Integrated Training Package on Emergency Preparedness and Response for Rapid Response Team (RRT)

Financial & Technical Support by United Nations Population Fund (UNFPA)
Nepal Red Cross Society (NRCS)

Government of Nepal
Ministry of Health
Department of Health Services
Epidemiology and Disease Control Division (EDCD)
Teku, Kathmandu
May 2017
Integrated Training Package on Emergency Preparedness and Response for Rapid Response Team (RRT)

Epidemiology and Disease Control Division (EDCD)
Department of Health Services
Ministry of Health
Kathmandu, Nepal
May 2017
ल्याउँदै निर्देशन गर्ने नेपालको सरकार स्वास्थ्य औद्योगिक संस्थाएको सेवा विभागको कार्यान्वयन समाप्त हुनेछ। यसले नेपालको स्वास्थ्य औद्योगिक संस्थाहरू र सरकारी स्वास्थ्य सेवा संस्थाहरूलाई आर्थिक र नैतिक सहयोग दिने केही प्रमुख गतिविधिको स्वरुपमा पर्ने बुझाउँछ।

ल्याउँदै निर्देशन नेपालको सरकार स्वास्थ्य औद्योगिक संस्थाहरूलाई आर्थिक र नैतिक सहयोग दिने केही प्रमुख गतिविधिको स्वरुपमा पर्ने बुझाउँछ। 

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नेपाल एकाधिकरण राज्याधिकारी तथा सरकारी सुरक्षीय स्वास्थ्य उपायको साधनहरूको महत्त्वमा लागि महत्त्वमा समान भएको छ। यी सरकार उपायको तत्त्वाकारी तथा बाँध्दै प्रार्थना गर्नुहोस्।

राष्ट्रिय सेवा निर्देशिका

दिन २०७८ साल, १ जुलाई

द्वारा प्रस्तुत

dha.भाई आचार्य

निर्धारकः


dha.भाई आचार्य

निर्धारकः


dha.भाई आचार्य
Acronyms

AIDS  Acquired Immunodeficiency Syndrome
CDO    Chief District Officer
CP     Contingency Plan
CRRT   Community Rapid Response Team
DDC    District Development Officer
DDK    Diarrheal Disease Kit
DDRC   District Disaster Relief Committee
DG     Director General
DOHS   Department of Health Services
D(P)HO District Public Health Office
EDCD   Epidemiology and Disease Control Division
EPR    Emergency Preparedness and Response
FHD    Family Health Division
GON    Government of Nepal
HA     Health Assistant
HIV    Human Immunodeficiency Virus
HMIS   Health Management Information System
IEHK   Inter-agency Emergency Health Kit
INGO   International Non-Government Organization
IFE    Infant Feeding in Emergencies
ITP    Integrated Training Package
KM     Kilometer
LDO    Local Development Officer
MISP   Minimum Initial Service Package
MIRA   Multi-Sectoral Initial Rapid Assessment
MoHP   Ministry of Health and Population
NGO    Non-Government Organization
NHTC   National Health Training Centre
NRCS   Nepal Red Cross Society
PFA    Psychological First Aid
PHN    Public Health Nurse
RH     Reproductive Health
RHAF   Rapid Health Assessment Format
RHD    Regional Health Director
RhDO   Regional Health Directorate Office
RRT    Rapid Response Team
SRH    Sexual and Reproductive Health
UNICEF United Nations Children Fund
UNFPA  United Nations Population Fund
WHO    World Health Organization
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Introduction

Nepal is a disaster prone country and faces various types of natural and man-made disasters, the most frequent natural disasters being floods and landslides. Nepal also lies in an earthquake prone zone and the earthquake of April 25, 2015 has been a devastating one. All these disasters not only cause deaths and casualties, but also displace people and cause infrastructural damage.

Nepal experiences disasters almost on an annual basis, with notable disasters occurring every few years.

- The most tragic disaster in Nepal are earthquakes:
  - In 1934, an earthquake with a magnitude of 8.3 struck Nepal and resulted in the deaths of 8,500 people.
  - In 1988, an earthquake with a magnitude of 6.6 struck Udayapur and resulted in the deaths of more than 700 people.
  - In 2015, an earthquake with a magnitude of 7.6 struck Gorkha and later in Dolakha resulted in more than 8970 deaths and around 23000 injuries.
In the years 1996-2000 nearly, 3,633 people died as a result of various epidemics.

During the period 1996-2000, nearly 1,380 died as a result of flooding and landslides.

The Koshi flood and succeeding flash floods in the west during the month of August/September 2008 displaced 55,000 people, and directly affected 240,000 people in Sunsari and Saptari districts.

In 2000, the Ministry of Health and Population (MoHP), Department of Health Services (DHS), and the Epidemiology and Disease Control Division (EDCD) established a mechanism for managing epidemics consisting of a Rapid Response Team (RRT) at three levels: central (1 RRT), regional (5 RRTs) and districts (75 RRTs). The objectives of these teams is to establish an early warning and reporting mechanism for potential epidemics, ensure preparedness for potential epidemics, manage disease outbreaks, and institutionalize disaster management.

Various activities were conducted in the past to address the issue of mobilizing health workers in case of outbreak or disasters. For example:

- EDCD regularly conducted different training programs on “Disaster Management and Response (2 days)”
- Epidemic Preparedness and Response (3 days)
- National Health Training Centre (NHTC) also adapted a 3-day training package for RRT members and health service providers on “Reproductive Health (RH) in Emergencies or Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH)”, targeted for use during crisis or post crisis situations

The training package, created for district to Ilaka level RRT members, will also aim to strengthen its disaster, crisis, and emergency response mechanisms.

The latest integrated training package (ITP) on Emergency Preparedness and Response (EPR) was developed in 2011 and trainings were carried out for Rapid Response Teams (RRT) across the country. However, over the years it was felt that the ITP needs to be updated in the light of the Earthquake of 2015.

In this context the EDCD in collaboration with UNFPA and Nepal Red Cross Society (NRCS) developed a task force to revise the ITP.
Objectives
The overall objective of the integrated training package is to enhance the emergency response capacity of RRT members during any kind of disaster, crisis or emergency.

Expected Outcome:
The expected outcome is that the RRTs (at the district and community levels) carry out effective and efficient emergency preparedness and responses at all levels, and are prepared to support in contingency planning.

Specific objectives:
- To enhance the RRT's capacity in initiating emergency preparedness and response actions and plan in close cooperation with relevant stakeholders
- To provide RRTs with the necessary knowledge and skills to conduct rapid assessments and effectively analyze the results
- To help in prioritizing key intervention areas of the RRTs based on the rapid assessments results
- To update knowledge in disease surveillance, outbreak investigation, and response
- To provide knowledge on Reproductive Health (RH) in Emergency which includes Minimum Initial Service package (MISP) on Sexual and Reproductive Health, and how to prepare an emergency response plan during crisis or post crisis situations
- To provide knowledge on other key areas such as mental health, psychosocial counseling, and nutrition that need to be addressed during a crisis or emergency
- To support in the logistics management capacity of RRTs

Integrated training package:
The Integrated Training Package on Emergency Preparedness and Response for Rapid Response Team is developed on the basis of past experiences and feedback/comments received from relevant stakeholders. The realization that the ITP needs updating was felt during the Earthquake of 2015 and several other happenings.

Major components of the integrated training package:
- Unit one deals with disaster management;
- Unit two deals with epidemic outbreak management and nutrition in emergency;
Unit three deals with *Reproductive Health in Emergency (Minimum Initial Service Package (MISP)), and mental health in emergency.*

This training package is prepared for the members of RRT. It is expected that it will help in increasing their capacity on emergency preparedness and response for any kind of disaster, crisis, or emergency.

**Participants:**

<table>
<thead>
<tr>
<th>Training Days</th>
<th>Participants</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 days</td>
<td>District level RRT members and In-charges of peripheral level health facilities</td>
<td>30</td>
</tr>
</tbody>
</table>

**Teaching methodologies:**

Following methodology will be used for training of the RRT on ITP

- Power point presentation and discussion
- Small group discussion
- Demonstration
- Brainstorming
- Video presentation
- Sharing of personal experience in responding to disaster, outbreak, crisis or emergency situations
- Exercises

**Teaching materials to be used in the training:**

- Flip chart, markers, board markers, white board, and news print
- Poster, photographs and animated disaster related videos
- Disaster, emergency, and crisis case studies
- Various assessment and analysis forms and formats

**Forms, formats and tools as part of teaching materials:**

- Rapid Health Assessment (RHA) Format
- Outbreak Recording Form
- Outbreak Reporting Form
- Daily Surveillance Form
- Multi sectoral Initial Rapid Assessment (MIRA)
Training components

Unit 1: Disaster Management
1.1: Basic concepts of disaster/emergency
1.2: Disaster management mechanism
   a) Disaster management policy and process in Nepal
   b) Functional Mechanism of RRT
   c) Setting priorities, Communication and coordination in disaster
1.3: Rapid Health Assessment and analysis in Emergency
1.4: Logistics and Financial management in emergency
1.5: Water, Sanitation and Hygiene and Environmental Health in Emergency
1.6: Sharing and lessons learnt by the participants

Unit 2: Epidemic/Outbreak Management and Nutrition Interventions
2.1: Communicable disease surveillance
2.2: Outbreak investigation and response
   a) Importance of outbreak investigations and its steps
   b) Prevention and Control of outbreak in disaster
   c) Laboratory investigation in outbreak
2.3: Outbreak investigation- Exercise
2.4: Communication and Coordination in Emergencies
2.5: Nutrition in Emergency
   a) Basic concept of nutrition in Emergency
   b) Measuring malnutrition and Infant Feeding in Emergencies guidance note of Nepal
   c) Assessing and Responding to severity of crisis
2.6: Child Health in Emergencies

Unit 3: RH in Emergencies and Mental Health
3.1: Overview of RH in Emergency
3.2: Components of MISP
3.3: RH Kits in Emergency
3.4 Monitoring and Evaluation with MISP Indicators
3.5 Mental health and Psychosocial Support in disaster
3.6 Exercise on Forms and Drills
### Suggested Training Schedule for 3 days

<table>
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<tr>
<th>Day One : Unit I Disaster management</th>
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<tbody>
<tr>
<td><strong>10:00–11:00</strong></td>
</tr>
<tr>
<td>• Registration, Welcome, Introduction</td>
</tr>
<tr>
<td>• Objectives and expected outcome</td>
</tr>
<tr>
<td>• Briefings on agenda /ground rules/remarks</td>
</tr>
<tr>
<td>• Pre-test (Optional)</td>
</tr>
<tr>
<td><strong>11:00–11:15</strong></td>
</tr>
<tr>
<td>Tea-Break</td>
</tr>
<tr>
<td><strong>11:15-12:00</strong></td>
</tr>
<tr>
<td>1.1 Basic concept of disaster/ emergency (45 Min)</td>
</tr>
<tr>
<td><strong>12:00-12:45</strong></td>
</tr>
<tr>
<td>1.2 Disaster management Mechanism (total 45 Min),</td>
</tr>
<tr>
<td>(a) Disaster management policy and process in Nepal (15 min)</td>
</tr>
<tr>
<td>(b) Functional mechanism of RRT and Contingency Planning (15 min)</td>
</tr>
<tr>
<td>(c) Setting priorities and communication in disaster (15 min)</td>
</tr>
<tr>
<td><strong>12:45-13:30</strong></td>
</tr>
<tr>
<td>Refreshment (Khaja) – (45 min)</td>
</tr>
<tr>
<td><strong>13:30-14:30</strong></td>
</tr>
<tr>
<td>1.3 Rapid Health Assessment (RHA) and analysis in emergency (60 min)</td>
</tr>
<tr>
<td><strong>14.30- 15.15</strong></td>
</tr>
<tr>
<td>1.4 Logistic and Financial management in Emergency (30 min)</td>
</tr>
<tr>
<td><strong>15:15-16:00</strong></td>
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<tr>
<td>1.5 Water, Sanitation and Hygiene (WASH) and Environmental Health in Emergency (45 min)</td>
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<tr>
<td><strong>16:00 -16:15</strong></td>
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<tr>
<td>Tea-Break</td>
</tr>
<tr>
<td><strong>16:15-17:00</strong></td>
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<tr>
<td>1.6 Sharing on lessons learnt on management in EQ 2015 (45 min)</td>
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</table>
### Day Two: Unit II Epidemic/Outbreak management and Nutrition Interventions

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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</thead>
<tbody>
<tr>
<td>10:00 – 10:15</td>
<td>Recap of day 1</td>
</tr>
<tr>
<td>10:15-11:00</td>
<td>2.1 Communicable Diseases surveillance (45 minutes)</td>
</tr>
<tr>
<td>11:00-11:15</td>
<td>Tea-Break</td>
</tr>
<tr>
<td>11:15– 12:30</td>
<td>2.2 Outbreak investigation and response (Total 1 hour 15 minutes)</td>
</tr>
<tr>
<td></td>
<td>(a) Importance of outbreak investigation and its steps (15 min)</td>
</tr>
<tr>
<td></td>
<td>(b) Prevention and control of outbreak in disaster (45 min)</td>
</tr>
<tr>
<td></td>
<td>(c) Laboratory investigations in outbreak (15 min)</td>
</tr>
<tr>
<td>12.30-13.00</td>
<td>2.3 Outbreak investigation Exercise (30 minutes)</td>
</tr>
<tr>
<td>13:00 –13:45</td>
<td>Refreshment (Khaja) -45 min</td>
</tr>
<tr>
<td>13.45- 14:15</td>
<td>2.4 Communication and Coordination in Emergencies</td>
</tr>
<tr>
<td>14:15-15:30</td>
<td>2.5 Nutrition in Emergency (Total 1 hour 15 min)</td>
</tr>
<tr>
<td></td>
<td>a) Basic concept on nutrition in emergency (20 min)</td>
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<tr>
<td></td>
<td>b) Measuring malnutrition and IFE Guidance note of Nepal (30 min)</td>
</tr>
<tr>
<td></td>
<td>c) Assessing and responding to the severity of crisis (20 min)</td>
</tr>
<tr>
<td>15:30-15:45</td>
<td>Tea-Break</td>
</tr>
<tr>
<td>15:45- 16:30</td>
<td>2.6 Child Health in emergencies (30 min)</td>
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</tbody>
</table>

### Day Three: Unit III RH in Emergency (MISP), and Mental Health

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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</thead>
<tbody>
<tr>
<td>10:00 – 10:15</td>
<td>Recap of day 2</td>
</tr>
<tr>
<td>10.15 - 11:10</td>
<td>Reproductive Health in Emergency (MISP) – (55 min)</td>
</tr>
<tr>
<td></td>
<td>3.1 Overview of RH in emergencies (MISP)</td>
</tr>
<tr>
<td>11:10– 11:25</td>
<td>Tea-Break</td>
</tr>
<tr>
<td>11:25- 11:55</td>
<td>3.2 Components of MISP (30 min)</td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
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<tr>
<td>--------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>11:55 – 12:15</td>
<td>3.3 RH Kits in Emergency (20 min)</td>
</tr>
<tr>
<td>12:15- 13.00</td>
<td>3.4 Monitoring and evaluation with MISP indicators (30 min) + exercise (15 min)</td>
</tr>
<tr>
<td>13:00 – 13:45</td>
<td>Refreshment (Khaja) 45 min</td>
</tr>
<tr>
<td>13:45-14:15</td>
<td>3.5 Mental Health and Psychosocial Support in Disaster (30 min)</td>
</tr>
<tr>
<td>14:15- 14.45</td>
<td>Exercise on Forms</td>
</tr>
<tr>
<td>15:15-15:30</td>
<td>Tea-Break</td>
</tr>
<tr>
<td>15:30- 16:30</td>
<td>Mock Drill</td>
</tr>
<tr>
<td>16:15- 16.30</td>
<td>Post-Test (optional)</td>
</tr>
<tr>
<td>16:30- 17:00</td>
<td>Closing</td>
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</table>
DAY ONE:
UNIT I:
Disaster Management
### Unit 1.1: Basic Concept of Disaster/ Emergency

<table>
<thead>
<tr>
<th>Duration:</th>
<th>45 minutes (including 15 min discussion)</th>
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</thead>
</table>
| Objectives:        | • To update the knowledge and understanding of basic concept of disasters/emergencies  
                      • To familiarize participants on frequently used terminologies, disaster management cycles, and consequences of various hazards. |
| Contents:          | • Introduction to basic concept of disasters/emergencies,  
                      • Terminology,  
                      • Disaster management cycle and  
                      • Consequences of various hazards |
| Methodology:       | Brainstorming, power point presentation, video presentation, discussion, matching of flash card |
| Brief on delivery of the sub-unit: | Disaster management cycles, and consequences of various hazards. The session will conclude with a summarization of key points. |
| Advance preparation: | Link with disasters faced by Nepal such as the Koshi floods in 2008 and 2015 Earthquake |

### Unit 1.2: Disaster Management Mechanism

| Sub-topic: | (a) Disaster Management Policy and Process in Nepal (15 min)  
                      (b) Functional Mechanism of RRT (15 min)  
                      (c) Setting Priorities and Communication in disaster (15 min) |
| Duration: | 45 minutes |
| Objectives: | To familiarize participants on disaster management policy and processes in Nepal, functional mechanism for Rapid Response Team, priority setting and communication in disaster |
| Contents: | • Disaster management mechanism (policy and process) in Nepal  
                      • Functional mechanisms of the Rapid Response Teams |
- Communication in disaster

Methodology: Power point presentation and discussion

Brief on delivery of the sub-unit: Power point presentation on the national disaster management policies and processes in Nepal, functional mechanisms for Rapid Response Teams of different levels (Central, Regional, District and Community) and Communication and coordination in disaster

Advance preparation: Policy, guidelines

<table>
<thead>
<tr>
<th>Unit 1.3:</th>
<th>Rapid Health Assessment and Analysis in Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration:</td>
<td>60 minutes (including 10 min discussion)</td>
</tr>
</tbody>
</table>
| Objectives: | To orient the participants on rapid health assessment  
To orient application of different types of forms and emergency analysis techniques |
| Contents: | - Rapid Health Assessment Form,  
- Syndromic Surveillance Form,  
- Outbreak recording and reporting Forms,  
- MIRA and its applications |
| Methodology: | PowerPoint presentation and Practice on forms |
| Brief on delivery of the sub-unit: | Brainstorming questions on different forms and formats used during times of crisis or emergency. Use different types of forms such as (RHAF, SSF, ORRF and MIRA) and how they should be filled out during an emergency or disaster |
| Advance preparation: | RHA Form, SS Form which need to be filled out daily during an emergency  
Outbreak Recording and Reporting Forms and MIRA |

<table>
<thead>
<tr>
<th>Unit 1.4:</th>
<th>Logistics and Financial Management in Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration:</td>
<td>30 minutes (including 5 min discussion)</td>
</tr>
<tr>
<td>Objectives:</td>
<td>To orient participants on emergency logistics management with budgets, kits and supplies including adaptation of international kits (RH kits), and supplies.</td>
</tr>
</tbody>
</table>
To ensure proper preparation with buffer stocking of drugs, supplies and kits

| Contents: | • Logistics management mechanisms in emergency,  
• Logistic estimation and buffer stocking  
• Financial management |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Methodology:</td>
<td>Power point presentation, discussion, and sharing ideas</td>
</tr>
</tbody>
</table>
| Brief on delivery of the sub-unit: | Initiation with lessons learnt from recent epidemics in terms of logistic management, followed by feedback from participants on the logistics management difficulties faced. Identification of the local procurement process for drugs, supplies, and kits along with a discussion on how to prepare in advance through buffer stocking system.  
EDCD has allocated some budget for each district to respond to emergencies. Besides, D(P)HO can request DDRC for more support in case it is necessary. The session will conclude with a summarization of key points. |
| Advance preparation: | List of supplies, drugs, and kits |

<table>
<thead>
<tr>
<th><strong>Unit 1.5:</strong></th>
<th><strong>Water, Sanitation and Hygiene and Environmental Health in Emergency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration:</strong></td>
<td>45 minutes (including 5 min discussion)</td>
</tr>
<tr>
<td><strong>Objectives:</strong></td>
<td>To provide basic knowledge on environmental health and sanitation during times of emergency (water purification, sanitation, waste disposal management)</td>
</tr>
</tbody>
</table>
| **Contents:** | • Importance of safe water, sanitation and hygiene and environmental health during times of emergency  
• Various methods of water purification for safe drinking water,  
• Prevention and control of communicable diseases through sanitation and waste disposal  
• Minimum standard based on Sphere Guidelines for |
<table>
<thead>
<tr>
<th>Methodology:</th>
<th>Power point presentation, demonstration, discussion, and sharing ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief on delivery of the sub-unit:</td>
<td>Initiation with a power point presentation on prevention and control of communicable diseases through water purification and waste disposal management. Demonstration of possible water purification. The session will conclude with a summarization of key points.</td>
</tr>
<tr>
<td>Advance preparation:</td>
<td>Pre-visit Jajarkot district experience of diarrhea epidemic and case studies from districts during earthquake</td>
</tr>
</tbody>
</table>

### Unit 1.6: Sharing and lesson learnt on management in 2015 earthquake by the participants: (Experience on Epidemics /Emergency /Disaster and its Response)

<table>
<thead>
<tr>
<th>Duration:</th>
<th>45 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives:</td>
<td>To learn from district experiences on management of 2015 earthquake including epidemic/ emergency/ disaster</td>
</tr>
</tbody>
</table>
| Contents: | • Sharing of the management during 2015 earthquake and immediate response on it  
• Response activities conducted,  
• Coordination and communication |
| Methodology: | Discussion, sharing of experiences and lessons learnt for further emergency preparedness |
| Brief on delivery of the sub-unit: | Initiation with sharing of lessons learnt from recent earthquake and epidemics. Analyze the preparedness and response provided as case studies. Finally come up with some of the recommendations and preparedness plan for future |
| Advance preparation: | Presentation will be made by participants through whichever methods they feel are most effective. |
DAY TWO:
UNIT II:
Management of Epidemic/Outbreak and Nutrition Interventions
### Unit 2.1: Communicable Disease Surveillance

<table>
<thead>
<tr>
<th>Duration:</th>
<th>45 minutes (including 5 min discussion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives:</td>
<td>To orient participants on communicable disease surveillance</td>
</tr>
<tr>
<td>Contents:</td>
<td>- Basic concepts, importance,</td>
</tr>
<tr>
<td></td>
<td>- principle, function, and</td>
</tr>
<tr>
<td></td>
<td>- components of surveillance</td>
</tr>
<tr>
<td>Methodology:</td>
<td>Power point presentation, discussion, and sharing ideas</td>
</tr>
<tr>
<td>Brief on delivery</td>
<td>Initiation with a power point presentation on the basic concepts, importance, principle, function, and components of surveillance, followed by a discussion on past surveillance experiences. Emphasis will be placed on recording and reporting of Syndromic Surveillance form. The session will conclude with a summarization of key points.</td>
</tr>
<tr>
<td>Advance preparation</td>
<td>Pre-visit Syndromic Surveillance Format</td>
</tr>
<tr>
<td></td>
<td>Recording and reporting format</td>
</tr>
</tbody>
</table>

