

Health and Nutrition Emergency Framework



Objectives

1. Background - need for the framework
2. Goal and objectives
3. Methodology – how it was developed, who was involved
4. Roll out – next steps to promote and use it widely
5. Key focal points

1. Background

Health and Nutrition sectors have often not been prioritised in emergency responses for the following reasons:

- Sector staff not deploying (cost or staff availability issues or higher prioritisation of other sectors, operational capacity)
- Lack of knowledge in the organisation that we do H&N in emergencies and what we do, how we do it
- No national H&N technical staff in countries affected by emergencies
- Organisational perception that 'others are doing it'

The space for emergency Health and Nutrition

- Health and nutrition are often one of the most urgent priorities and needs in emergency settings. **Health emergencies and nutrition emergencies are often specifically occurring and warrant large scale international responses.**
- According to the OCHA FTS Health (encompassing nutrition) is the largest funded sector after food in emergencies
- This has enabled many organisations to expand in it i.e. GOAL, IRC, Save
- World Vision as an organisation is adopting a multi-sector approach which includes health and nutrition
- World Vision has excellent background in H&N through quality community focused programming in most contexts. We are using our own unique approaches, different to medical organisations who may for example provide intensive support to few inpatient care facilities using expatriates.

UNOCHA – FTS 2016

	Original requirements USD A	Revised requirements USD B	Funding USD C	% Covered C/B	Unmet requirements USD B-C	Outstanding pledges USD D
Agriculture	645,026,583	638,440,563	169,667,305	26.58	468,773,258	0
Coordination and support services	764,498,294	781,424,108	439,808,326	56.28	341,615,782	6,703,297
Economic recovery and infrastructure	778,764,005	780,263,318	192,495,732	24.67	587,767,586	7,718,985
Education	627,153,334	636,513,501	302,583,427	47.54	333,930,074	0
Food	4,883,259,124	4,804,735,588	2,435,972,244	50.70	2,368,763,344	534,236
Health	2,437,320,302	2,402,899,863	1,057,031,431	43.99	1,345,868,432	4,561,471
Mine action	84,806,093	103,481,647	17,408,785	16.82	86,072,862	0
Multi-sector	5,623,426,976	5,558,919,560	3,046,422,024	54.80	2,512,497,536	7,463,344
Protection/Human rights/Rule of law	1,113,647,952	1,127,015,021	385,436,496	34.20	741,578,525	200,000
Safety and security of staff and operations	8,977,936	8,977,936	2,387,035	26.59	6,590,901	0
Sector not yet specified	62,303,087	62,303,087	2,337,979,725	3,752.59	-2,275,676,638	122,236,643
Shelter and non-food items	1,581,737,579	1,606,547,933	380,587,905	23.69	1,225,960,028	1,500,000
Water and Sanitation	1,198,863,332	1,222,887,607	487,049,344	39.83	735,838,263	560,000
Grand Total:	19,809,784,597	19,734,409,732	11,254,829,779	57.03	8,479,579,953	151,477,976

World Vision's history of Health and Nutrition activities in emergency responses

- World Vision has designated rapid response team members focused on health and nutrition
- A scoping was done to gather lessons learned on the types of H&N responses we have done as an organisation to look at how we implement specifically in these sectors in emergencies.

Where possible:

- Previous staff members were interviewed
- Reports were gathered from NOs and WV Central
- Senior staff members were consulted



Examples of the varying health and nutrition emergency responses

- **Zimbabwe cholera response 2008-9** – medical supplies to health facilities, partnering with MoH, health and hygiene promotion
- **Haiti earthquake 2010** – Mobile and static HFs, support to Hospitals, baby friendly spaces, health promotion
- **West Africa (Sahel Food and Nutrition Crisis – 2013)** – CMAM
- **Syria response 2013** – Mobile & static health facilities, WAYCS, Coordination role
- **Philippines Haiyan Typhoon 2013** – WAYCS, health facility rehabilitation, training of health workers
- **CAR 2014** - CMAM
- **Ebola 2015** – IPC, Mental Health, support to CHWs, vaccine roll out + non health activities i.e. safe burials,
- **Nepal earthquake 2015** – WAYCS, Health worker & CHW training
- **Iraq response** - Mental Health, Mobile and static clinics, WAYCS
- **Zika 2016** – support health services for pregnant women & referral, health education at community level

