
Key Thematic Issues: Conflict Mitigation, Disaster Risk Reduction, Early Childhood Development, Gender, HIV and AIDS, Human Rights, Inclusive Education, Inter-sectoral Linkages, Protection, Psychosocial Support and Youth			

1 Minimum Standards for Education. Preparedness, Response, Recovery. New York: Inter-Agency Network for Education in Emergencies; 2010 (https://www.right-to-education.org/sites/right-to-education.org/files/resource-attachments/INEE_Minimum_Standards_2010.pdf).

Annex 7 – Disability in humanitarian emergencies

The UN Convention on the Rights of Persons with Disabilities describes people with disability to include those “who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (1).

The International Classification of Functioning, Disability and Health (ICF-11) defines disability as an umbrella term for impairments, activity limitations and participation restrictions:

“Disability is the interaction between individuals with a health condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports).” (2,3)

Disability-inclusive humanitarian action

The UNICEF publication *The state of the world’s children 2013: children with disabilities* (4) describes disability-inclusive humanitarian action as informed by, and grounded in:

- A **rights-based** approach, based on the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities. Article 11 of the Convention on the Rights of Persons with Disabilities specifically calls on duty bearers to take all necessary measures to ensure the protection and safety of persons with disabilities in situations of conflict, emergency, and disaster, signifying the importance of the issue.
- An **inclusive** approach that recognizes that children with disabilities, in addition to their disability-specific needs, have the same needs as other children, disability being only one aspect of their situation: They are children who happen to have disabilities. Such an inclusive approach also addresses the social, attitudinal, informational and physical barriers that impede participation and decision-making by children with disabilities in regular programs.
- Ensuring **accessibility** and universal design of infrastructure and information. This includes making the physical environment, all facilities, health centers, shelters and schools, and the organization of health and other services, including communication and information systems, accessible for children with disabilities.
- **Promoting independent** living so that children with disabilities can live as independently as possible and participate as fully as possible in all aspects of life.
- **Integrating age, gender and diversity** awareness, including paying special attention to the double or triple discrimination faced by women and girls with disabilities.”

The CBM publication *Inclusion made easy* (5) lists four key principles for inclusion.

- **Awareness** of disability and its implications is the crucial first step for development programmes to become inclusive.
- **Participation** of people with disabilities is essential for genuine empowerment and community change.

- **Comprehensive** accessibility ensures that physical, communication, policy and attitudinal barriers are both identified and addressed.
- **Twin track** as an approach explicitly identifies particular actions for people with disabilities together actions for their mainstream inclusion.

Disability survey instruments for children and adolescents

The WHO's Model Disability Survey (MDS) is a general population survey that provides detailed information about how persons with disabilities live and the difficulties they face **(6)**. The brief version of the survey may be appropriate for use in humanitarian screening contexts **(7)**. The current versions are most appropriate for adults or older adolescents, but a child module is being developed.

References

1. UN Convention on the Rights of Persons with Disabilities. New York: United Nations; 2006 (<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html>, accessed 2 February 2020).
2. International Classification of Functioning, Disability and Health (ICF-11). Geneva: World Health Organization; 2018 (<https://www.who.int/classifications/icf/en/>, accessed 2 February 2020).
3. Disability and health. Fact sheet. Geneva: world Health Organization; 2019 (<https://www.who.int/en/news-room/fact-sheets/detail/disability-and-health>, accessed 2 February 2020).
4. The state of the world's children 2013: children with disabilities. New York: United Nations Children's Fund; 2013 (https://www.unicef.org/publications/index_69379.html, accessed 29 January 2020).
5. Inclusion made easy. A quick program guide to disability in development. Bensheim: CBM; 2012 (https://www.cbm.org/fileadmin/user_upload/Publications/cbm_inclusion_made_easy_a_quick_guide_to_disability_in_development.pdf, accessed 29 January 2020).
6. Disability and rehabilitation. Model Disability Survey. Geneva: World Health Organization and World Bank; 2017 (<https://www.who.int/disabilities/data/mds/en/>, accessed 29 January 2020).
7. Brief Model Disability Survey (Brief MDS). Implementation guide. Geneva: World Health Organization and World Bank; 2017 (<https://www.who.int/disabilities/data/Implementation-guide-Brief-MDS.pdf?ua=1>, accessed 26 April 2020).

Annex 8 – Feedback form

Thank you for giving us feedback to improve the operational guide and make it more useful to health managers working in humanitarian emergencies. Please make notes as you work your way through the guide, and complete the online form available at: https://www.research.net/r/cah_humanitarian_settings to provide feedback directly.


Country:
Organization:
Job title:
Name (optional):
Email (optional):

I found the operational guide to be:

Useful and relevant to my situation	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Easy to understand	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Practical, with clear actions	Strongly disagree	Disagree	Neutral	Agree	Strongly agree

Biggest strengths or benefits of the operational guide?

Biggest weaknesses or limitations of the operational guide?



Suggestions for improvement
(e.g. corrections, updates, additional resources to include, ideas to make it easier to use, etc.)