### Unit 2.2: Outbreak Investigation and Response

<table>
<thead>
<tr>
<th>Sub-topic:</th>
<th>(a) Importance of outbreak investigation and its steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration:</td>
<td>15 minute (including 5 min discussion)</td>
</tr>
<tr>
<td>Objectives:</td>
<td>To orient participants on importance of outbreak investigation, and its procedures</td>
</tr>
<tr>
<td>Contents:</td>
<td>Importance and steps of outbreak investigation</td>
</tr>
<tr>
<td>Methodology:</td>
<td>Power point presentation, discussion, and sharing ideas</td>
</tr>
<tr>
<td>Brief on delivery</td>
<td>Initiation with a power point presentation on the importance of outbreak investigation, and its procedures. The session will conclude with a summarization of key points.</td>
</tr>
<tr>
<td>of the sub-unit:</td>
<td></td>
</tr>
<tr>
<td>Advance preparation:</td>
<td>Pre visit Outbreak Recording and Reporting Format and its operation guidelines.</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Sub-topic:</strong></td>
<td>(b) Prevention and Control of Outbreak in Disaster</td>
</tr>
<tr>
<td><strong>Duration:</strong></td>
<td>45 minutes (including 15 min discussion)</td>
</tr>
<tr>
<td><strong>Objectives:</strong></td>
<td>To orient participants on the prevention and control of disaster outbreaks among displaced populations.</td>
</tr>
</tbody>
</table>
| **Contents:**       | • Consequences of disaster, Transmission of outbreak,  
                    • Prevention, diagnosis and case management,  
                    • Outbreak preparedness and response |
| **Methodology:**    | Power point presentation, discussion and sharing ideas |
| **Brief on delivery of the sub-unit:** | Initiation with a power point presentation on the process of prevention and control of various disaster outbreaks, discussion with sharing ideas on past disaster outbreak management. The session will conclude with a summarization of key points. |
| Advance preparation: | Pre visit Outbreak Recording and Reporting Format and its guidelines to use it. |
| **Sub-topic:**      | (c) Laboratory Investigation in Outbreak |
| **Duration:**       | 15 min |
| **Objectives:**     | To orient participants on laboratory investigation in outbreak |
| **Contents:**       | • Role and importance of laboratory diagnosis in outbreak investigation,  
                    • Sample collection and transport procedures  
                    • Common lab diagnostic tools |
| **Methodology:**    | Power point presentation, demonstration, discussion and sharing ideas |
**Unit 2.3: Outbreak Investigation Exercise**

<table>
<thead>
<tr>
<th>Duration:</th>
<th>30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives:</td>
<td>To provide practical knowledge on outbreak investigation</td>
</tr>
<tr>
<td>Contents:</td>
<td>Different scenario of a Cholera Outbreak</td>
</tr>
<tr>
<td>Methodology:</td>
<td>Group formation 2-3 persons in each group, Questionnaire will be distributed &amp; Group work in each questions and presentation</td>
</tr>
<tr>
<td>Brief on delivery of the sub-unit:</td>
<td>Group exercises and presentation by questionnaire forms step by step.</td>
</tr>
<tr>
<td>Advance preparation:</td>
<td>Materials for group work (Flip chart, markers and so on)</td>
</tr>
</tbody>
</table>

**Unit 2.4: Communication and Coordination during emergencies**

<table>
<thead>
<tr>
<th>Duration:</th>
<th>30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives:</td>
<td>To provide knowledge on appropriate communication and communication during emergencies</td>
</tr>
</tbody>
</table>
| Contents:        | • Communication during emergencies  
|                | • Coordination during emergencies   |
| Methodology:    | Presentation, Case studies and Discussion |
| Advance preparation: | Materials for case studies (Flip chart, markers etc) |

**Unit 2.5  Nutrition in Emergency**

| Sub-topic:       | (a) Basic concept on nutrition in emergency |
| Duration:        | 20 minutes |
| Objectives:      | To orient basic concept on why nutrition is important in crisis, assessing the severity of crisis and responding to the crisis |
| Contents:        | • Vulnerable people prone to nutritional problems,  
<p>|                  | • Immediate steps for nutritional activities (Focusing on pregnant woman, lactating woman, newborn, under five children and old people) |
| Methodology:     | Brainstorming, Power point presentation, discussion and sharing ideas |
| Brief on delivery of the sub-unit: | Initiation with sharing ideas on the importance of nutrition health during a disaster. This will be followed by a power point presentation and discussion on vulnerable people prone to nutritional complications, and immediate steps to be taken to address nutrition during times of emergency. The session will conclude with a summarization of key points on the continual need for of nutritional activities, especially for lactating mothers, pregnant mothers, the elderly, and children under the age of five. |
| Advance preparation: | Pre-visit guiding principles for feeding infants and young children during emergencies, WHO, Geneva |</p>
<table>
<thead>
<tr>
<th>Unit 2.5</th>
<th>Nutrition in Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-topic:</strong></td>
<td>(b) Measuring Malnutrition and IFE Guidance Note of Nepal</td>
</tr>
<tr>
<td><strong>Duration:</strong></td>
<td>15 minutes</td>
</tr>
<tr>
<td><strong>Objectives:</strong></td>
<td>To orient on measurement of malnutrition in emergency</td>
</tr>
</tbody>
</table>
| **Contents:** | • technique of measurement of malnutrition  
• IFE Guidance note of Nepal |
| **Methodology:** | Brainstorming, Power point presentation, discussion and sharing ideas |
| **Brief on delivery of the sub-unit:** | Initiate the session with sharing of knowledge on the importance of basic nutrition intervention during an emergency followed by a power point presentation on measuring malnutrition among young children and infant. It will be followed by orientation on IFE Guidance note of Nepal. The session will conclude with a summarization of key points on the need for continued collaboration and cooperation to effectively respond to nutrition needs during an emergency, focusing on young children and infants. |
| **Advance preparation:** | Sakir Tape for MUAC  
IFE Guidance note of Nepal |

<table>
<thead>
<tr>
<th>Unit 2.5</th>
<th>Nutrition in Emergency (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-topic:</strong></td>
<td>(c) Assessing and Responding to Severity of Crisis</td>
</tr>
<tr>
<td><strong>Duration:</strong></td>
<td>20 minutes</td>
</tr>
<tr>
<td><strong>Objectives:</strong></td>
<td>To orient on assessing the severity of crisis and responding to the crisis</td>
</tr>
</tbody>
</table>
| **Contents:** | • Vulnerable people prone to nutritional problems,  
• Immediate steps for nutritional activities (Focusing on pregnant woman, lactating woman, newborn, under five children and old people) |
Methodology: Brainstorming, Power point presentation, discussion and sharing ideas

Brief on delivery of the sub-unit: Initiate the session with discussion on vulnerable people (especially pregnant women, lactating women, newborn and under five children) during emergencies followed by a power point presentation on immediate steps for nutritional activities. Conclude the session with summarization of key points.

<table>
<thead>
<tr>
<th>Unit 2.6</th>
<th>Child Health in Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-topic:</td>
<td>(a) Child Health in Emergency</td>
</tr>
<tr>
<td>Duration:</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Objectives:</td>
<td>To orient and discuss the necessity of child health in an emergency</td>
</tr>
<tr>
<td>Contents:</td>
<td>Issues and concerns on child health during crisis</td>
</tr>
<tr>
<td>Methodology:</td>
<td>Power point presentation and question and answer</td>
</tr>
<tr>
<td>Brief on delivery of the sub-unit:</td>
<td>Child Morbidity and Mortality issues and concerns during an emergency followed by a power point presentation on specific concerns actions focusing on child survival. The session will conclude with a summarization of key points on need for the continued collaboration and cooperation to effectively respond to child survival during an emergency.</td>
</tr>
<tr>
<td>Advance preparation:</td>
<td>International Experiences in dealing with emergencies</td>
</tr>
</tbody>
</table>
DAY THREE:
UNIT III:
Minimum Initial Service Package (MISP) for Reproductive Health in Emergency and Mental Health
### Unit 3.1: Reproductive Health in Emergency

<table>
<thead>
<tr>
<th>Sub-topic: (a) Overview of Minimum Initial Service Package (MISP) for Reproductive Health in Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration: 55 minutes (including 5 min discussion)</td>
</tr>
<tr>
<td>Objectives: To orient participants on Reproductive Health during an emergency To provide basic knowledge on MISP in order to reduce mortality, morbidity, and disability of displaced populations</td>
</tr>
<tr>
<td>Contents: • RH in Emergency and • MISP</td>
</tr>
<tr>
<td>Methodology: Video presentation (Women in war), Brainstorming, Power point presentation, discussion and sharing ideas</td>
</tr>
<tr>
<td>Brief on delivery of the sub-unit: Initiate the session with a video presentation on disasters, followed by a brainstorming session. A power point presentation will be made regarding an overview of RH during an emergency, including importance of MISP for Sexual and Reproductive Health (SRH) during disaster, crisis, or post crisis situations. The session will conclude with a summarization of key points on what is NOT MISP.</td>
</tr>
</tbody>
</table>

### Unit 3.2: Components of MISP

<table>
<thead>
<tr>
<th>Major components of Minimum Initial Service Package (MISP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration: 30 minutes</td>
</tr>
<tr>
<td>Objectives: To orient participants on the five major MISP components and RRT’s role in monitoring the day to day implementation of</td>
</tr>
</tbody>
</table>
### MISP during any emergency or post emergency situation.

**Contents:**
- Five major components of MISP and
- RRT’s role in implementation during a disaster.

**Methodology:**
Brainstorming, Power point presentation, discussion and sharing ideas

**Brief on delivery of the sub-unit:**
Initiation with a brainstorming on the components of MISP, followed by a power point presentation and discussion of each component including role of RRTs. Finally sum up the session with key points on plan for comprehensive SRH services for the management of post crisis situation.

**Advance preparation:**
Use reference manual developed by NHTC on MISP in Nepali

<table>
<thead>
<tr>
<th>Unit 3.3</th>
<th>RH Kits in Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration:</strong></td>
<td>20 minutes</td>
</tr>
<tr>
<td><strong>Objectives:</strong></td>
<td>To orient on 13 different types of RH kits and to make familiarize with the RH Kits name.</td>
</tr>
<tr>
<td><strong>Contents:</strong></td>
<td>RH Kits (13 different types of RH Kits)</td>
</tr>
<tr>
<td><strong>Methodology:</strong></td>
<td>Brainstorming, Power point presentation, discussion and sharing ideas</td>
</tr>
<tr>
<td><strong>Brief on delivery of the sub-unit:</strong></td>
<td>Initiate with Brainstorming on the RH Kits with the support of Public Health Nurses (PHNs). Then display of power point presentation and discuss one by one RH kits including role of RRTs. Finally sum up the session with key points on plan for RH kits in order to make sure availability of RH kits during disaster.</td>
</tr>
<tr>
<td><strong>Advance preparation:</strong></td>
<td>Identify # of SBAs in district and identify # of RH kits in districts</td>
</tr>
<tr>
<td>Sub-topic:</td>
<td>(d) Monitoring and evaluation with MISP Indicators</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Duration:</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>
| Objectives: | To orient on conducting basic monitoring and evaluation for MISP  
| | To orient on needs assessment tools to plan for comprehensive SRH |
| Contents: | • Five essential M & E components  
| | • MISP Basic Demographic and Health Information  
| | • MISP Indicators based on five major components  
| | • MISP Monthly Data Collection (by using HMIS system) |
| Methodology: | Brainstorming, Power point presentation, discussion, and sharing ideas |

**Brief on delivery of the sub-unit:**
Initiation with a brainstorming session on the importance of monitoring and evaluation during disaster. This will be followed by a power point presentation and discussion on monitoring indicators for each MISP components, and the importance of monthly database updates using the HMIS system. The session will conclude with a summarization of key points on comprehensive SRH service planning based on post disaster situation evaluations.

**Advance preparation:**
- HMIS Monthly database  
- Reporting mechanism  
- Use reference manual developed by NHTC on MISP in Nepali
<table>
<thead>
<tr>
<th>Unit 3.5:</th>
<th>Mental Health and Psychosocial support in Disaster</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration:</strong></td>
<td>30 minutes</td>
</tr>
<tr>
<td><strong>Objectives:</strong></td>
<td>To orient participants on the importance of mental health, psychosocial support, and protection during emergency and post emergency situations</td>
</tr>
</tbody>
</table>
| **Contents:** | - Importance of mental health,  
- Psychological consequences due to disaster,  
- Psychological First Aid (PFA) and Counseling |
| **Methodology:** | Brainstorming, Power point presentation, discussion and sharing ideas |
| **Brief on delivery of the sub-unit:** | Initiate the session with sharing ideas on the importance of mental health during emergencies. Make a power point presentation on psychological consequences of a disaster, Psychological First Aid (PFA), and Counseling. Mention that the District Women and children's office has mechanism to provide psychosocial counseling and referral can be made. The session will conclude with a summarization of key points on the continual need for psychosocial counseling support during post disaster situations. |
| **Advance preparation:** | Pre-visit IASC guidelines on mental health and psychosocial support in emergency settings |

<table>
<thead>
<tr>
<th>Unit 3.6</th>
<th>Exercise on Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub Topic:</strong></td>
<td>Practice on Various recording and reporting forms</td>
</tr>
<tr>
<td><strong>Duration:</strong></td>
<td>30 minutes</td>
</tr>
<tr>
<td><strong>Objectives:</strong></td>
<td>To make participants confident on filling emergency and surveillance related forms</td>
</tr>
<tr>
<td><strong>Contents:</strong></td>
<td>Various forms for recording and reporting</td>
</tr>
</tbody>
</table>
### Methodology: Group Work

**Brief on delivery of the sub-unit:**
Form groups with 2-3 persons in each group. Provide them with recording and reporting forms and provide case studies from the district. Then ask each group to review another group's form and provide feedback. The session will conclude with a summarization of key points on contingency planning.

**Advance preparation:**
Sufficient number of copies of recording and reporting preparation
Case studies to fill in the forms (from the same district desirable, if not, case from adjacent district)

### 3.6 Mock Drill

**Duration:** 60 minutes

**Objectives:** To make participants mentally ready in case of any emergency or disaster.

**Contents:**
- Whistle blowing
- Place of gathering/exit
- Personal Safety
- Preparing Emergency Kit
- Deployment for field

**Methodology:** Exercise

**Brief on delivery of the sub-unit:**
Brief the participants about mock-drill. Repeat the major steps. Then create a situation of emergency and ask the participants to go for relief work.

**Advance preparation:**
Case study for drill
Emergency Kits
Adequate space for drill
Integrated training package

Forms, formats and tools as part of teaching materials:

The following forms are included in this ITP for easiness for training.

I. Rapid Health Assessment Form (RHAF) in Nepali and Guidelines in English
II. Multi sectoral Initial Rapid Assessment (MIRA) in English
III. Daily Surveillance Form for health Facilities
IV. Outbreak Recording Form in Nepali and Guidelines in Nepali
V. Outbreak Reporting Form in Nepali and Guidelines in Nepali
RAPID HEALTH ASSESSMENT FORMAT

िल्ला/ग.वि.स. /बाडा नं.: ………………………………… प्रतिबंधन पेश गरेको मिति: …………… प्रतिबंधन नं.: ……

प्रकोष्ठको प्रकार: …………………………………………… प्रकोष्ठ भएको मिति र समय: ……………………………

1. संचारको स्रोत (नाम, पद, संस्था, ढेकाला, फोन नं.): ……………………………………………………………………………………………………………………………

2. विपथापित/प्रभावितहरूको विशेषज्ञ:

<table>
<thead>
<tr>
<th>संख्या</th>
<th>मृत्यु</th>
<th>धार्मिक</th>
<th>हराएका</th>
</tr>
</thead>
<tbody>
<tr>
<td>उमेर</td>
<td>महिला</td>
<td>पुरुष</td>
<td>महिला</td>
</tr>
<tr>
<td>&lt; 5 वर्ष</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 5 वर्ष</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>जम्मा</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>विपथापित (पुर्ण/अनुपालन)</th>
<th>प्रभावित (पुर्ण/अनुपालन)</th>
</tr>
</thead>
<tbody>
<tr>
<td>परिवार संख्या</td>
<td>परिवार संख्या</td>
</tr>
</tbody>
</table>

3. स्वास्थ्य संस्थाको श्रेणी: पूर्ण  आयोग  बैठू  ……………………………………………………………………………………………………………………………………………………………………………………………
۴. ریفر دریافت‌کننده (اسم‌بند) هرکدام نام و سند: .................................................................

۵. پژوهش پانزدهم و بالای‌کاری‌های سال‌های: (سالهای، پرتره، رئیسکر یا آن): .................................................................

۶. ساختار سازمانی سازمان جوانان (بسته‌بندی‌ها، پایداری، مشاوره، پژوهشی، تنظیم‌های جوانان): .................................................................

۷. سازمان‌هایی که به‌عنوان، پاره‌نامه و دانش‌پذیری که اگر یک بوده: .................................................................

۸. دانش‌آموزانی که در سال‌های جوانان نهایی و سازمان‌هایی که اگر یک بوده: .................................................................

۹. ساختار سازمانی درست و آماده‌سازی‌های بسته‌بندی جوانان یا: .................................................................

۱۰. پژوهش سازمان پنجم سالهای بیننامه: جزئیات: ETERE ETERE ETERE

۱۱. پژوهش سازمان کامل ساختنی: ولیعکس یا گرافیر یا گرافیر

پایگاه‌داده‌ها ساخته: ................................................................. سازمان‌ها که پرسیده کنند: .................................................................

همسران نام: ................................................................. همسران نام: .................................................................

میثاق: ................................................................. میثاق: .................................................................
RAPID HEALTH ASSESSMENT GUIDELINES

A rapid health assessment form needs to be filled out by DHO / DPHO, the Rapid Response Team, or available health staff no later than 24 hours after a public health emergency occurs. It should immediately be faxed or in other ways communicated to the addresses given below.

WHEN TO USE THE ASSESSMENT FORMAT:

- An emergency is an exceptional situation exceeding the response capacity of the affected community
- For field assessment purposes, it can be defined as any event resulting in the death of more than one person, the injury of 10 people, or significant displacement of local population
- Rapid health assessments are not expected following road traffic accidents
- Unusual disease incidents need to be reported in the separate post-emergency syndromic surveillance format

HOW TO USE THE ASSESSMENT FORMAT:

Disaster and report information:

- Indicate district, VDC, ward no, reporting date and report number at the top of the form
- Categorize the type of disaster (e.g. flood OR landslide) along with the date and time of occurrence

1. Source of information:

- List name, position, contact number and address of key informant(s)

2. Health data and number of displaced / affected:

- Search accurate figures for the number of deaths / injured / missing and breakdown by gender / age
- Give exact OR estimated number of displaced and affected people (indicate validity by tick mark) based on number of families OR persons (indicate data unit and calculation method)
- Displaced people are homeless due to the disaster event and affected people are anyone who have experienced mortality, morbidity, loss of livestock or property
3. Damage to health facilities:
   - Assess damage to health facilities based on condition of physical structures, supplies and equipment. Indicate whether facilities remain fully operational / functional / non-functional

4. Referral services and referral hospital:
   - Mention referral services and list the referral hospital for seriously injured casualties

5. Active emergency responders:
   - Briefly list active emergency responders and describe response actions being taken

6. Health response being provided:
   - Describe health response being provided including assessments, coordination, first aid, mass casualty management, referral, provision of medicine, psycho-social support and logistics

7. Water quantity / quality:
   - Describe current status and risks related to water quantity / quality

8. Sanitation and hygiene:
   - Describe current status and risks related to sanitation and hygiene

9. Priority health needs:
   - Explain in detail priority health needs including medical supplies and equipment

10. Access:
    - Assess whether the accessibility to the incident site is good / fair / poor

11. Security:
    - Assess whether the security situation at the incident site is good / fair / poor

Signature and contact details of DHO / DPHO and reporter:
    - Don't forget to sign, indicate date and provide contact details of DHO / DPHO and yourself.