Examples of some key lessons learned

- Preparedness is critical
- H&N technical staff need to be deployed as first responders
- Little to no relationship with MoH pre-emergency at national level can create barriers
- Existing capacity of national staff and their experience of emergencies can affect the scale and pace of activities
- Cluster engagement critical to response success, avoidance of duplication and acquisition of funding
- Strong logistics required
- Adaptations i.e. remote management
- Partnership critical
- Willingness to try H&N and invest in it - where it is a new sector
- Compliance with WV Internal Procurement and Pharmaceutical Policy as well as international and national drugs and medical supplies regulations

The Health & Nutrition Emergency Framework

- Established to differentiate disasters as they pertain to emergency health response
- To describe the appropriate H&N response / interventions for WV per disaster type
- To determine H&N staff competencies required for implementation by response type.
- To establish and define protocols for response i.e. operational capacity, human resourcing required and staff capabilities, required health and nutrition commodities, preparedness activities by type



Methodology

Developed by Sustainable Health Team (Senior Emergency Nutrition Advisor) with consultation and input from various WV staff members with experience in emergencies:

1. Review of WV historic emergency responses
2. Review of WV project models, WHS, international guidelines etc.
3. Drafting of the Framework & preparedness annexes and review from technical staff
4. Drafting of operational capacity ideas, affirming staff core competencies, commodity lists

Objectives of our Health and Nutrition responses

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

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

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



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

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

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



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

- **SERVICES:** Support community and family health by recruiting, equipping, training and strengthening supervision of CHWs (Health posts) to undertake community mobilization, health education, referral system strengthening, surveillance and where appropriate health-focused conditional cash transfers.

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



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

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

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



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

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

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



Disaster Typology / Classifications

1. RAPID

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

Response time-frame

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



Disaster Typology / Classifications

2. SLOW

- Climatological: Drought, extreme temperatures
- Displaced populations
- **Response time-frame**
- Days → weeks from early warning until deterioration to the point of humanitarian action being required
- 0-5 days 'first steps'
- 30 days 'emergency response'
- 30-90 days 'continuing response'
- Phase out



Disaster Typology / Classifications

3. COMPLEX

- **Definition / sub-types**
- National conflict (fighting between groups)
- International conflict
- Displaced populations

Response time-frame

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



Disaster Typology / Classifications

4. DISEASE OUTBREAKS

- response time is counted from the time outbreak is declared (which ever criteria is used)

Airborne / person to person: Influenza, Meningitis, Measles, Ebola / Marburg

Waterborne (Faecal – oral): Cholera & AWD / ABD, Poliomyelitis, Typhoid, Leptospirosis

Vector: Dengue Fever, Zika, Yellow fever, Malaria, Leishmaniasis

Response time-frame

- 0-72 hours 'first steps'
- Up to 30 days 'emergency response'
- 30-90 days 'continuing response'
- Phase out
- Outbreaks may last for days or weeks or years.



Example... type 1 – Rapid

TYPE I: RAPID

Definition / sub-types

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

WV H&N Response History (Annex I)

Haiti

Nepal

Philippines

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

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

Anticipated Health and Nutrition Specific Needs

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

The health and nutrition needs will vary according to location and intensity of the disaster and the socioeconomic situation prior. Refer to pre-disaster situation including determinants of health and endemic diseases and pre-disaster nutrition

TYPE I RECOMMENDED RESPONSE PACKAGE

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

ASSESS

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

PLAN / COORDINATE

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

RAPID INITIAL ACTIVITIES

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

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

INTER-SECTOR LINKAGES

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

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

COORDINATION

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

CONTINUING RESPONSE ACTIVITIES

- **Continued assessment of availability and quality of health services in areas of operation:**

- Trauma and injury
- maternal health: ANC, delivery care including EmONC, postpartum care, care of the newborn
- Child Health and immunization: EPI, IMCI
- Reproductive health
- Nutrition: prevention, assessment and treatment (CMAM / IMAM) and IYCF support; prevention and treatment of micronutrient deficiency
- Communicable disease treatment and control: prevention, diagnosis, treatment, vaccinations, surveillance and reporting
- Non-communicable disease prevention and management (includes chronic disease, mental health & disability services).