Please complete and return / send to the following addresses: Director / Disaster Focal Point
Epidemiology and Diseases Control Division
Department of Health Services
Ministry of Health and Population
Tel: 977-1-4255796   Fax: 977-1-4262268
edoddhe@gmail.com

Technical Officer / National Operations Officer
Emergency and Humanitarian Action (EHA)
World Health Organization (WHO)
Pulchowk, Kathmandu
Tel: 977-1-4264033   Fax: 977-1-4264033/5527756
epeha@searo.who.int
Multi-Cluster Initial Rapid Assessment (MIRA) - Nepal for Multi-Hazards Scenarios as of July 2012

(This assessment form should be used in close coordination and review with the District Disaster Relief Committee (DDRC). Stakeholders are requested to use this format to collect and analyze information of affected VDCs and Districts)

### 1. Assessment Team Information

<table>
<thead>
<tr>
<th>Organizations participating</th>
<th>Date of assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>From</td>
</tr>
<tr>
<td></td>
<td>To</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of team leader</th>
<th>Contact Details</th>
</tr>
</thead>
</table>

### 2. Geographic Information (to be filled up in consultation with DDRC)

#### 2.1 Name of the District

#### 2.2 Type of Hazard/Disasters (Tick appropriate only):

- Flooding
- Epidemic
- Drought
- Earthquake
- Landslide
- Fire
- Hailstorm
- Others

#### 2.3 Using a map of the district, identify the VDCs/Communities that are affected by the disaster. Use the following categories:

- a. Worst affected (Highest impact)
- b. Highly affected (High impact)
- c. Moderately affected (Moderate impact)
- d. Lightly affected (Light impact)
- e. Not affected (No impact)

#### 2.4 On the same map, indicate which of the affected VDCs/communities cannot be reached by vehicle

#### 2.5 On the same map, indicate major concentrations of the Internally displaced people

#### 2.6 On the same map, indicate critical transportation infrastructural damage (roads, bridges, airports)

#### 2.7 On the same map, indicate potential security threats (dacoit, other groups, ...)

#### 2.8 Distance of the most affected VDCs from the DHQs (walking hours: .............. Driving hours ..............)

Following questions (3, 4 & 5) should be collected in DHQ in advance by the assessment team or prepared at the time of Disaster Preparedness and Response Planning in every District

### 3. District Level data to be considered (Collect Information from DPHO)

#### 3.1 Functioning health facilities in the district
<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Buildings</th>
<th>Adequate staff</th>
<th>Accessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total No.</td>
<td>No. of affected buildings</td>
<td>Yes</td>
</tr>
<tr>
<td>Sub Health Post</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Post</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Health Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If local (S)HP/PHC are inaccessible for VDC population please explain why:

3.2 How many cases of acute malnutrition are currently under treatment in the Hospital and/or Nutrition Rehabilitation Home?
(For district level facilities) Number: _______
(Optional)
- Is this different from previous/other years? Explain:
- Is there sufficient treatment capacity? Yes or No

3.3 Participation of community organization or community
a. Yes  b. No
If yes, provide
a) Name………………………
   b) Contact Number………..
c) Email

If there are concentrations of families displaced outside of their community of origin (in neighboring VDC or beyond) collects the following additional information for each location:

4. Sampled VDC/Community  (Randomly select a community(s) within affected areas for the detailed information on the following (if time does not allow, select a community from the worst and/or highly affected areas only)

<table>
<thead>
<tr>
<th>District</th>
<th>VDC</th>
<th>GPS of the sampled VDC: If not available, P-code of the VDC:</th>
<th>Mapping impact category (1-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visited Ward numbers:</td>
<td>Number of wards affected:</td>
<td>Name of Villages visited:</td>
<td></td>
</tr>
<tr>
<td>Altitude of the visited wards</td>
<td>Latitude (Y):</td>
<td>Longitude (X):</td>
<td></td>
</tr>
</tbody>
</table>

5. Population data (Village/Settlement level)

<table>
<thead>
<tr>
<th>5.1 Total population</th>
<th>Total</th>
<th>Male</th>
<th>Children &lt; 5 yrs</th>
<th>Total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affected level and population</td>
<td>Total Families</td>
<td>Female</td>
<td>Male</td>
<td>Children &lt; 5 yrs</td>
</tr>
<tr>
<td>5.2 Highly affected population (count)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3 Less affected population (count)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4 Number of Persons:</td>
<td>Male</td>
<td>Female</td>
<td>Children &lt; 5 hrs</td>
<td>Common cause</td>
</tr>
</tbody>
</table>
5.5 Affected groups or Vulnerable groups (Count number of persons in every case)

<table>
<thead>
<tr>
<th>Families with no shelter due to disasters</th>
<th>Unaccompanied elders &gt;60 years</th>
<th>Unaccompanied minors</th>
<th>Severely ill / Disabled</th>
<th>Pregnant / Lactating Women</th>
<th># Female headed households</th>
<th>Disadvantaged, Ethnic, religious, communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
</tbody>
</table>

6. Shelter and NFI

6.1 What is the level of housing damage?

- a) Total number of houses destroyed, no habitation whatsoever (requires complete reconstruction and demolished)
- b) Total number of severely damaged houses, unsafe for habitation (Walls, roof and column collapsed, hanging wall etc.)
- c) Total number of moderately damaged houses, that are safe for habitation but requiring minor maintenance (cracks evident but the structure intact)
- d) Total number of houses with no visual damage

6.2 Are community shelter facilities with water and sanitation provisions available? □ Yes □ No

If yes, indicate the type and number of facilities within the immediate community boundary and how many people can be adequately accommodated (Narrative):

- □ Public buildings (locations and accommodation capacity):
- □ Host families (locations and accommodation capacity):
- □ Other (locations and accommodation capacities):

6.3 What are the most likely immediate NFI needs of the community:

- □ Emergency shelter / tarpaulin
- □ Shelter tools
- □ Blankets
- □ Cooking utensils
- □ Buckets / jerrycans
- □ Clothing / material
- □ Other (specify):

Narrative:
### 7. Household food security

<table>
<thead>
<tr>
<th>7.1 What percentage of households lost percentage of their food stocks? (e.g. 40% of households lost 100%)</th>
<th>% of food stocks lost</th>
<th>Corresponding % age HH</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0-25%</td>
<td>□ 25-50 %</td>
<td>□ 75-100%</td>
</tr>
<tr>
<td>□ 50-75 %</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.1 Within these food stocks what type of food is available</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Cereal</td>
</tr>
<tr>
<td>□ Pulses</td>
</tr>
<tr>
<td>□ Vegetable</td>
</tr>
<tr>
<td>□ Meat</td>
</tr>
<tr>
<td>□ Oil</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.2 For those who have stocks remaining, on average, how long is it expected to last?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1-3 days</td>
</tr>
<tr>
<td>□ 4-7 days</td>
</tr>
<tr>
<td>□ 1-2 weeks</td>
</tr>
<tr>
<td>□ &gt;1 month</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.3 What is the predominant source of food?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before Crisis</td>
</tr>
<tr>
<td>□ Local shops/marketing</td>
</tr>
<tr>
<td>□ Government aid</td>
</tr>
<tr>
<td>□ Aid agencies</td>
</tr>
<tr>
<td>□ Own reserves</td>
</tr>
<tr>
<td>□ Others (Specify).................</td>
</tr>
<tr>
<td>Now</td>
</tr>
<tr>
<td>□ None.......</td>
</tr>
<tr>
<td>□ Local shops/marketing</td>
</tr>
<tr>
<td>□ Government aid</td>
</tr>
<tr>
<td>□ Aid agencies</td>
</tr>
<tr>
<td>□ Own reserves</td>
</tr>
<tr>
<td>□ Others (Specify).................</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.4 What percentage of households has access to cooking utensils?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/ no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.5 Does the community have access to fuel for cooking purposes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/ no</td>
</tr>
</tbody>
</table>

| Yes |
| If yes, what type of fuel used (tick appropriate one) |
| a) Firewood |
| b) Charcoal |
| c) Kerosene |
| d) Gas |
| e) Other specify) ............... |

<table>
<thead>
<tr>
<th>7.6 As a result of the emergency, are any of the following coping strategies practiced in the community?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Reduce food intake</td>
</tr>
<tr>
<td>□ Eating seeds/wild food/ less preferred foods/ low quality food</td>
</tr>
<tr>
<td>□ Increase in borrowing for consumption purposes</td>
</tr>
<tr>
<td>□ Sale of household assets (cooking utensils, jewellery etc.)</td>
</tr>
<tr>
<td>□ Sale of productive assets (tools, animals, machinery, land)</td>
</tr>
<tr>
<td>□ Migration to other locations</td>
</tr>
<tr>
<td>□ Reliance on external support (eg food/cash assistance)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated % of HH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

38
7.7 Who are the most vulnerable group of people to food insecurity?
- child headed households
- female headed households
- elderly headed households
- the disabled/severely ill
- Certain caste groups (Specify)............
- Others (Specify)...................

7.8 a. Are markets functioning? ☐ Yes ☐ No
b. Are markets accessible? ☐ Yes ☐ No
- If yes, what is the distance/ If no, what is the reason (describe)?
- If yes, what % of households has financial access?

7.9 If available, what are the prices of main commodities? (please strike commodity if not available)

<table>
<thead>
<tr>
<th>Unit</th>
<th>Now</th>
<th>Before disaster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheat flour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maize</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potato</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.10
a) What are the main livelihoods of this community? ;
b) Estimate % of the community that sees this as main livelihood;
c) What % families resumed their livelihoods?

<table>
<thead>
<tr>
<th>Main Livelihoods</th>
<th>If applicable, % of communities that see this as the main livelihood.</th>
<th>% resumed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>
7.11 At what stage of the cropping calendar is the community currently in and what impact will
the emergency have on this?
Describe possible impacts.................................................................
Suggestions for coping the situation.............................................

7.12 What is the expected loss as a result of crisis?
a) Crop area (Ropani/Bigha)
b) Irrigation infrastructure (number/meter of canal)
c) Fish ponds (number and area)
d) Food storage facility
e) Other significant loss (specify)..............................

7.13 What is loss related to livestock? (Number)
 a) cattle:  b) buffalo:
 c) goats/sheep:  d) pigs:
 e) poultry:
f) Animal shelter:

7.14 does this community have food for livestock?
if yes, how long will it last

7.15 a. Has there been or any indication of animal disease outbreak? (yes or No)
 b. Is the animal health service accessible? .....................

7.16 Any other relevant comments or observations..............................

8. WASH

8.1 Water Supply
Availability of clean drinking water (15 liters/person/day)?: □ 0-24%  □ 25-49%  □ 50-74%  □
Means of Verification: Interview with local government, utility etc. Verify with community if possible and observation

Primary water source:
 □ Open Well
 □ Tune Well/Hand pump
 □ Stream/river
 □ Storage/collection container
 □ Piped water system
 □ Other

Condition:
 □ Working
 □ Damaged (Repair required for minimum supply)
 □ Contaminated
 □ Destroyed
 □ Water Turbid

Alternate water source available?
 □ Yes  □ No
If yes, type/location/water clear or turbid (cloudy) or information available on water quality:
Facilities (material) required to supply minimum quality drinking water (e.g. repairs needed to water system):
8.2 Sanitary facilities

Affected population with access to functioning sanitary facilities (e.g. Latrines): ☐ 0-24%

Means of Verification: Interview with local government, health dept etc. Verify with community if possible and through observation.

Adequate personal hygiene supplies available (soap, sanitary cloth/napkins) ☐ Yes

Narrative (no. of family hygiene kit required):

9. Protection

9.1 Is there any displacement of the local population? If possible, note estimated number and where they have gone

9.2 Are there separated and unaccompanied children? (Y/N), Numbers (boys and girls)

9.3 Is there a registration / family tracing system in place? If so who is doing this?

9.4 What are the primary concerns of the most vulnerable groups at present (post disaster situation)?

<table>
<thead>
<tr>
<th>Group</th>
<th>Shelter/ security</th>
<th>Food/ water</th>
<th>Health/ education</th>
<th>Physical safety / violence including SGBV</th>
<th>Psychosocial support</th>
<th>Child labour/ trafficking</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 0 – 5 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children less than 18 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescents (10-24)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons with disabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older persons (aged 60+)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant/lactating women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnic Minorities ???</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9.5 Any other protection issues identified such as dacoits, loot, SGBV ..............................................................

9.6 Are there any community support mechanisms that can provide or refer to services (example GBV watch group Women’s Federations, Child Clubs, Child Protection Committees etc.)? If so, which..........................

10. Nutrition (If possible ask Female Health Care Volunteers or local medical staff)

10.1 What types and frequencies of foods are fed to infants and children under five years of age (most common first)?

<table>
<thead>
<tr>
<th>6-12 months:</th>
<th>Now:</th>
<th>Before disaster:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Types: __________________</td>
<td>Types: __________________</td>
</tr>
<tr>
<td></td>
<td>Frequencies: _____________</td>
<td>Frequencies: _____________</td>
</tr>
</tbody>
</table>
12-59 months
• Now: Types: __________  Frequencies: __________
• Before disaster: Types: __________  Frequencies: __________

10.2 Are there any changes in preparing the foods (hand washing, storage) and storage of foods? No or Yes, if yes, what are the changes?

<table>
<thead>
<tr>
<th>Now:</th>
<th>Before disaster:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Duration of storage: __________</td>
<td>• Duration of storage: __________</td>
</tr>
<tr>
<td>• Hand washing: __________</td>
<td>• Hand washing: __________</td>
</tr>
</tbody>
</table>

10.3 Is there indication of decreased/interrupted breastfeeding? No / Yes, If yes, what are the reasons?

What is replacing breastfeeding?
• For the children below six months:
• For the Children between 6-24 months:

10.4 Have there been any donations of infant formula or commercial baby foods or bottles or teats: No or Yes, If yes, source of donation(s) if known:

11. **Health** (Ask at health facilities and local communities)

11.1 Main health concerns

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhoea</td>
<td></td>
</tr>
<tr>
<td>Eye Infections</td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td></td>
</tr>
<tr>
<td>Dehydration</td>
<td></td>
</tr>
<tr>
<td>Snake Bites</td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td></td>
</tr>
<tr>
<td>Cough and Fever (ARI)</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin disease</td>
<td></td>
</tr>
<tr>
<td>Injuries/Trauma</td>
<td></td>
</tr>
<tr>
<td>Death of Mother and/or children following delivery</td>
<td></td>
</tr>
<tr>
<td>Any chronic conditions i.e. Diabetes, hypertension</td>
<td></td>
</tr>
<tr>
<td>psychosocial illness</td>
<td></td>
</tr>
</tbody>
</table>

11.2 Availability of medicines/medical supplies

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines: Equipments and supplies (including stretchers):</td>
<td></td>
</tr>
<tr>
<td>Adequate</td>
<td>Adequate</td>
</tr>
<tr>
<td>Inadequate</td>
<td>Inadequate</td>
</tr>
</tbody>
</table>

Specify needs:
___________________  __________________

11.3 Functioning of the nearest health facilities in village:

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Damaged</th>
<th>Availability of staff</th>
<th>Accessible</th>
<th>Power Supply</th>
<th>Water Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Post</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Sub Health Post</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Clinic/Nursing Home</td>
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</tr>
</tbody>
</table>

11.4 Who provides health care in that facility? _Nurse, _ Doctor, _ Midwife, _ Other (specify) : traditional healers etc.

11.5 Access to nearest health facility: _Easy; _ With obstacles (Explain); _ Very difficult (Explain). Distance in km:

11.6 Have there been any reports or rumors of any outbreaks or unusual increase in illness? ___No, ___Yes (Specify)
11.7 Have there been reports of non-infectious agents (such biological, chemical, nuclear, radiation, poisons or toxins)?  □ No; □ Yes (Specify)

12. Education
12.1 % of school affected
□ 0-24% □ 25-49% □ 50-74% □ 75-100%
□ Number of schools affected (optional & if possible).....

12.2 No. of children affected (disaggregate by gender)
ECD (Boy: ) (Girl: )
Basic School (Boy: ) (Girl: )

12.3 No. of teachers affected (disaggregate by gender)
ECD (Male: ) (Female: )
Basic School (Male: ) (Female: )

12.4 Are classes being taught and attended by the community? □ Yes □ No

12.5 What is the status of the school in the community?
□ Fully damaged, cannot be used in present condition
□ Partially damaged, cannot be used
□ Partially damaged but can be used with some maintenance
□ Water logged but can be used with some maintenance
□ Not affected

12.6 Have basic SCHOOL materials been affected? (Black boards / Teaching materials, books, stationeries, furniture, etc.)
□ Mostly lost
□ Partially lost
□ Not affected

12.7 Have EDUCATIONAL materials of the children been affected? (Text books, Stationeries, schoolbags, etc.)
□ Mostly lost
□ Partially lost
□ Not affected

12.8 Are school being used for any other purpose? □ Yes □ No (please specify if yes):

13. Emergency Telecommunications
13.1 What means of security telecoms and data services are available in the area?

<table>
<thead>
<tr>
<th>Means of Communication</th>
<th>Service Status (Yes/No)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio Room Coverage 24 x 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF / VHF Radio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sat phone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (e.g. HAM radio)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13.2 What means of public communication are available?
### Means of Communication

<table>
<thead>
<tr>
<th>Means of Communication</th>
<th>Service Status (Yes/No)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>FM/AM Radio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobile Phone (GSM, CDMA etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Landline</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13.3 Any alternate means of power backup available?

### 14. Logistics

13  
14

14.1 Are all affected areas accessible for humanitarian agencies? (please tick as appropriate)

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Don’t know</th>
<th>Partially operational</th>
<th>Fully operational</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Remarks: Please describe in short if affected area partially or fully accessible and attach map as appropriate

14.2 Are logistics basic services functioning post disaster? (please tick as appropriate)

<table>
<thead>
<tr>
<th>Logistics services</th>
<th>No</th>
<th>Don’t know</th>
<th>Partially operational</th>
<th>Fully operational</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fuel station</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Electricity</td>
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<tr>
<td>Road service</td>
<td></td>
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<tr>
<td>Transportation means</td>
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<tr>
<td>Air service</td>
<td></td>
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<tr>
<td>Others</td>
<td></td>
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</tr>
</tbody>
</table>

Remark: for detail please attach separate sheet

14.3 Since the disaster, what is the biggest logistics concern to the community? (please tick as appropriate)

<table>
<thead>
<tr>
<th></th>
<th>Debris/rubble</th>
<th>stagnant water</th>
<th>Landslide</th>
<th>Bridge damage/collapses</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Remarks: Please attach separate sheet in detail as appropriate

14.4 What is the severity of infrastructure damage in the area? (please tick as appropriate)

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>No damage</th>
<th>Partially &amp; functional</th>
<th>Partially &amp; not functional</th>
<th>Totally destroyed</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warehouses</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

44
### Government Buildings
- Custom office
- Private buildings
- Business houses
- Fuel stations
- Power stations
- Airport
- Helipads
- Others...

Remark: for detail please attach separate sheet

### 15. Displaced Population and Camp Coordination and Camp Management (CCCM)

13
14
15
15.1 Displaced Population

Number of families:

<table>
<thead>
<tr>
<th>Male</th>
<th>Female =</th>
<th>Children under 5 =</th>
<th>Elderly (Over 60) =</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women =</td>
<td>Lactating Mother =</td>
<td>Differently able =</td>
<td>Total Population =</td>
</tr>
</tbody>
</table>

15.2 Location of IDP site

a. Name of the IDP site:  
  b. Latitude:  
  c. Longitude:

15.3 Type and Classification of Site

Type  
- a. Spontaneous  
- b. Planned

Classification of site  
- a. Camp  
- b. Settlement  
- c. Urban Scattered IDP location

Ownership of land of the site  
- a. Private  
- b. Public  
- c. Other (Specify)

15.4 Origin of IDP

Where do most people originate from?  
- a. Nearby neighbourhood (1000m radius)  
- b. Other neighbourhoods (more than 1000m radius)

15.5 Registration of Displaced Population
### Registration conducted

- a. Yes
- b. No

<table>
<thead>
<tr>
<th>a. Number of registered HHs</th>
<th>b. Number of registered individuals</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### 15.6 Movement to and from the site

- Yes
- No

### How is population trend in the site?

- a. Increasing
- b. Decreasing
- c. Same as before

### 15.7 Services Provided at IDP Site

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
<th>Number:</th>
<th>Organisation:</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toilet provided</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Drinking water</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Shower facility</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Garbage management</td>
<td></td>
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<tr>
<td>Other services (Specify)</td>
<td></td>
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</tbody>
</table>

### 15.8 Vulnerable Population

Any information suggesting that some **group** are underserved

- a. Yes
- b. No

If yes, please specify

### 16. Prior Relief effort/assistance

16.1 Has the community received any assistance?

- Yes
- No

If Yes, who is providing what?

If No, are there any current plans to provide assistance?

16.2 Have all community members informed (regularly) about the disaster and assistance/response?
अभिलेख र प्रतिबंधन
बेला तथापि
स्वास्थ्य मन्त्रालय,
स्वास्थ्य सेवा विभाग
झितमितिन्द्रीयम तथा रोग नियन्त्रण महामहोष
सबूता रोग प्रकार अभिलेख फारम (Outbreak Recording Form)

<table>
<thead>
<tr>
<th>जिल्ला:</th>
<th>स्वास्थ्य संस्था:</th>
<th>श्रेणीपत्रया रोग / मिल्ड्रोम:</th>
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<table>
<thead>
<tr>
<th>क. स.</th>
<th>लोगीको नाम</th>
<th>उमेर</th>
<th>लिङ्ग</th>
<th>उमेर वि.</th>
<th>वेदना</th>
<th>रोग देखाएको फ्लो भिति</th>
<th>प्रयोगान्वयन रोग जनाको नामकरण लिकिसङ्ग नमुना</th>
<th>प्रयोगान्वयन जनाको विलिङ्ग</th>
<th>प्रयोगान्वयन ला नतीज</th>
<th>उपचार</th>
<th>भावना</th>
<th>लिको बनाएको</th>
<th>रेखापत्र बनाएको</th>
<th>मनुष्य भएको</th>
<th>कैफल्य</th>
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</thead>
<tbody>
<tr>
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यो प्रतिबंधन जिल्ला स्वास्थ्य / जनस्वास्थ्य कार्यालयमा व्यवस्थित रूपमा चलिनु पर्नु र माध्यमिन निकायको माण्डलको खण्डमा मात्र पठाउनु पर्नु।
सहवा रोग प्रक्रिया अभिलेख फार्म (Outbreak Recording Form) भवें विदेशिका

जिल्लामा सहवा रोगको प्रक्रिया सूचना प्राप्त भएको सुनिश्चित हुने विभिन्न न्यायिक रेस्पोन्स टीम परिचालन हुन्छ। प्रक्रिया भएको स्थानमा पुश्पांच रोगीको जाँच/उपचार गर्दै न्यायिक रेस्पोन्स टीमले यो फार्म प्रयोग गर्दै पहिलो विवरणहरू प्रदान गर्नुहोस्।

1. फार्मको सिरानीमा जिल्ला, स्थान्य संस्था, प्रक्रियाको रूपमा देखा परेको रोग/सिन्ड्रोमको नाम र मिति लेख्नु ।

2. फार्मको पहिलो ब्यास्रो रोगीको नम्बर संस्करण लेख्नु ।

3. फार्मको दोस्रो ब्यास्रो रोगीको नाम लेख्नु ।

4. फार्मको तेस्रो ब्यास्रो रोगीको उमेर लेख्नु ।

5. फार्मको चौथो ब्यास्रो रोगीको लिहिएको लेख्नु ।

6. फार्मको पाचौ ब्यास्रो स्थानीय तहको नाम लेख्नु ।

7. फार्मको छठो ब्यास्रो रोगीको ब्यास न. लेख्नु ।

8. फार्मको सातौ ब्यास्रो रोगीको टोलको नाम लेख्नु ।

9. फार्मको आठो ब्यास्रो ब्यास्रो रोगीको रोग देखा परेको मिति लेख्नु ।

10. फार्मको नवौ ब्यास्रो प्रयोगावली जाँचका लागि रोगीको रग, दिसा, पिसाव, खकार के नमुना लिएको हो सो लेख्नु ।

11. फार्मको दशौ ब्यास्रो कुनै कसिमको प्रयोगावली जाँच गरेको जस्तै: Culture, AFB, Blood Smear र यो हो लेख्नु ।

12. फार्मको एकौ ब्यास्रो प्रयोगावली जाँचको तरीका पॉजिटिव र नैग्निटिव हो लेख्नु ।

13. फार्मको बाँडी ब्यास्रो रोगीलाई कै स्पेसीन दिएको भए लेख्नु ।

14. फार्मको चौथो ब्यास्रो रोगीको नैजता -निको भयो, रर्फर गरियो र मृत्यु के भयो लेख्नु ।

48
### Outbreak Reporting Form

<table>
<thead>
<tr>
<th>झल्ना:</th>
<th>स्झस्थस्थ संस्था:</th>
<th>मिति:</th>
</tr>
</thead>
</table>

#### 1. Outbreak Information & Response

<table>
<thead>
<tr>
<th>क्रम</th>
<th>स्झस्थस्थ संस्था नाम</th>
<th>झल्ना संस्था नाम</th>
<th>झल्ना संस्था नाम</th>
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#### 2. Outbreak Investigation

<table>
<thead>
<tr>
<th>क्रम</th>
<th>स्झस्थस्थ संस्था नाम</th>
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</table>

### RRT-2
### Outbreak control measures

<table>
<thead>
<tr>
<th>क्रम</th>
<th>स्थानीय तह</th>
<th>संक्रमण रोग नियन्त्रण</th>
<th>उपचार-नियमन को संबंधित विवरण (Mass drug distribution, Case by case treatment, Mopping up, Insecticide spraying etc) सुझाव</th>
<th>दृष्टि आयोग का मूल्यांकन संबंधित विवरण</th>
<th>माध्यमिक नियंत्रण पार्केडस्ट सरकार</th>
<th>संक्रामक संबंधित मासूमित्व</th>
</tr>
</thead>
</table>

प्रतिवेदन तयार पार्श्वको नाम : 
पद : 
साही : 
(यो प्रतिवेदन तत्काली ईपिडमियोलॉजी तथा रोग नियन्त्रण महाशक्षको फ्याक्स नं. ०१-४२६२६६६ मा फ्याक्स गर्नौ होला (फोन नं. ०१-४२५६६९६) बा इमेल : ewarsedcd@gmail.com तथा बोधार्थ सम्बन्धित श्रेणीमा दिनुहोला।)
सर्वो रोग प्रकृति प्रतिबंधन फार्म (Outbreak Reporting Form- 2)- नं. 2 भने निर्देशिका

यस प्रतिबंधनमा तीन भाग छन्। भाग 1 मा प्रकृति सूचना तथा रेपोर्ट, भाग 2 मा प्रकृति अनुसंधान, भाग 3 मा प्रकृति नियन्त्रणका उपायहरु। जिल्लामा प्रकृतिको सूचना प्राप्त भई प्रकृति सुनिश्चित हुने वित्तीय ज्याप्लॉन स्मैन्र दीर्घ परिचालन गरिन्छ। ज्याप्लॉन स्मैन्र दीर्घ परिचालन गर्ने वित्तीय यस फार्मको छन्द 1 प्रकृपा सूचना तथा रेपोर्ट भेट्र तत्काल इपिडमियोलॉजी तथा रोग नियन्त्रण महाशक्तिमा फ्याम्स गर्नु पर्ने तथा बोधार्थ सम्बन्धित क्षेत्र स्वास्थ्य मा दिनु पर्दछ।

1. फार्मको मिरान्नी जिल्ला, स्वास्थ्य संस्थाको नाम र भिति लेख्न।
2. फार्मको भाग 1 को पहिलो छन्द फार्मको क्रम संख्या लेख्न।
3. फार्मको भाग 1 को दूसरो छन्दमा स्वास्थ्य तत्काल नाम लेख्न (निश्चित समुदाय, टोल, बडा नं. आदि का जानकारी भए सो पनि लेख्न)।
4. फार्मको भाग 1 को तेलो छन्दमा सूचना प्राप्त भएको शाक्षाय रोग वा सिन्धवको नाम लेख्न, रोगको लक्षणको मात्र सूचना प्राप्त भएको छ भने लक्षणहरू नु हुनै उलेख गर्न अथवा यस महाशक्तिमा तत्काल परिभाषा र सम्भलनस मापदण्ड पुस्तकको सहयोग लिने।
5. फार्मको भाग 1 को चौथो छन्दमा सूचना प्राप्त भए अनुसार अनुमानित रोगी तथा मृतक संख्या लेख्न।
6. फार्मको भाग 1 को पार्च छन्दमा प्रकृतिको सूचना कुने व्यक्ति माफिक आएको छ भने व्यक्तिको नाम तथा स्मृथि माफिक आएको छ भने संख्या का नाम लेख्न।
7. फार्मको भाग 1 को छेठी छन्दमा EWARS बाट सूचना पाएको हो भने सो लेख्न।
8. फार्मको भाग 1 को सातौं छन्दमा कुन मितिमा सूचना पाएको हो सो भिति लेख्न।
9. फार्मको भाग 1 को आठो छन्दमा ज्याप्लॉन रेपोर्ट स्मैन्र दीर्घ परिचालन भएको भिति लेख्न।
10. फार्मको भाग 1 को नवो छन्दमा उपचार टोलिमा कुन कुन व्यक्ति संघर्ष छ तिनको पद उलेख गर्न।
11. फार्मको भाग 1 को दशो छन्दमा पहिलो रोगी बेघिएको वा प्रकृति शुरु भएको भिति लेख्न।

प्रकृति भएको स्थानमा ज्याप्लॉन रेपोर्ट स्मैन्र पुस्तकमा प्रकृतिको अनुसंधान तथा नियन्त्रण गतिविधि शुरु हुन्छ, पहिले जिल्ला स्वास्थ्य/जनस्वास्थ्य कार्यालयमा प्राप्त कौशल सूचनाहरू संशोधन गर्नु पनि हुन्छ, त्यस्तै प्रकृति यस्तो स्थानमा बाटेको टोलीले यस फार्मको भाग 1 तल्लो संशोधन अनुसार भेट्र तत्काल जिल्ला स्वास्थ्य/जनस्वास्थ्य कार्यालय माफिक इपिडमियोलॉजी तथा रोग नियन्त्रण महाशक्तिमा पठाउनु पर्नु। तत्पश्चात टोलीले फार्म 1 को उपयोग गरेको त्यस्तो संकलन गर्नु पर्दछ र त्यस्तो आधारमा फार्म नं. 2 को दूसरो तथा तेलो भाग भन्नु पर्दछ।

1. फार्मको भाग 2 को पहिलो छन्दमा क्रम संख्या लेख्न।
2. फार्मको भाग 2 को दूसरो छन्दमा स्वास्थ्य तत्काल नाम लेख्न।
3. फारमकों भाग २ को तेस्रों खण्डमा सूचना प्राप्त भएको शंकास्पद रोग वा सिन्ड्जेमको नाम लेखे ।

4. फारमकों भाग २ को चौथों खण्डमा रोगको संभावित स्रोत लेखे, जस्तै भाडा पखाला भएमा इनार वा कुर्कार पानी स्रोत हुन सक्छ ।

5. फारमकों भाग २ को पाँचपेक्षा जोखिममा हुनेका जनसङ्ख्या लेखे, जस्तै भाडा पखाला भएमा सो इनार वा कुर्कार पानी उपयोग गरेका जनसङ्ख्या जोखिममा हुन सक्छ ।

6. फारमकों भाग २ को छह पेक्षा खण्डमा उमेर अनुसार रोगी तथा मृत्युको संख्या लेखे ।

7. फारमकों भाग २ को सातों खण्डमा रोगीको नितिजा सन्दर्भमा निको भएको, रेफर गरेको वा मृत्यु भएको लेखे ।

8. फारमकों भाग २ को आठपेक्षा खण्डमा प्रयोगशालालाई जाँचमा कृपा किसिमको नमूना लिएको लेखे ।

9. फारमकों भाग २ को नवपेक्षा खण्डमा कृपा किसिमको प्रयोगशालालाई जाँच गरेको जस्तै: Culture, AFB, Blood Smear को हो लेखे ।
References:


3. CHD, DOHS. CMAM National Protocol (OTP training guideline, treatment protocol), Nepal, 2014


8. WHO. Guiding Principles for Feeding Infants and Young Children During Emergencies, Geneva

9. Health Sector Emergency Preparedness and Disaster Response Plan, Disaster analysis, management framework and planning guidelines, September 2003

10. Sphere Project. Humanitarian Charter and Minimum Standards in Disaster Response (Sphere Handbook), 2004

11. Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, revision for field review 2010


16. Infant and Young Child Feeding in Emergencies, Operational Guidance for Emergency Relief Staff and Programme Managers, UNICEF


20. Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A distance learning module, revised November 2007


## Appendix 1:

**Member of Core Team for revision of Integrated Training Package on Emergency Preparedness and Response for Rapid Response Team**

<table>
<thead>
<tr>
<th>SN</th>
<th>Name</th>
<th>Designation &amp; Organization</th>
<th>Committee Designation</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Dr Guna Nidhi Sharma</td>
<td>Deputy Health Administrator, EDCD</td>
<td>Coordinator</td>
</tr>
<tr>
<td>2.</td>
<td>Dr Bhesh Raj Pokharel</td>
<td>Deputy Health Administrator, EDCD</td>
<td>Member</td>
</tr>
<tr>
<td>3.</td>
<td>Badri Nath Jnawali</td>
<td>Under Secretary, EDCD</td>
<td>Member</td>
</tr>
<tr>
<td>4.</td>
<td>Dr. Uttam Ghimire</td>
<td>IMO, EDCD</td>
<td>Member</td>
</tr>
<tr>
<td>5.</td>
<td>Bhim Prasad Sapkota</td>
<td>Public Health Administrator, MoH</td>
<td>Member</td>
</tr>
<tr>
<td>6.</td>
<td>Mr. Hari Karki</td>
<td>Humanitarian Coordinator, UNFPA</td>
<td>Member</td>
</tr>
<tr>
<td>7.</td>
<td>Damodar Adhikari</td>
<td>NPO, WHO</td>
<td>Member</td>
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<tr>
<td>8.</td>
<td>Sabin Adhikari</td>
<td>Program Coordinator, NRCS</td>
<td>Member</td>
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<tr>
<td>9.</td>
<td>Shambhu Kumar Mahato</td>
<td>PHI, EDCD</td>
<td>Member Secretary</td>
</tr>
</tbody>
</table>

**Consultant**

| 1  | Dr. Bal Krishna Subedi   |

**Terms of reference for the committee**

1. To guide on updating/ revising the Integrated Training package on Emergency and Disaster Preparedness
2. To support updating/revising the ITP
3. To finalize the ITP and recommend for endorsement
Appendix 2

List of Participants participating in Pre dissemination of integrated training package on emergency preparedness and response for RRT
Date: 29 December 2016
Venue: Swastik Foodland, Tahachal, Kathmandu

<table>
<thead>
<tr>
<th>SN</th>
<th>Name</th>
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<tbody>
<tr>
<td>1</td>
<td>Dr. Bhim Acharya</td>
<td>Director</td>
<td>EDCD</td>
</tr>
<tr>
<td>2</td>
<td>Dr. Guna Nidhi Sharma</td>
<td>Dep. Health Administrator</td>
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<td>3</td>
<td>Hari Karki</td>
<td>Humanitarian Coordinator</td>
<td>UNFPA</td>
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<td>4</td>
<td>Bijay Bharati</td>
<td>Health Delegate</td>
<td>CRC/NRCS</td>
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<td>6</td>
<td>Hari Prasad Acharya</td>
<td>PHI</td>
<td>EDCD</td>
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<tr>
<td>7</td>
<td>Pradip Rimal</td>
<td>PHI</td>
<td>EDCD</td>
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<td>Dr. Uttam Ghimire</td>
<td>IMO</td>
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<td>9</td>
<td>Dr. Sagar Raj Shakya</td>
<td>MSC</td>
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<td>10</td>
<td>Kunj Prasad Joshi</td>
<td>HEA</td>
<td>NHEICC</td>
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<td>11</td>
<td>Dr. Bhashar Raj Pokhrel</td>
<td>Dep. Health Administrator</td>
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<td>12</td>
<td>Laxmi Devi Regmi</td>
<td>Account Officer</td>
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<td>13</td>
<td>Dhan Prasad Paudel</td>
<td>MT</td>
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<td>Dabal Bahadur BC</td>
<td>LT</td>
<td>EDCD</td>
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<td>15</td>
<td>Dhruba Kumar Adhikari</td>
<td>PHI</td>
<td>DPHO, Kathmandu</td>
</tr>
<tr>
<td>16</td>
<td>Dr. Kedar Marhatta</td>
<td>MHC</td>
<td>WHO</td>
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<tr>
<td>17</td>
<td>Dr. Sudan Panthi</td>
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<td>18</td>
<td>Damodar Adhikari</td>
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<td>19</td>
<td>Dr. Rajan Bikram Rayamajhi</td>
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<td>20</td>
<td>Madhav Raj Ojha</td>
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<td>21.</td>
<td>Bhola Adhikari</td>
<td>Lab Technician</td>
<td>EDCD</td>
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<td>22.</td>
<td>Jay Krishna Yadav</td>
<td>Lab Technician</td>
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<td>Dhan Narayan Tamang</td>
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<td>Bishnu Khadka</td>
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<td>Dr. Santoshanand Jha</td>
<td>MO</td>
<td>Teku Hospital</td>
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<td>NPO</td>
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<td>32.</td>
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<td>34.</td>
<td>Tanka Prasad Chapagain</td>
<td>Senior PHA</td>
<td>PHC-RD</td>
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<td>Mohan Kumar Rauniyar</td>
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<td>38.</td>
<td>Manju Joshi</td>
<td>Senior Program Assistant</td>
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<td>Lalan Prasad Sah</td>
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<td>LMD</td>
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<td>Nripa Chaudahary</td>
<td>HA</td>
<td>NPRL</td>
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<tr>
<td>41.</td>
<td>Deepak Subedi</td>
<td>Lab Technologist</td>
<td>NPRL</td>
</tr>
</tbody>
</table>
Appendix 3:

List of contents of kits needed for disaster response as part of teaching materials:

- Diarrhoeal Disease Kit (DDK)
- Inter-agency Emergency Health Kit (IEHK)
- Reproductive Health (RH) kit- (Kit # 0-12)
- Dignity or hygiene kit
- Surgical Kit
Unit 1.1: Basic Concept of Disaster/Emergency

Background
- Nepal is prone to natural and man-made disasters
- Natural disasters are predictable – occurs every year
- This Emergency Preparedness and Disaster Response Training is expected to prepare health workers for the emergencies and disasters in Nepal and is expected to have a bigger impact than in situations where preparedness is random.
- So that, ultimately, we can save lives!

Earthquake in Nepal
- 1934 Kathmandu Valley Earthquake:
  - Deaths: 8,000
  - Injuries: 25,000
- 2015 Earthquake:
  - Deaths: 8970
  - Injuries: 23,000
  - Buildings destroyed and damaged: more than 5 lakhs

Types of Emergencies
- Natural
  - Earthquake
  - Flood
  - Landslide/Avalanche
  - Drought
  - Fire
- Human Activity related
  - Conflict
  - Bandh/Strike

Some important terminologies

<table>
<thead>
<tr>
<th>HAZARD</th>
<th>VULNERABILITY</th>
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<tr>
<td>A rare or extreme natural or man made trigger event that threatens to adversely affect human life, property or activity to the extent of causing disaster.</td>
<td>The level of disruption and loss a hazard can potentially cause in a community / society.</td>
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</table>

DISASTER
Any event that causes damage, ecological disruption, loss of human life, or deterioration of health and health services on a scale sufficient to warrant an extraordinary response from outside the affected community.
EMERGENCY
A state demanding immediate and extraordinary action that may be due to epidemics, to natural or technological catastrophes, to civil strife or other man-made causes.

PREPAREDNESS
Arrangements to reduce suffering, immediate and long-term avoidable mortality, morbidity and disability in any type of emergency and to build a bridge to development.

RESPONSE
Actions taken during and immediately after the occurrence of an event, to ensure that disaster effects are minimized and people are given immediate relief and support.

DISASTER EQUATION
Risk = Hazard x Vulnerability x Exposure
Capacity

Human factors are at play in determining vulnerability and capacity and thus the magnitude of a disaster (“Earthquakes do not kill people but buildings do”).

The Disaster Management Cycle

<table>
<thead>
<tr>
<th>Disasters</th>
<th>Number of casualties</th>
<th>Prone Regions</th>
<th>Effect on health facilities</th>
<th>Effect on health workers</th>
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<td>Earthquake</td>
<td>Many</td>
<td>All regions of Nepal</td>
<td>Severe</td>
<td>Severe</td>
</tr>
<tr>
<td>Flood</td>
<td>Few/Many</td>
<td>Terai regions</td>
<td>Severe/Moderate</td>
<td>Severe/Moderate</td>
</tr>
<tr>
<td>Landslide/Avalanche</td>
<td>Few</td>
<td>Northern hilly regions</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Drought</td>
<td>Few/Many</td>
<td>All regions of Nepal</td>
<td>Moderate</td>
<td>Severe/Moderate</td>
</tr>
<tr>
<td>Conflict</td>
<td>Few/Many</td>
<td>All regions of Nepal</td>
<td>Severe/Moderate</td>
<td>Severe/Moderate</td>
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<tr>
<td>Bandh</td>
<td>Low</td>
<td>All regions of Nepal</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Fire</td>
<td>Few</td>
<td>All regions of Nepal</td>
<td>Severe/Moderate</td>
<td>Moderate</td>
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Unit 1.2:
Disaster Management Mechanism

Sub Topic:
(a) Disaster management policy and process in Nepal

Background
- In Nepal, the Natural Calamity Relief Act was formulated in 1982 to coordinate, facilitate and manage the relief and rescue works during disaster.
- The act is the milestone major guiding document for disaster management in Nepal.
- The Act has provisioned for Central Natural Disaster Relief Committee (CNDRC)
  ➢ National Strategy for Disaster Risk Management, 2009

Central Natural Disaster Relief Committee (CNDRC)
- Minister of Home Affairs chairs the committee with members from line ministries, police, army, scouts, red cross etc
- The CNDRC takes overall responsibilities of coordination and policy decision regarding any disaster
- The MOHA leads the current disaster management system in Nepal
- Defines the national disaster relief system with relief committees at the national, regional and district level to coordinate the implementation
- Meets as and when required in and after disasters, mainly following floods and landslides every year
- Main role is to coordinate disaster relief operations through District Disaster Relief Committees chaired by CDO in the District Administration Office

Institutional Framework (in line with 1982 Act)

Emergency Response Mechanism (Government)
Clusters in Nepal

Cluster Approach is one of the Coordination Mechanisms for an effective humanitarian response

<table>
<thead>
<tr>
<th>Clusters</th>
<th>Cluster Head</th>
<th>Cluster Head Office/Coordinating Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Camp Coordination &amp; Camp Management</td>
<td>Ministry of Home Affair</td>
<td>EOM</td>
</tr>
<tr>
<td>2. Education</td>
<td>Ministry of Education</td>
<td>UNICEF / Save the Children</td>
</tr>
<tr>
<td>3. Shelter</td>
<td>Ministry of Urban Development &amp; Nepal Red Cross Society</td>
<td>EOM (UNHCR) &amp; Habitat</td>
</tr>
<tr>
<td>8. Food Security</td>
<td>Ministry of Home Affair During Emergencies</td>
<td>UNFPA</td>
</tr>
<tr>
<td>9. Telecommunications</td>
<td>Ministry of Information &amp; Communications</td>
<td>UNICEF</td>
</tr>
<tr>
<td>10. Logistics</td>
<td>Ministry of Home Affair</td>
<td>UNICEF</td>
</tr>
<tr>
<td>11. Early Recovery Network</td>
<td>Ministry of Water Information and Social Development</td>
<td>UNICEF</td>
</tr>
</tbody>
</table>

Sectoral working groups 1993....

- EDCD with the technical assistance from WHO revitalized health sector working group in year 2000 to promote health sector emergency planning
- Developed TOR and established an active inter-agency DWHG Secretariat which drafted a health sector emergency plan
- DWHG incorporated in the health system in 2005 with DG as Chairperson and the Director of EDCD as Member Secretary

Other initiatives

- A Emergency Health and Nutrition Working Group (EHNWG) established in 2005 with the facilitation from WHO and UNICEF
- WHO is providing technical support to MoH/DHS/EDCD for health sector emergency preparedness and disaster management
- UNFPA is providing technical and financial support to MoH/DHS/EDCD for health sector disaster preparedness including RRT training.
- NRCS, DP-Net, NSET-Nepal, NCDM are national organizations working on disaster management
- UNDP, ECHO, USAID, JICA and ICIMOD are main donor and international organizations supporting emergency preparedness and disaster response
- I/NGOs like Oxfam-GB, Action-Aid, World Vision, Merlin also are involved in Disaster Management.

Proposed Organizational Structure for DRM

- National Disaster Management Council
  - Committees (Preparedness, Relief, Rehabilitation)
  - National Disaster Management Authority
- Regional Disaster Management Committee
- District Disaster Management Committee
- Local Disaster Management Committee

Source: National Strategy for DRM, 2009

Preparedness Management Committee

- Coordinator: Minister for Local Development
- Co-coordinator: Member, NPC
- Members:
  - Secretaries (8 ministries)
  - DG-8, Joint Secretary, AIG-2, Colonel, MS
  - Chair persons 4
  - NGO (3 women, 2 Dalit and 2 Marginalized)
  - Experts-2
- Member Secretary- Executive Director
Regional Disaster Management Committee

- Chairperson: Regional Administrator
- Members:
  - Chiefs of all regional offices
  - NRCS
  - Nominated by Regional Administrator DDC Chairs
  - Women representative (Nominated by RA)
  - Representative of Preparedness committee
- Member Secretary- Deputy RA

District Disaster Management Committee

- Chairperson: Chief District Officer
- Members:
  - Chairperson of DDC or designee
  - Chief of all district level offices
  - Chiefs of all security entities
  - NRCS
  - Representatives of National Political Parties
  - Chair, District Industry & Commerce Association
  - Chief of Municipality
  - Three representatives of VDC chairs
  - Women Representative 2 (Nominated by CDO)
  - Three Representative of NGO and social activists
  - Two representatives from experts
- Member Secretary- LDO- DDC
1.2 Disaster Management Mechanism

Sub Topic b: Functional Mechanism of Rapid Response Team (RRT)

Objectives of RRT
- To establish an early warning and reporting mechanism for potential epidemics.
- To make preparations for potential epidemics.
- To manage disease outbreaks.
- Support in disaster management.

Structure
- In 2000, the MoHP, DHS/EDCD established a mechanism for managing epidemics.
- This mechanism consists of establishment of Rapid Response Team (RRT) at three levels:
  1. central (1)
  2. regional (5) and
  3. districts (75)

District Rapid Response Team
- Coordinator (DHO/DPHO)
- Focal person- HA/ Senior AHW
- Members:
  - Medical Officer,
  - PHN/SN/ANM,
  - Vector Control Assistant/MI,
  - EPI Supervisor,
  - AHW,
  - Lab Technician/Lab Assistant,
  - Health Education Technician,
  - Statistical Assistant,
  - RH focal person

Role of Regional Rapid Response Team
- Support in effective coordination between
  - the center and districts
  - NGOs, INGOs, UN agency and relevant donors.
- Provide backup services for district RRT

Role of Central Rapid Response Team
- Mobilize if the impact of the disaster is beyond the response capacities of the district and regional level RRTs.
- Facilitate in diagnosis of infectious diseases.
- Resource mobilization.
- Establish effective coordination for resources and additional assistance between
  - NGOs, INGO, UN agency and relevant donors other stakeholders
Disaster Management - Function

1. Emergency Preparedness
2. Disaster Response
3. Rehabilitation Activities

1. Emergency Preparedness
   - Prepare Emergency Preparedness plan
   - Institutionalize Early Warning and Reporting System (EWARS) and Information
   - Capacity Building (Training)
   - Keep buffer stock of medicines, kits, logistics
   - Manage safe water and Sanitation

2. Disaster Response
   - Carry out Initial Rapid Health Assessment (RHA)
   - Collection of health status information
   - Provide Health Services
   - Water and Sanitation
   - Disease Surveillance

3. Rehabilitation Activities
   - Health Services Package: Health Education, measures for communicable disease control, RH Series, surveillance and monitoring.
   - Mental Health (Counseling, reduce post disaster mental health consequences).
c) Setting of Priorities: Key Intervention Areas

Question

When something happens, what are the key areas of intervention that the health workers must look at?

Probable Answers

- Assessment
- Coordination
- Delivery of Essential Health Care Services
- Outbreak control
- Reproductive health
- Nutrition
- Immunization
- HIV/AIDS
- TB Control
- Psycho-social Support
- Others...

Prioritization

At times of disaster several activities need to be done. However limited time and resources do not permit to do all the activities. So, prioritization should be done to address the most needed actions.