Use assessment for advocacy of needs with MoH, clusters, donors and other NGOs and to determine direct support WV will provide within PHC remit.

- **Provision of medicines, medical supplies and equipment** from WV commodity list to District Hospitals, CHC, PHC, Health posts according to need including kits such as IEHK, Italian Trauma Kits, UNFPA RH kits, Midwifery kits, clean delivery kits, diarrheal disease kits (where appropriate). Provision of PHC standard medicines. Provision of hygiene materials for Infection Prevention and Control.
- **Support referral** through provision of vehicles and communication equipment at all health facility levels, strengthening promotion of referral networks through training / mobilization of CHWs. Advocacy with the Health Cluster to identify referral pathways for specialized services.
- **Structural rehabilitation of HFs damaged by disaster** i.e. water and sanitation, electricity supply (solar panels) for cold chain, repair of infrastructural damage, furnishing, use of tents for temporary expansion or isolation units etc.
Provision of Mobile Medical Services (where appropriate according to WV guidelines).
- **Capacity building** of MoH staff and CHWs through resourcing and/or leading trainings in all Primary Healthcare and Nutrition topics according to knowledge gaps and health needs identified. Address issues of no pay, reduction in pay and overwork by working with the cluster and the MoH on incentives and also prioritization where additional tasks are being pushed by other stakeholders i.e. pressure on CHWs for distributions can lead to neglect of health and hygiene promotion.
- **Preventative public health measures** – conduct a mapping of CHWs through liaison with HFs, CHW supervisors and the DHO. Equip PHC, CHC and health post / CHWs to provide health and hygiene promotion through trainings and provision of supplies including IEC, job aids and essential health and hygiene supplies such as LLIN, aquatabs, female hygiene products and condom for distribution to target vulnerable groups. Work with community, faith leaders, volunteer committees, schools and groups by facilitating trainings on key messaging and events. Ensure MMS (where functioning) are providing health and hygiene promotion.
- **Strengthen Reproductive and Maternal, Newborn and Child Health (RMNCH)** –in line with WV reproductive health policy and MNCH in Emergencies guidelines:
 - Provide Reproductive Health Kits: (blocks 1-5) to CHC and PHC
 - Support essential maternal and newborn care: where possible and feasible locate and mobilise SBAs and establishing referral links. Support referrals for appropriate services i.e. EmONC which vehicles and resourcing where appropriate. Support SBAs to undertake home visits within critical 24 to 48 hours after birth and to provide community education on essential newborn and maternal care (thermal care,

agencies. Submit HIS data to the Health Cluster on a regular basis as required. Provide support to HFs with accurate data collection avoiding double counting beneficiaries where information is manually tallied (cross check data entry with paper records at HFs). Linkage of program to LMMS beneficiary tracking system.