Rapid Health Assessment

- Must be done immediately
- Used to understand what are the main issues
- A mechanism to activate and deploy the Rapid Response Teams (RRT)
- Key areas to look at include:
  - Demographics
  - Potential health hazards among the affected population
  - Status of health facilities in the surrounding areas
  - The possible impact
- Refer to the RRT assessment form

Coordination

- In emergency situations, it is essential to have a mechanism to coordinate all response, to avoid confusion, overlap and/or gaps.
- Coordination mechanisms might exist, but these need to be activated.
- DDRC: CDO for overall disaster coordination
- Health and Nutrition Cluster Coordination: D(HP)HO
- Different tools available: WWW tracking, logistics tracking, situation report etc.
1. Delivery of Essential Health Care Services

- Ensure to provide essential health care services
- In emergencies, multiple injuries might happen. So, expanding emergency units, setting up field hospitals at camp sites might be needed
- Besides, providing emergency units, ambulance services to send injured to the nearest health facility on time.
- Minimum Initial Service Package for Reproductive Health
- Referral services needs to be more active and systematic.

2. Outbreak Detection and Control

- In emergencies, people are often displaced and have to live in crowded conditions for a long time.
- In such conditions, outbreaks are prone to occur.
- To ensure the outbreaks are detected early and treated properly, an early warning system must be implemented immediately.
- Necessary medicines and equipments should be made ready for dispatching.

3. Provide necessary service

- Reproductive Health including clean delivery services becomes important
- Immunization and nutrition services need to be continued
- Services for Tuberculosis control should be continued
- Treatment for HIV and STI should be continued
- Support for establishing services for psycho-social support

4. Obtain necessary support

- Collaborate with local NGO, clubs, pharmacies, IT media etc
- Request Regional RRT and Central RRT for more support

5. Regulate services

- Alerting about outbreak
- Reproductive health
- Nutrition
- Immunization services
- HIV and STI
- Tuberculosis
- Psycho-social support
- Logistics supply
Unit 1.3: Rapid Health Assessment

Source of information

- **Routine:**
  - Surveillance Systems (EWARS)
  - Health Management Information System (HMIS)
  - Civil registration (vital statistics)

- **Non-routine:**
  - Rapid Health Assessment (RHA)
  - Surveys

Rapid Health Assessment (RHA)

RHA is a “collection of subjective and objective information in order to measure damage and identify those basic needs of the affected population that require immediate response” (From: RHA protocols for emergencies, WHO, 1999)

It helps in:
- Confirming the disaster/emergency
- Describing the type, impact and possible evolution of emergency
- Measuring present and potential health impact
- Assessing adequacy of response capacity and additional needs
- Recommending priority action for immediate response

Types of Assessments

- Pre-disaster risk assessment
- Situation and damage assessment (Identifies the magnitude and extent of the disaster and its effects on the society.)
- Needs assessment (defines the level and type of assistance required for the affected population). Rapid health assessment (defines the magnitude of disasters and actors involved during response)
- Post-Disaster Syndromic Diseases Surveillance (defines the status of daily disease situation)- see annex II for reporting form

Note: The gathering of information for the situation assessment and needs assessment can be done at the same time. The information collected in the initial assessment is the basis for determining the type and amount of relief needed during the immediate response phase of the disaster.

Pre-disaster Risk Assessment

- Risk is the probability of harm or loss
- Requires two things:
  - Hazards: things that can cause harm
  - Vulnerability: things that can be harmed
- Know the hazards (potential to cause harm)
- Know what or who is vulnerable to hazards
- People & things exposed to hazards = risks
- Risks can be reduced
  - Change the hazard
  - Protect or move the vulnerable
  - Defer the risk (insurance or move the hazard)

Background

Rapid Health Assessment helps in analysing the situation for appropriate and timely response.
Pre-disaster Risk Assessment Cont...
- Pre-disaster assessments are important because they guide you in preparation
  - Mock/drills you practice in the hospital
  - Help you focus your medical staff training
  - Help you write a plan specific to a hazard
  - Help you project how many patients your health facility may have to treat and how many people may be exposed and require assistance

Rapid Health Assessment (RHA)
- Initial situation report (see annex I for reporting form).
- Additional Rapid Health Assessment to define further response needs.

Rapid Health Assessment Cont.
- Rapid Response Teams at the district level are key to initiate rapid health assessments.
- Rapid health assessments should be conducted immediately after the disaster in all impacted areas. Special attention should be paid to the most vulnerable groups.
- The information collection should be based on the attached format.
- The format should be filled in within 12 hours of any disaster and submitted to EDCD.

Additional Needs Assessment
- Within the first 5 days following the disaster.
- The assessment should be made by a joint team including professionals of different sectors (i.e. health, logistics, infrastructure, water supply and sanitation).
- The assessment should be carried out in a way that allows transparent consistent decision-making and implementing response actions.
- Should reveal gaps in response and identify needs not covered.

Key questions in a RHA
- Is there an emergency or not?
- What is the main health problem?
- What is the existing response capacity?
- What decisions need to be made?
- What information is needed to make these decisions?

How to conduct rapid health assessments

1. Plan the assessment
2. Determine what information to gather
3. Coordinate with other organizations
4. Form the assessment team
5. Make administrative arrangements for visits
6. Collect Data
7. Analyze data
8. Present results and plan for action in the appropriate reporting format.

The “8 steps”
Main steps of a RHA

- Set the assessment priorities
- Collect the data:
  - review existing information
  - inspect the affected area
  - interview key people
  - carry out a rapid survey
- Analyse and interpret the findings
- Present results and conclusions

The population:
- numbers, characteristics, & trends
- morbidity and mortality

The vital needs:
- security
- food
- water
- shelter & sanitation
- clothes and blankets
- domestic utensils and fuel
- health care including health response to GBV

The support systems:
- information
- logistics
- coordination
- resource flow

Other relevant contextual issues

Which information?

Decide

- Are the current levels of mortality and morbidity above the average for this area and this time of the year?
- Are the current levels of mortality, morbidity, nutrition, water, sanitation shelter and health care acceptable by international standards?
- Is a further increase in mortality expected in the next two weeks?
- ADVISE ACCORDINGLY and FOLLOW-UP INCLUDE STUDIES ON ANALYSIS BASED ON QUESTIONNAIRES

RHA: a few tips

- Don’t be too ambitious: time is short
- Being roughly right is generally better than being precisely wrong or precisely late

Beware: wrong conclusions from the RHA can do more harm than not taking any action
Unit 1.4: Logistic Management in Emergency

Types of Kit
- Diarrhoeal Diseases Kit (DDK) - WHO
- Inter-Agency Emergency Health Kit (IEHK) - WHO
- Reproductive Health Kit (RH Kit) – UNFPA
- Surgical kit - WHO

What does the Diarrhoeal Diseases Kit Contain?
It contains:
- Oral Rehydration Solution
- Antibiotics
- Intravenous Infusions

It is intended for 100 severe cholera cases (cholera treatment unit), plus 400 moderate cholera cases (oral rehydration unit), and 100 adults plus 100 children affected by Shigella dysentery.

What does an Inter-Agency Emergency Health Kit contain?
- The Interagency Emergency Health Kit is designed principally to meet the initial primary healthcare needs of a displaced population without medical facilities and is for use in the early phase of emergency.
- The kit is not designed and not recommended for the re-supply of existing healthcare facilities.
- The IEHK contains sufficient medical supplies to support at least 10,000 people for a period of 3 months.
- There are two units: Basic and Supplementary

Content/composition Inter-Agency Emergency Health Kit cont...
- Each Basic Unit contains:
  - oral and topical medicines, (not injectables)
  - medical devices, renewable
  - medical devices, equipment
  - module: malaria items for the treatment of uncomplicated malaria

Note: BASIC UNIT is intended for primary healthcare workers with limited training.
**Content/composition IEHK...**

- One Supplementary Unit contains:
  - medicines (MEDS)
  - essential disposables (INFS)
  - medical devices, renewable (RENW)
  - medical devices, equipment (EQPT)
  - module: patient post-exposure prophylaxis (PEP)
  - module: malaria items
  - module: psychotropics (Pt)
  - module: narcotics (Nt) (can be replaced by tramadol)

Note: SUPPLEMENTARY UNIT is intended for professional health workers or physicians and should be used with at least one or more Basic Units.

**Content/composition Surgical Kit**

- The kit is estimated to cover the needs for medical disposable equipment for approximately 100 surgical inpatients for 10 days, particularly in the post operative phase.
- The kit contains all essential medical disposables; bandages, compresses, drains, tubes, syringes, needles, catheters, infusion accessories, gloves, sutures, burn dressings, hygiene equipment, plaster of Paris and sterilisation accessories.

**Content/composition of Reproductive Health Kit**

- The Reproductive Health Kits have been created to facilitate the implementation of reproductive health services during the early phase of a crisis.
- The Reproductive Health Kits need to be ordered during that phase.
- The RH Kits contain essential RH drugs, supplies and equipment to be used for a limited period of time and for a fixed number of people.

**How to get it?**

- Cluster lead (WHO) can coordinate with concerned agencies to get the kits
  
  And/or

- The MOH can directly request concerned agencies for supplying the kit

**Logistic estimation and Buffer Stocking**

- Necessary logistics (medicines, materials etc) should be estimated beforehand and adequate quantity sent to the affected area
- A significant quantity should be kept at district/ local level as buffer stocking
- Advance request should be sent to region/center in case of large epidemic or disaster

**Financial Management**

- The district (Public) Health Office is provided with some money every year to address the need in case of emergency and disaster, which can be used ASAP
- The District DRC also can support in such scenario
- The DDC/urban or rural municipalities can also support for addressing the emergency/ disaster
Unit 1.5:
Environmental Health and Sanitation in Emergency

(Minimum standard based on Sphere Guidelines)

What is Sphere?
- The Sphere Project is a humanitarian Charter and Minimum standard in Disaster response. It represents the core principles regarding humanitarian assistance in disaster.
- Sphere project aims to enhance the effectiveness and quality of humanitarian assistance in emergencies and thus a significance difference to the lives of people affected by disaster.

Five Minimum Standards of Sphere
- Water supply and sanitation
- Nutrition
- Food aid
- Shelter and site planning
- Health services including reproductive health

Environmental Health and Control of Communicable Diseases
- Water and sanitation
- Excreta disposable
- Vector control
- Solid waste management
- Control of communicable disease
  - prevention
  - diagnosis and case management
  - outbreak Preparedness
  - outbreak Response

Key Indicators of water and sanitation
- Average water for cooking, drinking and personal hygiene: 15 litre/day
- Distance from house to water source: 500 meter.
- At least 1 water point for 250 people
- Flow of water: 7.5 litres/minutes, quing time: 15 minutes to fill 20 litres of water

Minimum standard of water and sanitation cont...
- Sanitary survey indicate-low faecal contamination
- People drink water from the protected source
- No negative health effect detected in short term use of water contaminated by chemical (including carry-over of treatment chemical or radiological sources.)
Water Related Technical Guidelines

| Health centres and Hospital | 5 litres/out patient/day  
40-60 litres/inpatient/day |
| Cholera Centre              | 60 litres/patient/day  
15 litres/carer/day         |
| Therapeutic feeding centre  | 30 litres/in-patient/day  
15 litres/carer/day         |
| School                      | 3 litres/people/day for drinking & hand washing |
| Public toilet               | 1-2 litres/user/day for hand washing  
2-8 litres/users/day for toilet cleaning |

Minimum standard of water and sanitation cont...

- Each household has at least two clean water collection containers of 10-20 litres with narrow neck
- At least 250 gm of soap available for personal hygiene/person/month
- Sufficient bathing cubicles available with separate for male and female
- At least two washing basin for 100 peoples.

Excreta disposal standard

- A maximum of 20 people use one toilet
- Separate toilet for male and female
- At least 50 meters from the dwelling
- Should be built in such away that can be used by all including children and pregnant women
- Easy to keep clean
- Provides degree of privacy
- Minimum fly and mosquito breeding

Vector control standard

- All displaced population are settled in locations that minimise their exposure to mosquito
- Vector breeding and resting sites are modified
- Intensive fly control is carried out
- People infected with malaria are diagnosed early and received treatment

Vector control standard cont...

- Bedding and clothing are aired and washed regularly
- People with treated mosquito nets (LLIN) use them effectively.
- People are educated properly regarding the special attention and precaution

Solid waste management standard

- Refuse container-100 meter from communal refuse pit
- At least 1(100litre) refuse container is available per 10 families
- Medical waste is separated and disposed separately
- No contaminated medical waste at any time in living areas
- Clearly marked and appropriately fenced refuse pit
Drainage Standard
- Drains are kept clean, dwelling are kept free of standing water
- Shelters, paths and water and sanitation facilities are not flooded by water
- Water point drainage is well planned, built and maintained
- Drainage water do not pollute existing surface or cause erosion

Communicable disease (a) Prevention
- Water, sanitation and hygiene promotion
- Access to adequate food and management of malnutrition
- Community education
- Mass vaccination campaign and routine ongoing vaccination

Communicable disease (b) Diagnosis and case management
- Use of standard guidelines and protocols
- Ensure availability of lab services
- Educate community to seek early treatment and care
- In malaria endemic region establish 24 hrs diagnosis of fever

Communicable disease (c) Outbreak Preparedness
- Prepared outbreak investigation and control plan
- Investigation and control protocols available to relevant staffs
- Staffs received training on outbreak management
- Reserve stock of essential drugs and other supplied available

(c) Outbreak Preparedness cont...
- Identified source of vaccination.
- Mechanism of rapid procurement established
- Sites for vaccination and treatment of infectious patients are identified
- A laboratory is identified for diagnosis
- Sampling materials and transport media for the infectious agents available.

Communicable disease (d) Outbreak Response
- HMIS includes an early warning components
- Initiation of outbreak investigation occurs within 24 hours of notification
- Outbreak should be described according to time, place and person
- Appropriate control measures that are specific to the disease and context are implemented
- Case fatality rate are maintained at acceptable levels:
  - Cholera: 1%, Shigella (dysentery): 1% or lower,
  - Typhoid: 1% or lower
Sub Topic:
(b) Importance of safe drinking water for prevention and control of water borne diseases

राष्ट्रिय खानेपानी गुणस्तर मापदण्ड - २०६२

- नेपाल सरकारले “राष्ट्रिय खानेपानी गुणस्तर मापदण्ड - २०६२” तौलिएको छ।
- यसमा खानेपानीको लागि भौगोलिक, रासायनिक र सुङ्ग जीवित पारामितरहरूको अधिकतम मात्रा तौलिएको छ।
1) क्योरिनेसन
- खानेपानीमा क्योरिन नामक रसायनको भोल मिलाई गुढीकरण गर्न प्रक्रिया लाई क्योरिनेसन भनिन्छ।
- जीवाणु नट पन्नका साथे आइरन, स्क्वाइत, हाइड्रोजन सल्फाइड जस्ता रासायनिक तत्वहरू पनि केही गर्न सक्छ।
- पीयुङ : वातावरण र जनस्वास्थ्य संस्थाले (ENPHO) २०७९ देखि पीयुङ नामक क्योरिन कोल (०.५%) सोडियम हाइड्रोक्लोराइड भोल। उपायन र विषयी वितरण गर्न आएको छ।
- बाटर्गाउँ : Population Services International/Nepal (PSI) नामक संस्थाले सन् २००२ मा बाटर्गाउँ नेपाली वजारमा प्रवेश गरेको छ।

2) उमाल्लो
- भरप्याबो र प्रचालित विधि
- तापफल्मले गदा पानीमा भाका रोगजन्य जीवाणुरु नट छुन्छ।
- विवर स्वास्थ्य संस्थालका अनुसार पानी उमाल्लो कम्तीमा एक भूलको उमाल्लोपथि खानेपानी जीवाणुरुलथ छ।
- राग्रोमा उमाल्लोको मननलो पानीमा रोगजन्य जीवाणुरु हुन सक्छ।

3) फिल्टर
- फिल्टर भनेको पानीलाई छानो सफा गर्न एउटा सजिलो विधि हो।
- वजारमा विभिन्न किसिमका फिल्टरहरू पाइन्छन्।
  - क्यांडल फिल्टर,
  - कोलाइडल सिंबर फिल्टर
  - वायोस्फूड फिल्टर?

ध्यान दिनुपर्ने कुराहुः
- क्योरिन भोल उलेख गरिएको मात्रमा वही वा कम राखु हुदैन।
- क्योरिनको भोल राखको ३० मिनेटपछि मात्र पानी खानुपछि।
- क्योरिन कोलाइडल हावत, बुखो, बिच र तुमामा पनि दिनुहुन्छ।
- क्योरिनको भोल कॅंटेंटलबो नभेगाउँ ठाउँमा राख्नुपछि।
- केही गरी क्योरिनको भोल शरीरमा पर्मा हुँन तुल्य प्रासाद पानीले पानीलाई पुनर्खात्मक हुन भएका छ।

ध्यान दिनुपर्ने कुराहुः
- ध्यानलो पानी उमाल्ला यस्मा भएका टॉस पदार्थहरू (जस्तै, गुली, माटो) आदि हटाउन्छ।
- ल्याउँदा ध्यानलो पानीलाई थियाएर छानेपछि मात्र उमाल्लोपछि।
- पानीलाई उमाल्ली सकेपछि सफा भाडोमा छोपेपर राख्नुपछि, जस्तै गदा पानी पुनः दूरित हुन पाउँदैन।

कोलाइडल सिंबर फिल्टर
- कोलाइडल सिंबर फिल्टर खानेपानीमा भएका कीटाणु हटाउन्छ एक प्रभावकारी उपाय हो।
- सक्षम प्रभावित भनेको चाँदि लेखा गरिएको माटोको ठूलो साइजको क्यांडल/पॉट (डिफ़र) हो।
- यो व्याप्तात्मक ठूलो कीटाणुलाई धूलनुपट रूपमा, भने क्यांडलमा लेखा गरिएको चाँदि पानीमा भएका कीटाणुलाई मात्रा कम गर्नेछ।
### ध्यान दिनुपरें कुराहुः

- फिल्टरको क्याप्टर नर्म दर्ता भांिहु भ्रमण रामोसज्ञ भएको गर्नुपर्दछ।
- सबै भएको यात्रा सालेन्द्रको प्रयोग कहिल्या गर्नु हुँदैन।
- फिल्टरको धारा र क्याप्टरको वास, नट रामोसज्ञ कर्पोर्याउँछ।
- फिल्टरलाई सूचनको प्रकाश नपने समलेल ब्याबनामा रानुपर्दछ।
- फिल्टरको क्याप्टरलाई पानीमा कहिल्य सामान्य छुट्नु हुँदैन।
- फिल्टरको धारा फोर छात्र छुट्नु हुँदैन।

### बायोस्याप्ड फिल्टर

- ध्यान्यापार्न मध्ये ध्यान, धमिलोपन, आइरन र गन्ध हटाउने एक सरल धर्मृत विधि हो।
- क्याप्टर र प्लास्टिकको भाल्डामा फिल्टर र बाल्टालाई तह भिडाइ रखेको र ध्यान्यापार्न मध्ये तलामार्फ्ट ध्यान्यापार्न व्याख्याएको र भनिन्छ।
- फिल्टरमा पानी छन्दालाई बाल्टा र फिल्टरको तलबको पानीमा भएका ध्यान, धमिलोपन, आइरन आदि छानिन्छ र पानी पिउन योग्य हुन्छ।

### ४) सोडिस

- सॉडिसका पानी पुनर्दर्शित
- सरल र सस्तो प्रविधि
- परसैलिङ्गनिक परिणाम र तलबले दुध मग जीवानु नष्ट हुने र रसायन नष्ट भएको भनिन्छ।
- खेह गएको बोल्टलको पुन: प्रयोग हुने
- सामान्य जानकारीको भर्मा गरेको भनिन्छ।
- इलाम मा लागेको खर्च भनेको छ।

### सीमितता

- एकं पटकमा धेरै मात्रामा पानी पुनर्दर्शित गरी निम्नलिङ्ग
- मौसममा निर्भर हुने।
- पानी क्षेत्रमा (३० नूटन) भन्न ठेठी भएको प्रभावकारी नहुन्छ।

### ध्यान दिनुपरें कुराहुः

- ब्यापारी १० से मिले (चौड़ा) भएको, नक्शिक्रियिएको, नक्शिक्रियिएको र पारस्परिक भोलश्चिम प्रपोत प्रयोग गर्नुपर्दछ।
- रहिन सात भिक्षाको भोलश्चिम प्रयोग गर्नु हुँदैन।
- परस्पर धारावा आश्चर्यका वादल लागेमा एक दिन र पुरा बादल लागेमा दुई दिनमा भोलश्चिम धारामा रोपनुपर्दछ।
Unit 2.1: Communicable Disease Surveillance

Surveillance
Surveillance is the ongoing systematic collection, analysis and interpretation of data; and the dissemination of information to those who need to know in order that action may be taken

Surveillance is the systematic use of data for action

Process of Disease Surveillance

- Collection
- Analysis
- Interpretation
- Dissemination

Public Health Action

Goal of Surveillance
The reduction of morbidity and mortality through the control and/or prevention of disease.

Types of Surveillance
- Passive (Health facility – District – Region/Centre )
- Active (Designated Officer regularly looks for diseases of interest using standard case definition for notifiable diseases)

Surveillance: Function

Core Function
- Detection
- Reporting
- Investigation & confirmation
- Analysis & interpretation
- Action / response

Support function
- Training
- Supervision
- Resources
- Standards case definitions /guidelines

Uses of Surveillance
- Epidemic (outbreak) detection
- Epidemic (Outbreak) prediction
- Monitoring trends in disease
- To identify changes in agent and host factors
- Evaluating an intervention
- Monitor progress towards a control objective
- Monitor programme performance
- Estimate future disease impact
- Generate hypotheses and stimulate public health research
Surveillance: General Principle

- **Health Care System**
  - Data
  - Evaluation
  - Feedback
  - Action

- **Public Health Authority**
  - Reporting
  - Information
  - Analysis & Interpretation
  - Decision

Surveillance Reports

Purpose of surveillance reports:
- To communicate with people
- To disseminate information
- To educate the reader
- To direct, stimulate and motivate the person responsible for action

Surveillance: Basic Component

- A good network of motivated people
- Clear case definition and reporting mechanism
- Efficient communication system
- Basic but sound epidemiology
- Laboratory support
- Good feedback and rapid response

To detect outbreaks of diarrhoea by monitoring the incidence of cases of acute gastro enteritis

Cases of acute gastro enteritis in a hospital by epidemiological weeks, May - September 2008

Disease Indicators

The measures that you use to monitor a disease e.g.
- Number
  - No of cases of malaria reported
  - No of cases of falciparum malaria reported
- Rate
  - Number of cases of ARI in children under 5 years per 100,000 population
- Ratio
  - Proportion of children with ARI who die
Disease Indicators

- They may be indicators of
  - Disease incidence
    - Cases of Kala-azar per 100,000 population
  - Effectiveness of treatment
    - Case fatality in measles

Surveillance: Tasks

- Peripheral level: Detect, Treat, Report
- Intermediate level: Analyse, Investigate, Report, Respond, Feedback
- Central level: Analyse, Investigate, Confirm, Respond, Plan and Fund, Feedback
- International level: Analysis and feedback, Support, Policy and targets, Funding

Surveillance: Data Flow

- Peripheral level
  - Clinical (Suspected)
- Intermediate level
  - + Supportive Laboratory data
  - + Epidemiological link (probable)
- Central level
  - Diagnostic Laboratory (Confirmed)
- International level
  - Regional reference laboratory

Our Role in Surveillance

1. Identify cases under surveillance
2. Notify district focal surveillance person
3. Activate / Notify RRT
4. Case Investigation
5. Notify Regional/Central Disease Control

Role of Clinicians

IMMEDIATELY NOTIFY HOSPITAL FOCAL SURVEILLANCE PERSON SO THEY CAN NOTIFY THE District Team

Advise parents about the case investigation, tell them health officials will take a history, take specimen for lab confirmation

Know where to refer patients for treatment

At Health facilities:

- All health workers including RRT team should have a basic understanding of epidemiology, mainly communicable disease surveillance, thus district and below district level health workers should get trainings
- Pre-position of drugs and other essentials at district and sub-district levels
Role of Basic Health staff / Community Health Volunteers

- Look for “suspect cases” of diseases under surveillance
- Immediately report these “suspect cases” to a clinician or alert the hospital focal surveillance person.

Role of the District Team

- Make sure staff at health facilities in your district know how to identify and report cases
- Investigate every reported case
- Complete case investigation form, collect specimen. Complete line listing
- Ensure cold chain, and transport specimen to designated lab as soon as possible
- Provide feedback to healthcare staff on the laboratory results

Syndromic Surveillance during Disaster (see annex II for syndromic surveillance form)

Rapid Response Teams – must coordinate with District Disaster Relief Committee + EDCD to reduce further morbidity and mortality.

ALL HEALTH EVENTS RELATED TO DISASTERS SHOULD BE REPORTED PROMPTLY AND REGULARLY, WITH SUBSEQUENT ACTION

Functioning disease surveillance system and intact environmental health services are crucial in protecting public health and in responding to the outbreaks

Well prepared, least affected
Unit 2.2: Outbreak Investigation and Response

Sub Topic: (a) Importance of outbreak investigation and its steps

Definition of outbreak

- Occurrence of more cases of disease than expected in a given area among a specific group of people over a particular period of time
- Two or more linked cases of the same illness

Objectives of Outbreak investigations

1. To control ongoing outbreaks
2. To prevent future outbreaks
3. To provide statutorily mandated services
4. To strengthen surveillance at local level
5. To advance knowledge about a disease

Steps of an outbreak investigation

- Confirm existence of an outbreak/epidemic (clinical & laboratory) – confirm diagnosis
- Establish a working case definition for the outbreak
- Identify, count number of cases & determine size of population at risk (to calculate attack rate)
- Look for additional cases & follow up contacts
- Develop and test hypothesis
- Implementation of control measures
- Write a report with recommendations

DETECTION Routine surveillance Clinical/laboratory General public Media

Is this an outbreak?

Diagnosis verified?
Clinical + laboratory
Link between cases?
Expected numbers?

Outbreak confirmed

Immediate control measures?
Treatment
Prophylaxis
Exclusion/isolation
Public warning
Hygienic measures

Further Investigation?
Unknown etiology
(pathogen/source/transmission
Cases serious
Cases still occurring
Public pressure
Training opportunity
Scientific interest

Assistance?
Epidemiologist
Microbiologist
Environmental specialist
Public health personnel
Physician/Medical Officer
Paramedics
Lab personnel
Health educator
Others

Outbreak Investigation Team

Assess situation
Examine available information
Preliminary hypothesis?
Case definition
Case finding

Description epidemiology

Case definition

- Standard set of criteria for deciding if a person should be classified as suffering from the disease under investigation
- Clinical criteria, restrictions of time, place, person

Example case definition - Cholera

Suspect
Acute watery diarrhea (passage of 3 or more loose or watery stools in the past 24 hours), with or without vomiting in a patient aged 5 years or more

Example case definition - Cholera...

- Probable
  - Not applicable
- Confirmed
  - Isolation of *Vibrio cholerae* from stool of patient

Identify & Count cases
Clearly identifiable groups
Communities
Hospitals
Laboratories
Schools
Workplace, etc.

Obtain information
Identifying information
Demographic information
Clinical details
Risk factors

Perform descriptive Epidemiology
Orient cases by
- Time
- Place
- Person

Implement control measures
May occur at any time during the outbreak!!

Control the source of the pathogen
Interrupt transmission
Modify host response
Prevent recurrence

Identifying information
Demographic information
Clinical details
Risk factors

Orient cases by
- Time
- Place
- Person
**Response /control**
- Treat cases according to recommended treatment guidelines
- Implement disease specific control & preventive measures
- Prevent further exposure (isolation, quarantine, contact tracing)
- Prevent infection (e.g. vaccination, Public awareness, enhanced surveillance)

**Control the source of pathogen**
- Remove the source of contamination
- Remove persons from exposure
- Inactivate/neutralise the pathogen
- Isolate and/or treat infected persons

**Interrupt transmission**
- Interrupt environmental sources
- Control vector transmission
- Improve personal sanitation

**Modify host response**
- Immunize susceptible
- Use prophylactic chemotherapy

**Post outbreak evaluation**
- Assess timeliness of outbreak detection and response
- Assess appropriateness & effectiveness of control intervention
- Integrate/translate lessons learnt into policy
- Write and disseminate outbreak report

**At the end**
- Prepare written report and disseminate (see annex III for reporting form)
- Communicate public health messages
- Evaluate performance
### Unit 2.2
#### Outbreak Investigation and Response

Sub-unit B. Prevention and Control of Outbreak in Disaster

---

### Control of Communicable Diseases
- Control of communicable disease
  - Prevention
  - Diagnosis and case management
  - Outbreak Preparedness
  - Outbreak Response

---

### Communicable disease

**(a) Prevention**
- Water, sanitation and hygiene promotion
- Access to adequate food and management of malnutrition
- Community education
- Mass vaccination campaign and routine ongoing vaccination
- Vector Control measures

***(b) Diagnosis and case management***
- Use of standard guidelines and protocols
- Ensure availability of lab services
- Educate community to seek early treatment and care
- In malaria endemic region establish 24 hrs diagnosis of fever

---

### Communicable disease

**(c) Outbreak Preparedness**
- Prepared outbreak investigation and control plan
- Investigation and control protocols available to relevant staffs
- Staffs received training on outbreak management
- Reserve stock of essential drugs and other supplied available

***(c) Outbreak Preparedness cont...***
- Identified source of vaccination.
- Mechanism of rapid procurement established
- Sites for vaccination and treatment of infectious patients are identified
- A laboratory is identified for diagnosis
- Sampling materials and transport media for the infectious agents available.
Communicable disease  
(d) Outbreak Response  
- HMIS includes an early warning components  
- Initiation of outbreak investigation occurs within 24 hours of notification  
- Outbreak should be described according to time, place and person  
- Appropriate control measures that are specific to the disease and context are implemented  
- Case fatality rate are maintained at acceptable levels: 
  - Cholera: 1%, Shigella (dysentery): 1% or lower, Typhoid: 1% or lower  

Vector Control  
- It is important to control vectors during emergencies and disaster to safeguard people  
- Various measures can be applied  
- Use of bed net is very important to ward off the vectors  
- Hygienic measures are all important
Unit 2.2: Outbreak Investigation and Response

Sub Topic:
(c) Laboratory investigation in outbreak

Laboratory Preparedness for Outbreak Investigation

- Information collection
- Planning for lab. activities
- Formation of laboratory team
- Individual role & responsibility
- Accessories management
- Working together with outbreak investigation team

Procedure
Steps of laboratory procedure for outbreak investigation:
1. Patient’s registration & Outbreak investigation/requisition form fill-up
2. Patient preparation & specimen collection
3. Preservation & storage of the specimen
4. Transportation/shipment of the specimen

Laboratory form for outbreak investigation
(see annex IV for form)
Each specimen must be accompanied by a request form which details:
- Address: Dist/VDC/Municipality/Ward No./Tole/Phone no.
- Occupation
- Patient’s name, age, gender, outpatient or inpatient number, ward or health center.
- Type and source of specimen
- Investigation required.
- Specimen storage temperature
- Specimen transferred in
- Date and time of collection.
- Sample collected by:
  - Name--------signature--------date & time of collection---

Proper specimen collection
- Proper collection technique.
- Appropriate time of collection.
- A sufficient quantity of specimen.
- Appropriate collection devices and container.
- Appropriate transfer media.
- Whenever possible, obtain sample prior to administration of antibiotics.
- For respiratory sample collect as soon as possible once symptoms occurs.
- Transport time/ temperature.
- Proper labeling.

Sample Transport Medium
- VTM (virus transport medium) for Nasal, throat and respiratory specimen.
- Alkaline peptone water to transfer rectal swab and fresh stool sample for cholera like diarrhoeal cases.
- Cary-blair medium for the preservation and transportation of salmonella, shigella, vibrio and yersinia species.
Storage of Specimen

- All specimen must be kept at 2-8°C after collection.
- All specimen must be transported at 2-8°C in cold box within 24 hours of collection.
- If delay in transportation, ice pack must be changed in every 24 hours for maintaining proper cold chain.

Transport of Specimen

- Use triple layer packaging system for specimen packing.
- The transport time should be kept to a minimum.
- Transport specimen in cold box with ice packs as soon as possible.
- Include detail information of sender and receiver with name and mobile phone number
- Co-ordinate with reference laboratory before and after sample transportation.

Packing and labelling of Category A infectious substances

Importance of Bio-safety & waste disposal

- Wear personal protective equipment (PPE) eg-mask, gloves and gown during sample handling.
- Apply aseptic technique for sample collection and packing.
- Dispose infected materials in disinfectant solutions or incinerate.

Rapid diagnostic test kits

- Dengue
- Malaria- pv/pf
- Kala-azar
- Leptospirosis
- Influenza

Available of transfer media

- NPHL
- Regional health directorate
- Regional hospital
Field Kit for specimen collection

- Cold box with ice pack
- VTM: for influenza like illness or respiratory sample collection
- Alkaline peptone water: to transport stool sample (cholera case)
- Cary-blair media: to transport stool sample for diarrhoeal disease outbreak
- Marker / laboratory form for outbreak investigation
- Packing tape
- Sterile disposable swab stick/syringe
- Gloves
- Gown
- Mask
- 70% alcohol
- Plain sterile vials/ test tubes
- Zip-lock bag
Unit 2.4: Communication and Coordination During Emergencies

Communication during Disaster
- Very important function during disaster
  - To obtain necessary support
  - To provide services
  - To collaborate and coordinate activities

Important communicating steps during a disaster
- Report early
- Always use the identified focal person (spokesperson) to communicate public messages.
- Use any pre developed template on reporting
- Ensure the information is accurate. If no information - say so and why.
- Update the information on a regular basis.
- Provide consistent reports.
- Be sensitive to cultural differences.
- Identify credible modes of communication.
- Always follow up on the media reports to ensure accuracy.

Line of Communication and Coordination

- District RRT: DHO/DPHO
  - Regional RRT: RHD
  - Centre RRT: EDCD

Best Practices for effective communication
- Build trust
- Announce early
- Be transparent
- Respect public concern
- Plan in advance

Communication before a natural disaster/outbreak
Before the hazard/outbreak communicate about risks of the disaster
- External communication
  (through the media or direct social mobilization)
  - To warn about risk or hazard
  - To educate about prevention measures
  - To cope with public health issues arising during a natural disaster or outbreak
- Internal communication
  - To draw a plan on disaster risk communication plan,
  - Identifying the focal persons (spokesperson), lines of communication, mode of communication etc
Communication during a natural disaster/outbreak

External communication (through media briefings, press releases or interviews)
- To provide information about the event
- To warn people most likely to be affected
- To motivate public, political and institutional response
- To deny false rumors

Internal Communication
- To link scientists, disaster mitigation officials, and the public
- To alert authorities
- To assess damage
- To coordinate rescue and relief activities
- To account for missing people

Communication after a natural disaster/outbreak

- Communication is important during the rehabilitation stage
- RRTs may not be involved to a large extent at this stage
- Report on the situation of the affected areas, particularly progress of rehabilitation and reconstruction efforts
- Provide guidance on how the community can collaborate with rehabilitation efforts

Public Health Messages for Outbreak Situations

Outbreak Investigation Messages
Base your message on the three four components of descriptive epidemiology
- Person
- Place
- Time
- Response

Coordination during Emergencies

- Coordinate all the activities with DDRC
- Inform higher authorities as early as possible and seek help if needed
- Conduct RRT meeting as required and mobilize the team
- Identify a focal person to coordinate the activities
- All staff under D(P)HO might need to be mobilized, so make list of all the staff, their contact number and call back if out of station
- Coordinate with local authorities and civil society as necessary
2.5 Nutrition in Emergency

(A) Basic Concept of Nutrition in Emergencies

What is Nutrition in Emergencies

- Severity of nutritional crisis.
- An emergency using acute malnutrition or wasting in the population as one indicator of distress.
- Crisis threshold of acute malnutrition as defined by WHO to set thresholds above which particular emergency interventions should be started.
- Severe impact of diseases, food crisis in an extreme stages as malnutrition and mortality are so severe as to be labelled ‘famine’.

Who are most nutritionally vulnerable in emergencies?

- Physiological vulnerability (e.g., young children, pregnant and lactating women, older people, the disabled and people living with chronic illness such as HIV and AIDS)
- Geographical vulnerability (e.g., people living in drought- or flood-prone areas or in areas of conflict)
- Political vulnerability (e.g., oppressed populations)
- Internal displacement and refugee status (e.g., those who have fled with few resources)

Sub Topics:
(a) Basic concept of nutrition in emergency
(b) Assessing the severity of crisis
(c) Measuring malnutrition
(d) Responding to the crisis

What are the causes of nutrition emergencies?

- Emergencies where acute malnutrition rates rise are usually directly caused by severe shortages of food combined with disease epidemics.
- Some populations are vulnerable as a result of underlying factors such as poverty, chronic food insecurity and poor infrastructure, e.g., nutrition emergencies are much more likely to occur in developing countries than in the developed world.
- HIV and AIDS, global climate change, natural disasters, conflict, acute food and livelihood crisis’, political crisis or economic shocks can trigger a nutrition emergency.

What is malnutrition?

“A state in which the physical function of an individual is impaired to the point where he or she can no longer maintain an adequate bodily performance processes such as growth and development, pregnancy, lactation, physical work, and resisting and recovering from disease”
What types of malnutrition occur in emergencies?

The main nutritional problems of concern in emergencies are:

• acute malnutrition (wasting), especially in young children – the clinical forms of this are kwashiorkor characterized by oedema (swelling due to fluid retention) and marasmus

• micronutrient deficiencies especially iron, vitamin A and iodine deficiencies (common in disadvantaged populations) and vitamin C, thiamine and niacin deficiencies (outbreaks have occurred in emergency-affected populations).

**Nutrition Indices – Review Emergency Contexts**

<table>
<thead>
<tr>
<th>Stunting (Chronic)</th>
<th>Underweight (Both)</th>
<th>Wasting (Acute)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index</td>
<td>H/A</td>
<td>W/A</td>
</tr>
<tr>
<td>Moderate</td>
<td>&lt; -2 SD</td>
<td>&lt; -2 SD</td>
</tr>
<tr>
<td>Severe</td>
<td>&lt; -3 SD</td>
<td>&lt; -3 SD</td>
</tr>
</tbody>
</table>

*Cut off points for MUAC have differed from agency to agency – these cut offs are consistent with cluster guidance.

**The Impact of Malnutrition Malnutrition & Child Mortality**

- Pneumonia 19%
- Diarrhea 17%
- Malaria 8%
- Other 10%
- Injuries 3%
- Measles 4%

Source: Lancet Child Survival Series

**How Does Malnutrition Happen “a concept”**

- Immediate Causes
  - Disease
  - Oedema
  - Kwashiorkor
  - Marasmus

- Underlying Causes
  - Inadequate dietary intake
  - Insufficient health services
  - Inadequate care for children and women

- Basic Causes
  - Inadequate access to food

- Political and Ideological Superstructure
  - Economic structure

**Nutrition Indices – Review Emergency Contexts**

- Moderate Acute Malnutrition

*Cut off points for MUAC have differed from agency to agency – these cut offs are consistent with cluster guidance.
### Nutrition Indices – Review Emergency Contexts

<table>
<thead>
<tr>
<th>Stunting (Chronic)</th>
<th>Underweight (Both)</th>
<th>Wasting (Acute)</th>
<th>Severe Acute Malnutrition (SAM)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Index</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>&lt; -2 SD</td>
<td>&lt; -2 SD</td>
<td>&lt; -3 SD, &lt; 70% Median, or MUAC &lt; 115 mm*</td>
</tr>
<tr>
<td>Severe</td>
<td>&lt; -3 SD</td>
<td>&lt; -3 SD</td>
<td>&lt; -3 SD, &lt; 70% Median, or MUAC &lt; 115 mm*, or Oedema</td>
</tr>
</tbody>
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### Nutrition Indices – Review Emergency Contexts

<table>
<thead>
<tr>
<th>Stunting (Chronic)</th>
<th>Underweight (Both)</th>
<th>Wasting (Acute)</th>
<th>Global Acute Malnutrition (GAM)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Index</strong></td>
<td></td>
<td></td>
<td></td>
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Unit 2.5: Nutrition in Emergency
Sub-Topic C. Measuring Malnutrition

(c) Measuring Malnutrition
Indicator Cutoffs: Weight-for-Height, MUAC, Bilateral Pitting Oedema

Note: cutoffs might vary according to the context, agency and national guidelines.

<table>
<thead>
<tr>
<th>Weight for Height Cutoffs, Children 6-59 Months</th>
<th>Severe Acute Malnutrition</th>
<th>Moderate Acute Malnutrition</th>
<th>Stunted Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>WNH &lt; 70% of the median</td>
<td>WNH &lt; 80% and ≥ 70% of the median</td>
<td>WNH &lt; -2 z and ≥ -3 z: Moderate Acute Malnutrition</td>
<td></td>
</tr>
</tbody>
</table>

Weight-for-height as a percentage of the median is based on the NCHS (National Center for Health Statistics) 1978 references and is the measure most commonly used in CMAM programmes. Some countries may require use of z-scores, which may be based on the WHO 2006 Growth Standards.

• Mid-Upper Arm Circumference (MUAC):
  Target Children: Children 6 months to 5 years
  MUAC assessment:
  • Normal: ≥12.5 cm
  • Moderate acute malnutrition: >11.5 cm to < 12.5 cm
  • Severe acute malnutrition: <11.5 cm
  MUAC and weight gain tables for lamination.xls
  • Percentage of the Median:
    Percentage of the Median = \frac{\text{Measured weight}}{\text{Median weight of reference population}} \times 100
    e.g. \frac{9.9 \text{ kg}}{11.5 \text{ kg}} \times 100 = 86.1% of the median

• SD or Z score:
  \text{SD} = \frac{\text{Measured weight} - \text{median weight of reference population}}{\text{Standard deviation of the reference population}}
  e.g. \frac{9.9 \text{ kg} - 11.7 \text{ kg}}{0.906} = -1.8 SD score

• Percentage of the Median:
  Percentage of the Median = \frac{\text{Measured weight}}{\text{Median weight of reference population}} \times 100
  e.g. \frac{9.9 \text{ kg}}{11.5 \text{ kg}} \times 100 = 86.1% of the median

Technique of measurement of Malnutrition
• Various techniques can be used to measure malnutrition in emergencies. The most used are:
  - Weight for Height
  - Mid-Upper Arm Circumference (MUAC)
  - Measurement of Body Mass Index (BMI)

BMI = \frac{\text{Measured weight} - \text{height}^2}{\text{kg}}
\text{m}^2

- e.g. 50 kg
  \text{1.6 m}^2
  \text{BMI} = 19.5

<table>
<thead>
<tr>
<th>Status</th>
<th>Edema</th>
<th>BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well nourished</td>
<td>No</td>
<td>≥ 18.5</td>
</tr>
<tr>
<td>Mildly malnourished</td>
<td>No</td>
<td>18.4 to 17</td>
</tr>
<tr>
<td>Moderately malnourished</td>
<td>No</td>
<td>16.9 to 16</td>
</tr>
<tr>
<td>Severely malnourished</td>
<td>May be yes &lt; 16</td>
<td></td>
</tr>
</tbody>
</table>
2.6 b IFE Guidance Note

(Sub section of 2.6 Basic Nutrition Intervention in Emergencies)

Recommendations from guidance note

- **Provide fortified foods to all families with under-five children and/or pregnant and lactating women.**
- **Strive to provide cooking facilities and fuel to all displaced families** for food preparation, including preparation of complementary foods.
- **Only** where individual cooking facilities are not available, **joint cooking facilities should be considered** to ensure appropriate complementary feeding for infants in a hygienic manner.
- **Provide high-energy biscuits (BPS)** as supplementary feeding to children aged 2-5 years.
- **Ensure early initiation and continuation of breastfeeding** of infants and young children up to the age of 24 months.

Recommendations cont...

- Those responsible for the care of mothers and children should be provided with adequate information to **support breastfeeding and appropriate complementary infant and young child feeding.**
- For those infants and young children whose mothers are absent or incapacitated, as much as possible, ways should be identified to breastfeed.
- There should be **no distribution of breast-milk substitutes, even to infants whose mothers are absent or incapacitated,** in order to feed orphans, or infants separated from their mothers, please refer to the contact persons at CHD for the current guidance from CHD/MoHR (see also joint statement on protection of breastfeeding in emergencies)
- **Special attention should be given to feeding pregnant and lactating mothers (supplementary and nutritional balanced rations)** in order to encourage success breastfeeding.
Unit 2.5
Nutrition in Emergency

Sub-Topic B: Assessing and Responding to Severity of Crisis

(b) Assessing the Severity of Crisis

Severity of a Crisis
Three Criteria
1. Prevalence of malnutrition in relation to internationally defined benchmarks and thresholds
2. Trends in rates of malnutrition over time – pre-crisis including seasonality
3. The relationship between malnutrition and mortality

Severity of Crisis
Benchmarks and Thresholds

<table>
<thead>
<tr>
<th>Severity</th>
<th>Prevalence of GAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptable</td>
<td>&lt; 5%</td>
</tr>
<tr>
<td>Poor</td>
<td>5 – 9%</td>
</tr>
<tr>
<td>Serious</td>
<td>10 – 13%</td>
</tr>
<tr>
<td>Critical</td>
<td>&gt; = 15%</td>
</tr>
</tbody>
</table>

WHO, Management of Malnutrition in Major Emergencies, 2000

Severity of Crisis
Malnutrition-Infection Cycle

Inadequate dietary intake
- Appetite loss
- Nutrient loss
- Mal-absorption
- Altered metabolism
- Deaths

Weight loss
- Growth faltering
- Lowered immunity
- Mucosal damage
- Deaths

Disease

(c) Responding to Crisis

Responding to Crisis Prevention Before Cure

Early Intervention vs Late Intervention

Food security/General Distribution vs Supplementary feeding vs Therapeutic feeding vs Cost/Benefit

Responding to Crisis

- Early Warning Systems
- Agricultural production such as crop production and livestock farming
- Markets such as domestic and international trade (import/export), prices of key staples and livestock
- Vulnerable groups such as monitoring poverty
- Nutrition and health status of populations
Responding to Crisis Prevention Before Cure

Ensure the population has adequate access to appropriate quantities of quality food (SPHERE = 2100 kcal/day)

- Market-based interventions
- Cash transfers
- General food distribution or blanket supplementary feeding
- Nutritional Surveillance

Responding to Crisis Selective Feeding

Early Intervention
- Supplementary feeding
- Therapeutic feeding

Late Intervention
- Supplementary feeding
- Therapeutic feeding

Responding to Crisis Screening

Many now advocate for using MUAC alone, the nutrition cluster recommends continued use of W/H Stage

Responding to Crisis Traditional Approach

Traditional approach

No Malnutrition
- Screening
- Moderate (=2 SD to -3 SD or 70% - 80% Median)*
- Severe (=3 SD or <70% Median/Oedema)*
- Supplementary Feeding
- Recovered
- Therapeutic Care

Responding to Crisis Phase I Stabilization
- Phase II Rehabilitation

Treatment
- Anesthetic, Anti-emetic, Vitamin A, etc.