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

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

PHASE OUT / RECOVERY

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

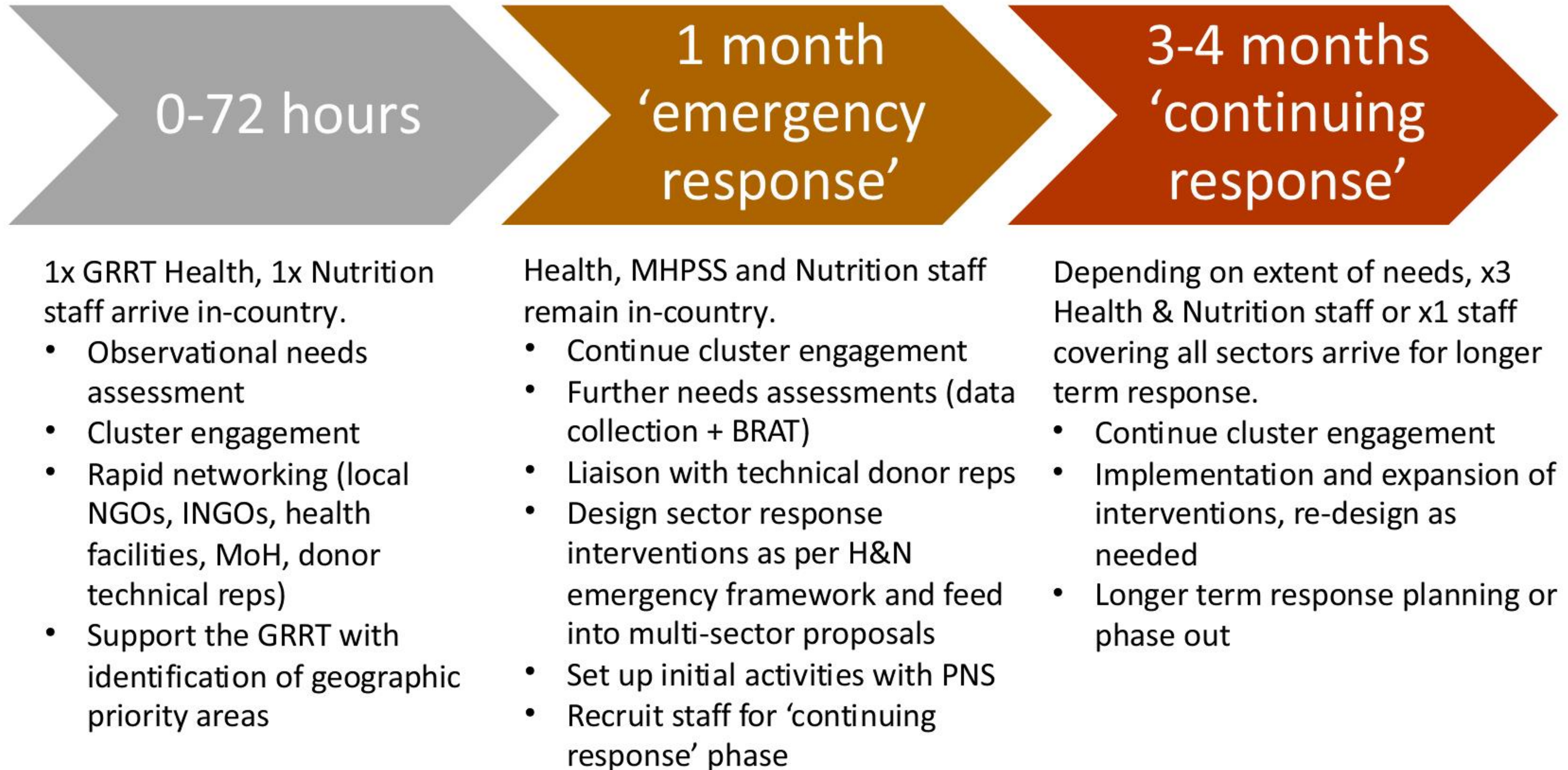
Other components accompanying the
framework

Preparedness

“IT WASN’T RAINING WHEN NOAH BUILT THE ARC”

- 4 Annexes by Disaster Type (Rapid, Slow, Complex, Disease)
- Summary points: Triggers, Surveillance, Coordination (enabling factors) and Planning

Develop recommendation on human resources and operational capabilities: mapping the process



Type 1: Rapid

- 0-72 hour - Health Manager, Nutrition Manager and depending on emergency MPHSS Technical specialist also prioritized to deploy. Depending on the extent of the health and nutrition needs, retain positions for continuing response or hire one H&N Manager. If MMS needed deploy / hire pharmacist and medical warehouse specialist

Type 2: Slow

- Nutrition Manager prioritized to deploy. Remote / surge support from GC / GRRT Health Advisor. Mental Health & Psychosocial Support (MHPSS) Technical specialist prioritized to deploy if possible. Remote support from Gender/GBV specialist.

Type 3: Complex

- Health Manager prioritized to deploy. Remote / surge support from GC / GRRT Nutrition Advisor. Remote support from Mental Health & Psychosocial Support (MHPSS) Technical specialist.

Type 4: Disease Outbreaks

- Health Manager prioritized to deploy. In the event of large scale epidemics such as Ebola, Mental Health & Psychosocial Support (MHPSS) Technical specialist prioritized to deploy. Remote / surge support from GC / GRRT Nutrition Advisor.

Competencies listed (Health, Nutrition and MHPSS)- example...