Care
- Attend to complications (e.g. shock, hypoglycemia)

Feed
- F-75 Therapeutic Milk
- 200ml/kg/day

Quantity
- 100ml/kg/day
- 5 to 4 Weeks
Responding to Crisis

Traditional Approach

- Highly effective in reducing case specific mortality, BUT...
  - Extremely labor intensive – Costly
  - High potential for cross infection
  - Child & caretaker are away from family for 20+ days – high opportunity cost
  - Poor Coverage

Responding to Crisis

Supplementary Feeding

“Blanket”
- Prevent malnutrition by providing a food supplement to all members of vulnerable groups such as children <5 and pregnant and lactating women (alluded to earlier)

“Targeted”
- Prevent moderately malnourished women and children from becoming severely malnourished by providing a food supplement to malnourished individuals

Responding to Crisis

Supplementary Feeding

“Wet” Rations
- Food is prepared and consumed on-site (ration is determined according to child’s nutritional requirements)

“Dry” Rations
- Food is taken home and consumed with family (ration often increased to account for intra-household allocation)

Responding to Crisis

Supplementary Feeding

- A Retrospective study of Emergency Supplementary Feeding Programmes notes only 41% achieve objectives. Carlos Navarro-Colorado. June 2007. ENN and SC UK. Available at www.ennonline.net/research
- Fortified blended foods inadequate in both caloric and micronutrient content - Ready to Use foods are far superior
- Potential use of RUTFs in supplementary feeding programs – both in prevention of malnutrition, and in treatment of moderate malnutrition

Responding to Crisis

OECD

Responding to Crisis

Crisis

Supplementary Feeding

• Forty of severes can be treated as outpatients

Responding to Crisis

Crisis

Supplementary Feeding

• Wet Rations
  - Food is prepared and consumed on-site (ration is determined according to child’s nutritional requirements)

• Dry Rations
  - Food is taken home and consumed with family (ration often increased to account for intra-household allocation)

Responding to Crisis

Crisis

Supplementary Feeding

Complications:
- anorexia
- severe oedema (3+) or
- marasmus with any level of oedema, or
- the presence of associated complications (e.g. extensive infections, severe dehydration, severe anaemia, hypothermia, hypoglycaemia or the patient not being alert).

Responding to Crisis

Crisis

Supplementary Feeding

Uncomplicated

Complicated
Responding to Crisis

**OTP – First Contact**

- Medical Assessment
- Appetite Assessment
- Presumptive treatment: Antibiotic (amoxicillin), Anti-malarial, and Vitamin A and/or Folic Acid in cases presenting with deficiency symptoms
- Ready to Use Therapeutic Food (RUTF)

**Inpatient Care**

<table>
<thead>
<tr>
<th>Phase I Stabilization</th>
<th>Phase II Rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>Antibiotic, Anti-malarial, Vitamin A, etc.</td>
</tr>
<tr>
<td>Care</td>
<td>Attend to complications (e.g. shock, hypoglycemia)</td>
</tr>
<tr>
<td>Food</td>
<td>F-75 Therapeutic Milk</td>
</tr>
<tr>
<td>Quantity</td>
<td>135ml/kg/day</td>
</tr>
<tr>
<td>Time</td>
<td>1-7 Days</td>
</tr>
</tbody>
</table>

WHO, Management of Severe Malnutrition, 1999

**Weekly Follow Up**

- Medical exam
- RUTF
- De-worming for children above 1 year of age – Week 2
- Measles immunization for all children above 9 months of age – Week 4

**Feeding Care**

- Complicated
- Uncomplicated

**Simplified Decision Tool**

<table>
<thead>
<tr>
<th>Finding</th>
<th>Action required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food availability at household level &gt; 1/2 of household available and access can be made adequate</td>
<td>Increase general ration and local food availability and access can be made adequate</td>
</tr>
<tr>
<td>Malnutrition rate (WAZ) under 10% with no aggravating factors</td>
<td>Target at household level and intervention to be made through regular community surveillance</td>
</tr>
<tr>
<td>Malnutrition rate (WAZ) 10-15% or 8-12% plus aggravating factors</td>
<td>Supplementary feeding targeted to individuals identified as malnourished in vulnerable groups. Therapeutic feeding for SAM individuals</td>
</tr>
<tr>
<td>Malnutrition rate (WAZ) 15% or more</td>
<td>Therapeutic feeding for all members of vulnerable groups. Therapeutic feeding for SAM individuals</td>
</tr>
</tbody>
</table>

**Micronutrients**

The Silent Killer

- Over 2 billion people affected in the world
- Increases the general risk of infectious disease and of dying from diarrhea, measles, malaria and pneumonia
- Emergency affected populations are at increased risk of deficiency
Micronutrients
Prevention Before Cure

• Ensure the population has access to key micronutrients
  – Local foods
  – Fortified foods
  – On-site fortification
  – Supplements
  – Multiple Micronutrient Powders
Unit 2.6: Child Health in Emergency

Sub-Topic a): Child Health in Emergency

Reasons for continued high mortality among children in complex emergencies

- Inadequate food aid, shelter, water, sanitation
- Inappropriate infant and child feeding
- Preventive measures against outbreaks not sufficient (e.g. immunization, clean drinking water)
- Case management of sick children not appropriate

Childhood morbidity in complex emergencies

- Morbidity may vary by phases of emergency. During acute emergency, the most common causes are: diarrheal diseases, acute respiratory infections, measles, malaria, and severe malnutrition
- Outbreaks of other infectious diseases are also common: polio in Angola (Valente 2002), pertussis (WHO 2003), leishmaniasis (Rowland 1999, Ahmad, 2002) in Afghanistan, meningococcal meningitis in Sudan (Newton 2000), and typhoid fever in Bosnia and Herzegovina (Bradic 1996)
- Complex emergencies can disrupt disease control programmes and facilitate the transmission of diseases by exacerbating crowded conditions and poor nutritional status and contribute to resistance

Special Pediatric Considerations in Disaster Preparedness

- Children are more vulnerable: Medically, psychological vulnerabilities and response to illness e.g. susceptibilities to dehydration and shock.
- Children need special management plans e.g. require different dosages or different antibiotics and antidotes to many agents.
- Emergency responders, medical professionals, and children’s health care institutions require special expertise and training to ensure optimal care of those exposed to chemical, biological, or nuclear agents.
- Children’s developmental ability and cognitive levels may impede their ability to escape danger.

Major causes of under 5 morbidity and mortality in humanitarian emergencies

- Diarrheal diseases
- Measles
- Malaria
- Acute respiratory infections and pneumonia
- Malnutrition
- Micronutrient deficiencies

The facts… show a much higher mortality of children in emergencies

- Children under 5 made up 17% of the population, but contributed to 65% of all age deaths - Kurdish Refugees (MMWR, 91)
- Under 5 mortality was 5 times the crude mortality rate - Mozambican refugees in Malawi (MMWR, 93)
- Death rates among unaccompanied children, mostly orphans, among Rwandan refugees was 20-80 times higher than the U-5 mortality rate before the crisis (Dowell, 95)

Role of Malnutrition and micronutrient deficiencies

- Prevalence of acute malnutrition (weight-for-height 2 standard deviations below the reference mean) among children < 5 years of age in internally displaced and conflict-affected populations between 1988 and 1995 was 31% among 11 surveys, and was as high as 80% in the Sudan in 1993 (Toole 1997).
Problem of unaccompanied children

- Korean War or Nigerian Civil War many were abandoned infants (Sapir 1993).
- (Rwandan refugee) Most deaths (85%) occurred more than 2 days after arrival at the centers, suggesting that early and appropriate care could have significantly reduced mortality in this group of children.

Other health problems, that need to be addressed, include HIV/AIDS, physical and sexual abuse, psychosocial health problems and trauma.

Other communicable diseases

- Polio in Angola
- Cutaneous leishmaniasis in Afghanistan
- Meningococal meningitis in Sudanese Refugees
- Typhoid in Bosnia
- TB/HIV

Neonatal Health

- Burundian refugees in Tanzania accounted 16% deaths in neonates and mothers
- Problem of LBW
- 19% Neonatal mortality in Pakistan

Diarrhoea-Prevention in Emergency

- 27% fewer diarrhoeal episodes in Malawi refugees with soap distribution
- Covered container with spout reduced diarrhoeal disease by 31%

Challenges: ensuring good practices

*How to achieve universal standards of care?
*Training
  - need for pre-emergency training
  - how best to conduct training in an emergency?
  - what levels of health workers should be targeted?
*Implementation and quality assurance
  - develop guidelines
  - modify existing guidelines (e.g. IMNCI, ETAT)
  - work with governments to endorse standards
  - distribute guidelines through partners

Priority interventions for Children

- Diarrhea Prevention, Oral rehydration therapy (ORT)
- Ensuring food security and feeding programmes for severely malnourished infants,
- Measles immunization and Vitamin A supplementation.
Differences in the Care of Children in Complex Emergencies & Stable Situations

- Rapid assessment and treatment of large numbers of severely ill children
- Less uniform health care delivery
  - multiple organizations
  - different types of health care worker
  - high staff turnover
- Inadequate referral services and supply delivery system

Strengths of IMCI Guidelines

- Address major causes of child mortality
- Integrate case management & prevention
- Targeted to clinical officers and Workers
- Potentially combined with Emergency Triage Assessment and Treatment
- Can be simplified for CHWs and village volunteers

Limitations of Standard IMNCI Guidelines

- Training course too long to be implemented in complex emergencies
- Referral facilities to manage severe disease frequently not in place
- Time required for single patient encounter too long in acute phase of emergency
- No community outreach
- Disease surveillance not addressed

Material & Learning Principle

- Learners module with Photographs
- Laminated Charts as job aid
- Facilitator guide
- Video clippings (optional)
- Interactive process
- Drills
- Learning by doing
- Video, photographs and role plays
Potential users

- Health (medical & paramedical personnel)
- NGO
- CHW

Anticipated health problems and interventions

<table>
<thead>
<tr>
<th>Days 1-3</th>
<th>Injury/drowning and deaths</th>
<th>Psychosocial problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Safe disposal of corpses</td>
<td>Injury management</td>
</tr>
<tr>
<td></td>
<td>Psychological support</td>
<td>Psychosocial support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Days 3-5</th>
<th>Diarrhoeal diseases</th>
<th>Respiratory infections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health promotion</td>
<td>Respiratory support</td>
</tr>
<tr>
<td></td>
<td>- Sanitation, environment</td>
<td>- Personal hygiene</td>
</tr>
<tr>
<td></td>
<td>- Water purification</td>
<td>- Immunization (measles)</td>
</tr>
<tr>
<td></td>
<td>- ORS</td>
<td>- Emerging disease surveillance (morbidity/mortality)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5-10 days</th>
<th>Above plus: Dehydration, nausea, conjunctivitis, and infections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Above plus: Antibiotics for pneumonia</td>
</tr>
<tr>
<td></td>
<td>Drugs for skin infections and conjunctivitis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>&gt;10 days</th>
<th>Above plus: Vector-borne diseases (malaria, DF)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ongoing surveillance</td>
</tr>
<tr>
<td></td>
<td>Health education, measures for vector control, antimalarial</td>
</tr>
<tr>
<td></td>
<td>Supplementary feeding program</td>
</tr>
<tr>
<td></td>
<td>Rebuilding health infrastructure</td>
</tr>
</tbody>
</table>

Response & Survival: Golden Hours

- Time is a critical factor in disaster-related injuries and victim survival rates
- Post-earthquake studies have demonstrated that the first 24 hours following the event represents the golden window of time in which survival rates is higher
- Correlation between victim survival rates and the rapidity of search and rescue capability
3.1: Reproductive Health (RH) in Emergency

Sub Topic:
(a) Overview of RH in Emergency

Learning Outcomes
By the end of the session, the participants should be able to:
- Explain why SRH and the MISP are important in crises
- Know where to access key tools and resources to support implementation of SRH in crises

Start with MISP video
- Project the video on MISP
- Explain to participants that they will now watch a short video to provide a vivid examples of the context.
- Take approximately 5 minutes and invite participants to share their impressions of the video
- Discuss on the participants ideas around why it is important to address SRH needs to people in crisis situations such as shown in the video.

Right to SRH

“All migrants, refugees, asylum seekers and displaced persons should receive basic education and health services”

Chapter 10, ICPD Programme of Action, 1994

Why RH in emergencies?
- Mandatory provision as a right
- Duty of state (as per its commitments expressed through international treaties, conventions ....)
- Need fulfillment (both biological and psychosocial)
Emergency Halts Other Lifelines but....

• People won’t stop being pregnant
• People won’t stop having sexual life (even in shelters)
• People can’t stop giving birth
• Exploitation, violence rather increases
• ....

RH needs continue ... in fact, increase during crisis

• Risk of sexual violence may increase during social instability
• STI/HIV transmission may increase in areas of high population density
• Lack of FP increases risks associated with unwanted pregnancy
• Malnutrition and epidemics increase risks of pregnancy complications
• Childbirth occurs on the wayside during population movements
• Lack of access to comprehensive emergency obstetric care increases risk of maternal death

Why Maternal and Newborn Health in Crisis and Post-Crisis Situations

Newborn Mortality in Nepal

• Globally, 9 to 33 babies out of every 1000 born die in the perinatal period.
• In Nepal 33 babies out of every 1000 born die in the perinatal period.
• Every hour 2-3 newborn die
• Major causes of newborn death are:
  ▪ Asphyxia,
  ▪ Infection,
  ▪ Hypothermia and
  ▪ low birth weight

Reproductive Health (RH) in Emergency

Can’t predict or prevent complications...
... but can prevent deaths by reducing DELAY:

“The three delays”

1. First Delay: Delay in decision to seek care
2. Second Delay: Delay in reaching health facility
3. Third Delay: Delay in receiving appropriate treatment or Emergency Obstetric Care Services

Can you think about three delays during crisis/Disaster?

How long does it take to die?
Estimated average interval from onset to death for major obstetric complications, in the absence of medical intervention

<table>
<thead>
<tr>
<th>Complications</th>
<th>Hours</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemorrhage</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>— Postpartum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Antepartum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ruptured Uterus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eclampsia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstructed labor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Maine et al, 1991
What should be of Primary Focus during Emergency?

Continuum promoting healthy mothers and babies through:
- Care during pregnancy
  (Antenatal Care – ANC)...........Yes or No?
  Pitfalls: ANC not part of MISP!
- Care at the time of delivery,
  Including Emergency Obstetrics
- MISP
- Care after delivery
  (Postnatal Care – PNC)...........Yes or No?
  Not part of MISP

Challenges to meeting SRH needs in Crises

- Lack of prioritisation of SRH in emergencies;
- Limited of awareness of the MISP amongst local, national, development & humanitarian actors;
- Poor implementation of the priority services outlined in the MISP;
- Lack of responders qualified or trained to implement the MISP;
- Inadequate coordination;
- Inadequate dedicated funding to implement the MISP;
- Lack of awareness among beneficiaries about benefits & location of MISP services

Referral mechanisms: challenges and solutions

What if ensuring 24/7 referral services may not be possible due to insecurity in the area?

- Ensure that staff qualified in basic EmONC are available at all times at the primary health care level to stabilize patients with basic EmONC
- Establish system of communication (radio) to communicate with more qualified personnel for medical guidance and support

“Standard” population

- Adult males 20%
- Women of reproductive age (WRA) 25%
- Crude birth rate 4%
  - Number of pregnant women
  - Number of deliveries
- Complicated abortions/pregnancy 20%
- Vaginal tears/delivery 15%
- Caesarean sections/delivery 5%
- WRA who are raped 2%
- WRA using contraception 15%
  - Oral contraception 30%
  - Injectables 65%
  - IUD 5%

In displaced population, 4% of the total population will be pregnant at a given time

Inter-Agency Working Group on RH in Refugee Situations (IAWG)

Formed in 1995: >30 UN, NGO, Academic, Donors
- Minimum Initial Service Package (MISP)
- Inter-agency Field Manual (IAFM)
- The MISP
- Comprehensive RH
- Maternal Health
- Family Planning
- Gender-based Violence
- STI, HIV/AIDS
- What is the MISP?
  - Minimum
  - Initial
  - Service
  - Package
  - basic, limited reproductive health
  - for use in emergency, without site-specific needs assessment
  - services to be delivered to the population
  - supplies (e.g. RH kit) and activities
  - coordination and planning
There are reports of rapes and abductions.

Comprehensive SRH care services
- Family planning programme
- Safe motherhood: abortion care, ANC/delivery/newborn/PNC
- STI/HIV prevention and management
- GBV prevention and management
- Gynaecology: infertility, fistula, cervical and breast cancer screening/treatment
- Urology: infertility, male sexual dysfunction, male reproductive cancer screening/treatment
- Active discouragement of harmful traditional practices; FGM, early marriage, selective abortions...
- Accessible for all: adolescents, elderly, sex workers/clients, ex combatants, uniformed staff, IDUs...
- Integrated in PHC and public health packages
- Links to other service sectors

Exercise
THE SITUATION
- After flooding 20,000 people displaced to a improvised camp in a mountainous region.
- Some overwhelmed health centres scattered in the district
- The nearest town with a hospital is 20 km away.
- Women fetch water in the river and walk for 2 hours to find firewood
- There are reports of rapes and abductions

THE RESPONSE
- What are the immediate needs of these people? Water; food; shelter; basic health care
- You are participating as the RH coordinator in the first health coordination meeting. Which RH interventions should be implemented as a priority?

What is NOT MISP?
- Extensive RH needs assessment before starting services
- Comprehensive RH services:
  - Ante- and post-natal care
  - Family planning
  - STI program
  - Prevention of other forms of GBV (not SV)
- Training (CHWs, midwives, TBAs, doctors)
- IEC campaigns (i.e. for condom distribution)
MISP implementation in Nepal: Progress so far

- Koshi Flood Response 2008/2009
- Mid-Western Flood 2014: RH kits distribution
- Earthquake response 2015
  - RH services since beginning
  - RH camps
  - Maternity home/transition homes
  - RH kits and supplies
  - Training on CMR
  - Support to birthing centres
- MISP Evaluation 2015: Kathmandu and Sindhupalchowk
- Integrated the MISP components in 20 districts DRRPs
- Adapted MISP training package by NHTC
- Adapted the ASRH toolkit in humanitarian settings
- Trained almost 500 health Service Providers and stakeholders on MISP and ASRH toolkit in humanitarian setting
- Prepositioning of RH kits since 2013

Key finding of MISP implementation in Nepal

- All MISP services and priority activities were largely available in both Kathmandu and Sindhupalchowk
- Some services were only partially available based on the availability at a limited number of facilities in the district
- Comprehensive/quality is concerned in some health facilities of the remote areas
- Major gap in community knowledge about culturally sensitive reproductive health issues, the benefits of seeking care, and the location of services for sexual violence, STIs, and HIV
- Many key informants were not aware of what services were available at each health facility for the CMR, specifically the use of EC and PEP
**Lessons learned**

- Identify a strong and respected **coordinator**
- **Transparant collaboration** facilitates implementation
- Prevention of GBV requires a concerted effort, sensitivity and staff preparation
- **People use condoms** during an emergency
- **Clean delivery kits** provide essential supplies for deliveries outside health facilities
- **Referral Center** requires strong 24/7 referral centers to provide comprehensive RH services
- Logistics preparedness is essential for prompt use of RH kits
- Satisfactory implementation requires **pre-planning**

**Key Messages**

- MISP is an inter-agency standard
- MISP ensures basic RH services in crises
- Promptly implemented MISP saves lives
RH in Emergency

Unit 3.2:
Sub Topic:
b) Major Components of MISP

Components of MISP
There are 5 components of MISP:
• Component # 1: Identify agency/persons to facilitate Coordination and Implementation
• Component # 2: Prevent and manage the consequences of sexual violence
• Component # 3: Reduce transmission of HIV/STIs in Crises
• Component # 4: Prevent excess neonatal and maternal morbidity and mortality
• Component # 5: Plan for comprehensive SRH services, integrated into primary health care, as soon as possible

Component # 2:
Prevent and manage the consequences of sexual violence
• Prevent and manage the consequences of sexual violence
  ✓ plan camp design
  ✓ medical response (Emergency Contraceptives [EC], STI/HIV prevention)
  ✓ inform the community and other actors
  ✓ protection of at risk groups
• All community health workers need to be aware of GBV in crisis
• Seek multi-sectoral support; involving police, watch group, volunteers, Women Human Rights Defenders (WHRD)

Learning Outcomes
By the end of the session, the participants should be able to:
• Describe the components of the MISP including key actions
• Know the role of RRT in preparedness and implementation of MISP during disaster/emergency

Component # 1:
Identify agency/persons to facilitate COORDINATION & IMPLEMENTATION
✓ Organization
✓ Individual
• RH issues will be taken up by Helath Cluster
• Lead by DHO/DPHO
• Health cluster will be the working platform for all RH related actors
• The focal person/coordinator will be identified
Guiding principles in responding to Sexual Violence (SV)

• Safety
• Confidentiality
• Respect
• Non-discrimination

Role of the Health Sector

• Respond to sexual violence
  – Provide clinical care
  – Collect forensic evidence
  – Refer for further crisis intervention
• Prevent sexual violence and stigmatisation, in collaboration with other sectors

Clinical Care

Tips for history taking and examination

– Compassionate and non-judgemental
– Survivor’s own pace, no unnecessary repeating
– Explain everything you are going to do
– Do not do anything without consent
– Follow History and Examination forms
– Document everything thoroughly

Medical management: forensic evidence

<table>
<thead>
<tr>
<th>Forensic evidence is collected during the clinical examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>– to confirm recent sexual contact</td>
</tr>
<tr>
<td>– to show that force or coercion was used</td>
</tr>
<tr>
<td>– to possibly identify the assailant</td>
</tr>
<tr>
<td>– to corroborate the survivor’s story</td>
</tr>
</tbody>
</table>

Types of evidence that can be collected

– **Medical documentation**
  – Injuries
  – Presence of sperm (<72 hours)
  – State of clothes

– **Clothes**

– **Foreign materials**

– **Foreign hairs?**

– **DNA analysis?**

– **Blood or urine for toxicology testing?**

Clinical care: treatment

• Treat life threatening complications first

• STI prevention
  - Syphilis, chlamydia, gonorrhoea (other infections if common)
  - Use local treatment protocols
  - Hepatitis B vaccination, if indicated

• Prevent HIV transmission (PEP)
  - If incident **<72 hours** and risk of transmission:
    - Zidovudine (AZT) + Lamuvidine (3CT) for 28 days
Considerations when providing Post exposure prophylaxis (PEP)

- HIV testing is **not a requirement** for supplying PEP
- PEP if survivor presents < 72 hours of rape, but: **first dose the sooner the better**
- Provide one-week, then three-week supply but: **full supply if the survivor cannot return**
- Schedule return visit one day prior to last dose
- For recurrent exposures requiring repeat PEP: *Crisis intervention. Offer protection*

Clinical care: treatment

- Prevent pregnancy:
  - < 5 days
  - Preferred: levonorgestrel 1.5 mg *single dose*
  - Or: ethinylestradiol 100 mcg + levonorgestrel 0.5 mg, two doses 12 hours apart (Yuzpe)
  - Alternative: IUD (very effective, but need skills!)
- Injury care
  - Clean and treat wounds
  - Provide tetanus prophylaxis and vaccination
- Refer for higher level care if needed

Component # 3: Reduce transmission of HIV in Crises

Reduce HIV transmission by
- standard precautions
- free condoms
- Safe and rational blood transfusion

Possible links between Sexual Violence, STIs and HIV in crises

Waste management

Instrument processing

It is important to perform the steps in the appropriate order for several reasons:
1. Decontamination kills viruses (HIV and Hep B) and should always be done first to make items safer to handle
2. Cleaning should be done before sterilization. HLD to remove debris
3. Sterilization (eliminates all pathogens) should be done after use or storage to minimize the risk of infections during procedures. (HLD may not eliminate spores)
4. Items should be used or properly stored immediately after sterilization
Ensure rational and safe blood transfusion

• In order to ensure safe blood transfusion services during crisis or emergency or disaster, need to link with Nepal Red Cross Society (NRCS) and Blood Bank.

This part will be taken care of by NRCS/ Blood Bank

Guarantee availability of free condoms

• Condoms are an effective method for prevention of HIV and STI transmission
• Make good quality condoms available
• Ensure sufficient supplies
• Distribution strategy
• Humanitarian staff also use condoms
• Where possible include existing IEC materials
• Monitor uptake (# “use”)
• Re-order based on uptake

Component # 4: Prevent excess neonatal and maternal morbidity and mortality

Prevent excess neonatal and maternal morbidity and mortality
• Emergency obstetric and newborn care (EmONC)
  ✓ Basic EmONC in primary health care facilities
  ✓ Comprehensive EmONC in referral hospitals
• Referral system for emergencies (transport/communication)
• Clean home deliveries

Maternal and Newborn Health (MNH)
Continuum promoting healthy mothers and babies through:

Care during pregnancy (Antenatal Care – ANC)

Pitfalls: ANC not part of MISP!

Care at the time of delivery, Including Emergency Obstetric Care services

Referral mechanisms: challenges and solutions

What if ensuring 24/7 referral services may not be possible due to insecurity in the area?

- Ensure that staff qualified in basic EmONC are available at all times at the primary health care level to stabilize patients with basic EmONC
- Establish system of communication (radio) to communicate with more qualified personnel for medical guidance and support
- Utilize ambulance network mobilization

The 3 Delays: What can be done in your setting?

1) Delay in the decision to seek care:
- Teach CHWs, women, men about the complications that need emergency treatment
  NOT PART OF THE MISP
2) Delay in reaching health facility:
- Initiate establishment of 24/7 referral system to manage EmONC (Emergency Obstetrics & Neonatal Care)
- Communication system (radio, mobile phone, medical record)
- Transportation (stretchers, vehicle, security, transport at night)
- Clean delivery kits distributed to all visibly pregnant women in case 2nd delay cannot be overcome and women need to deliver outside the health facility
3) Delay in receiving appropriate care at the health facility:
- Equip health centers and hospitals
- Train health workers in emergency obstetric procedures

Kits
6, 8, 9, 10, 11, 12
Comprehensive EmONC (CEmONC)
At hospital with operating theater
(1 per 150,000 – 200,000 people)
• Provided by team of doctors, anesthetists, midwives and nurses
• BEmONC (steps 1-6), plus
• Perform surgery (Cesarean section, laparotomy for ectopic pregnancy, anesthesia)
• Perform safe blood transfusion

Summary: MNH Crisis Situations
• Establish referral system
• Supply referral level (CEmONC)
• Midwife delivery kits (health facility, BEmONC)
• Clean delivery kits (home deliveries in case access to health facility not possible)
• Plan for antenatal care (ANC) and postnatal care (PNC) integrated into primary health care (PHC) services as soon as possible

Component #5:
Plan for comprehensive SRH services
• Plan for comprehensive RH services, integrated into PHC
✓ collect background information
✓ plan to integrate RH in health system reconstruction

<table>
<thead>
<tr>
<th>Health systems building blocks</th>
<th>Plan for comprehensive RH services, e.g.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service delivery</td>
<td>- identify RH needs</td>
</tr>
<tr>
<td></td>
<td>- identify suitable sites for RH service delivery</td>
</tr>
<tr>
<td>Health workforce</td>
<td>- assess staff capacity and train</td>
</tr>
<tr>
<td>Health information system</td>
<td>- include RH information in HIS</td>
</tr>
<tr>
<td>Medical commodities</td>
<td>- support/strengthen RH commodity supply lines</td>
</tr>
<tr>
<td>Financing</td>
<td>- identify RH financing possibilities</td>
</tr>
<tr>
<td>Governance, leadership</td>
<td>- review RH-related laws, policies, protocols</td>
</tr>
</tbody>
</table>

Role of RRT in implementing MISP during Disaster Preparedness
• Integrate MISP for SRH in Health Sector disaster Preparedness Plans (e.g. Five components)
• Ensure the capacity building of service providers
• Ensure the prepositioning or availability of RH Kits
• Strengthening coordination mechanism (Health & Protection Clusters, inter-cluster and DDRC)
• Establish strong co-ordination with existing partners
• Continue advocacy on the importance of SRH during emergency response

• Ensure the coordination through established mechanism
• Early identification of RH needs
• Ensure the RH services including the GBV
• Collect the information and availability of data
Learning Outcome
By the end of the session, the participant will be able to:
- Prepare a rational order of RH kits for the provision of RH services in crises or emergencies
- Know where to access key resources to support implementation of RH in crises

“Standard” population
- Adult males 20%
- Women of reproductive age (WRA) 25%
- Crude birth rate 4%
  - Number of pregnant women
  - Number of deliveries
- Complicated abortions/pregnancy 20%
- Vaginal tears/delivery 15%
- Caesarean sections/delivery 5%
- WRA who are raped 2%
- WRA using contraception 15%
  - Oral contraception 30%
  - Injectables 65%
  - IUD 5%

RH kits for emergency situations
13 Kits:
- Block 1 (kit 0 to 5)
  Primary health care/health centre level
  Supplies for 10 000 people for 3 months
- Block 2 (kit 6 to 10)
  Health centre level or referral level
  Supplies for 30 000 people for 3 months
- Block 3 (kit 11 and 12)
  Referral level
  Supplies for 150 000 people for 3 months

Rapid assessment & SRH
- Number and location of target population
- Number and location of health facilities
- Number and types of health care personnel
- SRH supplies logistics
**RH Kits for emergency situations**

**Block 1**
*Primary health care/health centre level*
*10 000 people for 3 months*

Kit
0  • Training and administration
1 A & B  • Condoms (male & female)
2 A & B  • Clean delivery (individual & attendant)
3 A  • Post-rape (EC/STI prevention)
3 B  • Post-rape (PEP)
4  • Oral and injectable contraception
5  • STI drugs

**Kit 2: Clean Delivery Kit**

**Kit 3: Rape Treatment Kit**

**RH Kit 5: STI Drugs**

**RH kits for emergency situations**

**Block 2**
*Health centre level or referral level*
*30 000 people for 3 months*

Kit
6  • Delivery (Health Centre)
7  • IUD insertion
8  • Management of complications of abortion
9  • Suture of cervical and vaginal tears
10  • Vacuum extraction

**Kit 6: Clinical Delivery (Health Facility)**
Management of Obstetric Complications such as PPH, eclampsia

Kit 8: Management of Complications of abortion (MVA set)

Kit 10: Vacuum Extraction for Delivery (Manual) Kit

RH kits for emergency situations
Block 3
Referral level
150 000 people for 3 months

Kit 11A
Kit 11B
Kit 12
• Surgical (reuseable equipment)
• Surgical (consumable items and drugs)
• Blood transfusion (HIV testing)

Important to remember
• RH Kit 6 & 11: Diazepam and pentazocin are controlled substances - required import licence from the country of destination prior to shipment, therefore should be procured locally
• RH Kit 6, 8, 11B & 12: Oxytocin and tests for blood group, HIV and Hepatitis as well as the Rapid plasma reagin (RPR) test need to be kept cool.
• Cold chain must be maintained during transportation and storage
Provide other important supplies

- Meet pre-existing family planning needs
  - Basic FP methods to meet spontaneous demand (Kit 4 & 7)
- Ensure syndromic treatment for STIs
  - Antibiotics to treat people presenting with an STI symptom (Kit 5)
- Meet needs for menstrual protection
  - “Hygiene” or “dignity” kits

Hygiene Supplies

- There is no “global” kit, it is community specific
- For women:  
  - sanitary supplies for 3 months  
  - Underwear (3 large)  
  - soap, soap powder, toothpaste, toothbrush, aspirin  
  - bucket for washing  
  - what else? ASK!
- For men  
  - shaving supplies, soap, toothbrush, toothpaste  
  - condoms

Hygiene supplies

- No “global” kit, community specific
- For women: Dignity Kits (17 items)
- Reusable sanitary Napkins, underwear, Petticoat, Maxi, T-shirt, Sari/Dhoti, Sweater, Shawl, Thin Towel (Gamchha), Flash Light, Cloth washing soap,Comb, Nail Cutter, Tooth Brush, Tooth Paste, Bathig Soap, Bag to keep Clothes or Bucket
  - what else? ASK!
- For men
  - shaving supplies, soap, toothbrush, toothpaste
  - condoms
  - what else? ASK!

In-country transport and distribution

RH kits for emergency situations

Who does what?

- Determine needs and make a distribution plan
- Contact UNFPA Country Office or HQ (HRB or PSB)
- Funding: NGO’s own funds, Flash, CERF, CAP
- UNFPA - HRB can assist in determining needs
- UNFPA Procurement Services: pro-forma invoice, contacts shipping agents, shipping arrangements
- Supplies shipped within 48 hours

www.womenscommission.org
www.rhrc.org

(Reproductive Health Response in Conflict)
RH in Emergency

Unit 3.4:
Sub Topic:
d) Monitoring and Evaluation of MISP Indicators

Learning outcomes

By the end of the session, the participant should be able to:
- Conduct basic monitoring and evaluation for the MISP implementation
- Outline existing needs assessment tools to plan for comprehensive SRH

Monitoring and Evaluation of MISP Indicators

Plan for COMPREHENSIVE SRH services, integrated into Primary Health Care

• Baseline SRH information and Monitoring and Evaluation
• Identify sites for future delivery of comprehensive SRH
• Assess staff and identify training protocols
• Procurement channels

Five essential components of Monitoring and Evaluation

1. Definition of essential data to collect
2. Systematic collection of data
3. Organization and analysis of data
4. Implementation of health interventions based on the data
5. Re-evaluation of interventions

MISP Basic Demographic and Health Information

<table>
<thead>
<tr>
<th>Basic demographic and health information</th>
<th>1st month</th>
<th>2nd month</th>
<th>3rd month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of women of reproductive age (age 15-49, estimated at 25% population)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Number of adult male (estimated at 20% of population)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude birth rate (estimated at 4% of population)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age specific mortality rate (including neonatal death 0-28 days)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex specific mortality rate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Confidential health
Coordination 1st
team
Staff
Material
Sexual
Sufficient
HIV
knowledgeable
Condom procured
Bank)
SGBV
Maternal
%
#
checklist
MISP
Transmission
of
trained
of
health
for
maternal
neonatal death
Transfusion
of
integrated
implementation (retrained) in
multi
District
health
FOR
WHO,
status
Current
Gap/s identified
(WHAT, WHERE, WHEN, WHO)
Action to be taken
(WHAT, WHERE, WHEN, WHO)
Response
Preparadness
Budget
Remarks

District Disaster (RH) Action Plan

MISP Indicators for M & E

<table>
<thead>
<tr>
<th>Coordination</th>
<th>1st month</th>
<th>2nd month</th>
<th>3rd month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall RI coordinator in place and functioning under health coordination team or health cluster</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Material for implementation of the kit available and used</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinated multi-sectoral systems to prevent sexual violence in place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidential health services to manage cases of sexual violence in place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff trained (retrained) in sexual violence prevention and response</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Transmission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sufficient materials in place for universal precautions by trained knowledgeable health workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom procured and made available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood for transfusion consistently screened (Link with NRCS and Blood Bank)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MISP Indicators for M & E cont...

Maternal and Neonatal Mortality and Morbidity

% of Obstetric complication
# of maternal death
# of neonatal death
SGBV integrated in to health care delivery mechanism

MISP monthly data collection linking with HMIS

<table>
<thead>
<tr>
<th>Monthly data collection</th>
<th>1st month</th>
<th>2nd month</th>
<th>3rd month</th>
</tr>
</thead>
<tbody>
<tr>
<td># of condom distributed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of CHDK distributed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of sexual violence cases reported in all sectors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of health facilities with supplies for universal precautions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic demographic and health data collected</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MISP Indicators for M & E

<table>
<thead>
<tr>
<th>Maternal and neonatal mortality and morbidity</th>
<th>1st month</th>
<th>2nd month</th>
<th>3rd month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear: Home delivery kit (CHDK) available and distributed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calculate the # of CHDK needed to cover govt births for 3 months (estimated population = 0.04x25)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RH including CHDK kits available in the health centres</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral hospital assessed and supported for adequate number of qualified staff, equipments and supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral system for Obstetric emergencies functioning 24/7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post referral services shelter provisioned</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning kit Comprehensive RH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic background information collected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sites identified for future delivery of comprehensive RH services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff assessed, training protocols identified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procurement channels identified and monthly drug consumption assessed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Unit 3.5: Mental Health in Disaster

CONTENT
- Introduction
- Mental health Consequences of Disaster
- Nepal Perspective
- Intervention: Prevention/Treatment
- Q & A

OBJECTIVE
- Increase awareness
- Motivation for all stakeholders
- “Do No Harm”

INTRODUCTION
- Disaster = Distress
  - Physical/ economic/ecological dimension
  - Emotional
  - Psychological/social/Cultural
  - Spiritual

Who are Affected?
- “No people who experience disaster is untouched by it”
- Directly affected people
- Indirectly affected:
  - Witnessing a traumatic event (eye witness or television)
  - Learning of a family or friend’s traumatic experience
  - Responders also experience stress

Psychological Consequences of a Disaster

Distress Responses

- PTSD
- Acute Psychosis
- Major Depression
- Anxiety disorder
- Alcohol & Sub use

Behavioral Changes

- Change in travel patterns
- Smoking
- Alcohol consumption

Phases of Disaster: Emotional Response

- Pre-disaster
- Disillusionment (LGBQ
- Rebuilding

Timeline:
- 1 to 3 Days
- 1 to 3 Years

Trigger Events and Anniversary Reactions
Common Responses to a Traumatic Event

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Emotional</th>
<th>Physical</th>
<th>Behavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td>poor concentration</td>
<td>confusion</td>
<td>light-headedness</td>
<td>irritability</td>
</tr>
<tr>
<td>disorientation</td>
<td>feeling overwhelmed</td>
<td>dizziness</td>
<td>arguments with friends and loved ones</td>
</tr>
<tr>
<td>indecisiveness</td>
<td>feeling lost</td>
<td>gastro-intestinal problems</td>
<td>withdrawal</td>
</tr>
<tr>
<td>shortened attention span</td>
<td>fear of harm to self and/or loved ones</td>
<td>rapid heart rate</td>
<td>excessive silence</td>
</tr>
<tr>
<td>memory loss</td>
<td>feeling nothing</td>
<td>tremors</td>
<td>inappropriate humor</td>
</tr>
<tr>
<td>unwanted memories</td>
<td>feeling abandoned</td>
<td>grinding of teeth</td>
<td>increased/decreased eating</td>
</tr>
<tr>
<td>difficulty making decisions</td>
<td>uncertainty of feelings</td>
<td>fatique</td>
<td>change in sexual desire or functioning</td>
</tr>
<tr>
<td></td>
<td>volatile emotions</td>
<td>poor sleep</td>
<td>increased smoking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>pain</td>
<td>increased substance use or abuse</td>
</tr>
</tbody>
</table>

Factors Influencing Response to Traumatic Events:

1. The Disaster:
   - Degree and nature of exposure
2. The community
   - Level of preparedness, available resources and social support, past experience, culture, leadership
3. The Victims
   - Developmental level: Age, education
   - Mechanisms or coping strategies/ personality
   - Ability to understand what has happened
   - Personal meaning of the event:
     * perceived disruption, support and benefit

Typical Reactions—children

- fears and anxieties
  - crying, whimpering, screaming
  - excessive clinging
  - fear of darkness or animals
  - fear of being left alone
  - fear of crowds or strangers
  - problems going to sleep/bedwetting
  - nightmares
  - sensitivity to loud noises
  - alcohol and other drug use

- irritability
  - confusion
  - disobedience
  - depression
  - refusal to go to school
  - reluctance to leave home
  - behavior problems in school
  - poor school performance
  - fighting

Help: General Principle

- Reassurance: verbal support
- Correct Information: honest but discrete frightening details. When viewing news better together, with volunteers to answer questions
- Encourage to express emotions. Listen attentively
- Try to maintain a normal household, social and recreational activities when appropriate.
- Acknowledge reactions associated with the traumatic event, and help take steps to promote physical and emotional healing (appropriate help seeking)

Populations at Risk for Psychiatric Problems

- Those exposed to the dead and injured
- The elderly or the very young
- People with a history of previous exposure to traumatic events
- Previous history of mental illness.

Some Do’s

- Do Say-
  - These are normal reactions to a disaster.
  - It is understandable that you feel this way.
  - You are not going crazy.
  - It wasn’t your fault, you did the best you could.
  - Things may never be the same, but they will get better, and you will feel better.
Don’t say:

- It could have been worse.
- You can always get another pet/house.
- It’s best if you just stay busy.
- I know just how you feel.
- You need to get on with your life.

Psychological First Aid (PFA)

**Definition**

- An approach designed to
  - provide basic comfort and support
  - reduce the initial stress caused by traumatic events
  - foster short and long term adaptive functioning

Psychological First Aid

Who? When? Where?

- Used during and immediately after trauma/disaster
- PFA can be used by anyone
- May be used for everyone, adults and children
- May be used anywhere
- Provides immediate emotional and practical support

Basic Objectives

- Listen
- Help people feel safe
- Offer practical assistance
- Connect to social supports
- Provide information on response, recovery, stress and coping
- Enable to take care of self

Delivery...

- Be visible
- Maintain confidentiality
- Operate within your organizational rules of survivor engagement
- Be calm, courteous, organized and helpful
- Be sensitive to cultural, ethnic and community concerns
- Operate within your comfort level

Behaviors To Avoid

- Never presume to know everything what the person is experiencing
- Do not assume that everyone is traumatized
- Do not label/diagnose or patronize
DISASTER COUNSELING SKILLS

• Disaster counseling involves both listening and guiding, but *not imposing*!

• **ESTABLISHING RAPPORT**
  - Conveying respect and being nonjudgmental are necessary ingredients for building rapport.

• **ACTIVE LISTENING**
  - Some tips for listening are:
    * Allow silence - time to reflect and become aware of feelings, prompt the survivor to elaborate. Simply "being with" the survivor and their experience is supportive.
    * Attend nonverbally - eye contact, head nodding, caring facial expressions, and occasional "uh-huhs" let the survivor know that the worker is in tune with them.

DISASTER COUNSELING SKILLS cont...

• **Paraphrase** —
  - repeat portions of what the survivor has said, understanding, interest, and empathy are conveyed
  - checks for accuracy, clarifies misunderstandings, and lets the survivor know that he or she is being heard.

• **Reflect feelings** —
  - notice that the survivor’s tone of voice or nonverbal gestures suggests anger, sadness, or fear
  - helps the survivor identify and articulate his or her emotions.

• **Allow expression of emotions** —
  - tears or angry venting is an important part of healing; I
  - work through feelings so that better engage in constructive problem-solving.
  - let the survivor know that it is OK to feel

When to Refer to Mental Health Services?

• **Disorientation** - dazed, memory loss, inability to give date or time, state where he or she is, recall events of the past 24 hours or understand what is happening

• **Mental Illness** - hearing voices, seeing visions, delusional thinking, excessive preoccupation with an idea or thought, pronounced pressure of speech (e.g., talking rapidly with limited content continuity)

• **Inability to care for self** - not eating, bathing or changing clothes, inability to manage activities of daily living

• **Suicidal or homicidal thoughts or plans/acts**

• **Problematic use of alcohol or drugs**

• **Domestic violence, child abuse or elder abuse**

POST-TRAUMATIC STRESS DISORDER

Following S/S present for longer than one month:

• **Re-experiencing** the event trauma-specific nightmares or flashbacks, or distress over events that resemble or symbolize the trauma.

• **Routine avoidance** of reminders of the event or a general lack of responsiveness

• **Autonomic Arousal**: Increased sleep disturbances, irritability, poor concentration, startle reaction, regressive behavior

Post Traumatic Stress Disorder cont...

• Rates: 2 - 29%

• May arise weeks or months after the event

• May resolve without treatment, but some form of therapy by a mental health professional is often required

• Vulnerability to developing PTSD:
  - characteristics of the trauma exposure itself
  - characteristics of the individual
  - post-trauma factors (e.g., availability of social support, emergence of avoidance/numbing, hyper-arousal and re-experiencing symptoms)

Prevent Suicide

• **Get help from professionals.** Ask for help from doctors or other leaders who are trained to help

• **Stay in touch with family.**

• **Stay active**

• **Keep busy.** Help others in need, community or school etc

• **Suicide HELPLINE..**
Key Messages

• Many mental health consequences:
  • Disaster stress and grief reactions are normal responses to an abnormal situation
  • Several Mental disorder may be precipitated
  • The burden/ morbidity not less than any physical illness
• Social support systems are crucial to recovery
• Mental health intervention must be incorporated along with other health plans:
• Preventable+ treatable with proper intervention
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