Behaviours

1. Provide technical leadership for health and situation assessment	<p>2.1 Lead needs assessments guided by internationally agreed and WV internal tools including <i>MIRA</i>, <i>HESPER</i>, <i>HeRAMS</i> and <i>BRAT</i></p> <p>2.2 Lead health team to identify relevant program interventions that meet the needs of the most vulnerable</p> <p>2.3 Analyse the data collected to identify the priority needs upon which to base the health components of the response and recovery strategy</p> <p>2.4 Ensure links between the health programs and other programs are built to maximize integration (e.g Education in emergencies, Children Protection in emergencies and WASH)</p>
2. Provide technical leadership for the design and implementation of emergency health programming	<p>3.1 Apply project cycle management and tools to health programming</p> <p>3.2 Demonstrate the ability to work with ambiguity and to decide and initiate action with limited assessment data and information based on context, and be flexible in approach.</p> <p>3.3 Share WV health emergency response models, including <i>MMU</i>, <i>WAYCS</i>, <i>MISP</i> and prioritize based on the assessment data</p> <p>3.4 Advocate for and share WV health policies e.g. Reproductive Health (RH), milk policy</p> <p>3.5 Formulate health response strategy, proposals and work plans taking funding and WV mandate into account and based on assessed needs</p> <p>3.6 Clearly communicate health program parameters (strategy, design, implementation standards) to the health team</p> <p>3.7 Plan and program in conjunction with related sectors</p> <p>3.8 Explain how plans incorporate the transition into recovery</p> <p>3.9 Design and manage program budget in collaboration with Finance according to donor requirements and WV standards</p> <p>3.10 Lead health team to meet programming standards and expectations for implementation of HHN interventions</p> <p>3.11 Lead personnel and financial management of diverse health team and program, in multiple locations and with multiple funding sources</p>

Also includes supportive information and enabling skills!

Enabling skills	Enabling knowledge	Enabling attitudes
<ul style="list-style-type: none"> Strategic thinking Decision making Leadership Management (personnel, financial) Foster inter-sectoral collaboration Communication and negotiations High level of diplomacy and networking Training and facilitation skills Personal safety 	<ul style="list-style-type: none"> Comprehensive knowledge of Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCHA) Basic knowledge of: <ul style="list-style-type: none"> epidemiology communicable diseases Infant and Young Child Feeding (IYCF) Early Childhood Development (ECD) Health emergency response assessment instruments: <ul style="list-style-type: none"> <i>HeRAMS</i> <i>MIRA</i> <i>BRAT</i> WV HHN policies and guidelines both in humanitarian and development areas <ul style="list-style-type: none"> Reproductive Health policy Milk and Breast Milk Substitute Policy HIV policy WV Pharmaceutical Policy Emergency health interventions: <ul style="list-style-type: none"> mobile clinics, <i>WAYCS</i>, HIV in emergencies, Psychosocial First Aid infection prevention control clinical management of GBV survivors Minimal Initial Services Package for Reproductive Health (MISP for RH) Cross-cutting issues such as gender, age, disability, HIV 	<ul style="list-style-type: none"> Willingness to live and work in a challenging environment and under pressure Commitment to transfer knowledge Ability to work under pressure and in extreme conditions Ability to maintain performance expectations in diverse cultural contexts, psychologically stressful environments, highly ambiguous contexts and physically demanding conditions with limited resources Ability to communicate cross-culturally, sensitive to other cultures Flexible worldview, emotional maturity and physical stamina

Operational Capabilities for Health and Nutrition Response Packages.

- Warehouse space in Regional Office countries for prepositioning storage of medicines, medical supplies and equipment including IEHK, Italian Trauma Kits, UNFPA RH kits, Midwifery kits, clean delivery kits, diarrheal disease kits.
- Funding for surge deployments of key Health and Nutrition sector staff.
- Supply chain mechanisms in place i.e. key suppliers identified, agreements in place for rapid procurement and shipping for emergencies.
- Emergency response roster of key technical staff (deployable) made up of professionals internal and external to WV

Commodity packages

- PHC drugs
- Medical supplies and equipment
- Nutrition supplies and equipment



Roll out – next steps

- Difficult to establish given organisation restructure
- Feedback is needed from the H&N CoP
- Need to determine TSO involvement with HEA
- Framework and accompanying documents need to be shared and discussed with HEA i.e. Dan Kelly and Trihadi Saptoadi

Key focal points

HEA

- Claire - Director of the HOps Global Tech Team
- Ando Raobelison - Emergency MNCH Specialist
- Antony Peter - Emergency Nutrition Specialist

Sustainable Health Team

- Mesfin - Partnership Leader Health and Nutrition

Questions

