

Concept Health in Emergencies

SRC International Cooperation



Swiss Red Cross

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Acronyms

BHC	Basic health care
DREF	Disaster Relief Emergency Fund
ERT	Emergency response team
ERU	Emergency response unit
FACT	Field assessment and coordination team
HIV	Human immunodeficiency virus
ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
IMCI	Integrated Management of Childhood Illnesses
LRRD	Linking relief, rehabilitation and development
MNCH	Maternal, neonatal and child health
MSF	Medecins Sans Frontières
NCD	Non-communicable disease
NGO	Non-governmental organisation
PNS	Participating National Society
RDU	Rapid deployment unit
RDRT	Regional disaster response team
SDC	Swiss Agency for Development Cooperation
SRC	Swiss Red Cross
WASH	Water, sanitation and hygiene
WHO	World Health Organization

1 Introduction

1.1 Rationale and scope

Climate change, population growth and conflicts are increasing the number and complexity of disasters. They have a negative impact on the basic health of the people affected as well as on the capacity of the health system to respond to those needs. The Swiss Red Cross (SRC) responds to the needs of vulnerable people affected by disasters by saving lives, alleviating suffering and responding to basic health needs. Additionally, the SRC provides support for the local health systems' capacity to prepare for and respond to disasters. To this end, the SRC operates in emergency relief, reconstruction/rehabilitation and long-term development cooperation.

The SRC applies the integrated approach to disaster management that has been adopted by the International Federation of Red Cross and Red Crescent Societies (IFRC) and is defined as “the organisation and management of resources and responsibilities for dealing with all humanitarian aspects of emergencies (...) in order to decrease the impact of natural and man-made hazards and the possibility of disaster”.¹ Thus, apart from ensuring the survival of the people concerned, the SRC supports measures to lessen the impact of disasters, enhance household and community coping mechanisms, restore or improve pre-disaster living conditions and develop organisational and community preparedness and response capacities. Although the SRC does not work directly in conflict situations, it provides support for conflict victims (e.g. who are fleeing the conflict to neighbouring districts or countries). The concept presented in this publication therefore applies by analogy to situations of conflict and humanitarian crisis.

This thematic concept is the SRC's response to recent trends in disasters and disaster management with regard to health. It outlines the SRC's basic principles and priority action areas relating to health and the health sector during an emergency. Interventions associated with the determinants of health, e.g. water, sanitation and hygiene (WASH) and nutrition are further elaborated in concepts of their own. The concept takes account of experience and lessons learned from past operations. Its primary purpose is to establish the framework of reference and action for SRC staff in the Department of International Cooperation (IC Department), but it is also intended to serve as a basis for dialogue within the International Red Cross and Red Crescent Movement and with partner organisations, public authorities, donor agencies and other interested institutions. A learning process on “Health in fragile contexts” within the SRC's IC Department covers the period from 2013 to 2016. The aim of the learning process is to specify targeted interventions for health in fragile contexts. Findings will feed into the health in emergencies concept in the years ahead.

1.2 Strategic and institutional framework

The SRC Strategy 2020 for International Cooperation defines two principal core areas: health and disasters. The health in emergency concept lies at the intersection of both sectors and represents one of the thematic priorities of the International Cooperation Department. Apart from the Strategy, the two most relevant concepts of the SRC policy framework are the Health Policy and the Disaster Management Concept. The conceptual objective of the health in emergencies concept is to bring those policies together as one thematic concept.

The SRC bases its activities on the seven Fundamental Principles of the International Red Cross and Red Crescent Movement: humanity, impartiality, neutrality, independence, voluntary service, unity and universality.

SRC's work is guided by the policy framework of the IFRC and the SRC:

IFRC Strategy: The IFRC's Strategy 2020 "Saving Lives, Changing Minds"ⁱⁱⁱ renews the commitment to humanitarian aid and calls for more action to prevent and reduce the underlying causes of vulnerability. "Health in emergencies" unites Strategic aim 1 (save lives, protect livelihoods and strengthen recovery from disasters and crises) with Strategic aim 2 (enable healthy and safe living).

SRC Strategy 2020: The SRC's overarching strategy defines disaster management and development cooperation as one of its four core business areas. This intervention area relates exclusively to SRC engagement at the international level.

SRC Strategy 2020 for International Cooperationⁱⁱⁱ: The SRC's overall goal for international cooperation is to enable healthy and safe living for vulnerable groups and communities. Within the Strategy 2020 for International Cooperation, health in emergencies covers both spheres of activity, the sphere of activity for disasters and the sphere of activity for health. The thematic priorities for health in emergencies are basic health care and epidemic control.

SRC Health Policy^{iv}: The health policy defines seven thematic intervention priorities, one of which is health in emergencies.

SRC Disaster Management Concept^v: The SRC focuses on five thematic priorities: health; water, sanitation and hygiene; shelter and non-food items; food security and livelihood support; restoring family links.

Other SRC concepts: Additional guidance is provided by the concepts on linking relief, rehabilitation and development (LRRD), the concept on partnership and the concept on knowledge management.

The SRC adheres to the following standards:

- The Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organisations in Disaster Relief;^{vi}
- The Humanitarian Charter and Minimum Standards in Disaster Response (Sphere).^{vii}

In addition, the SRC uses the following guidelines:

- Public health guide in emergencies (John Hopkins and Red Cross/Red Crescent);^{viii}
- Médecins Sans Frontières (MSF), Clinical Guidelines, Diagnosis and Treatment Manual, Essential Drugs;
- MSF, Guidelines for Cholera and Meningitis;
- World Health Organization (WHO), HIV/AIDS guidelines in emergencies and IASC Guidelines for Addressing HIV in Humanitarian Settings;^{ix}
- WHO/UNISDR/PHE, Disaster Risk Management for Health Fact Sheets;^x
- WHO, Guidelines for medicine donation;^{xi}
- PAHO/WHO/ICRC/IFRC, Management of Dead bodies after Disasters.^{xii}

1.3 Building on SRC experience of health in emergencies over the past decade

The SRC is a major player among Swiss humanitarian organisations and enjoys broad public confidence. It is viewed by donor agencies as a professional organisation and known as a competent and reliable partner within the International Red Cross and Red Crescent Movement (Movement). As a member of the Movement, the SRC is part of the world's largest humanitarian and development network of volunteers and staff. Its range of experience related to health in emergencies spans the following areas:

- The SRC has a pool of experienced health specialists (nurses, doctors, laboratory technicians and midwives).
- The SRC has geographically broad experience in health in emergencies in Africa, the Americas and Asia.
- The SRC has contributed to ensuring access to basic health care services in various major and medium-sized disasters.
- The SRC has contributed several times to the treatment and prevention of epidemics (cholera, meningitis) in various contexts.
- The SRC has experience of sharing and using multilateral operational tools, joint training programmes and Movement-wide cooperation mechanisms and is well aware of the advantages and limitations of coordinated response operations.
- The SRC supports a model programme of public health in emergencies as part of disaster preparedness and has integrated the LRRD approach into long-term development programmes.
- The SRC builds on vast and outstanding experience gained through implementing long-term development projects in the health sector.

In the coming years, the SRC will focus in particular on:

- strengthening its own response capacity with regard to health in emergencies and linking it with WASH, shelter, food security and restoring family links;
- strengthening the local preparedness for health in emergencies in all SRC programmes;
- setting up a pool of junior and senior staff for SRC operations as well as secondments to the IFRC and the International Committee of the Red Cross (ICRC);
- providing health in emergencies management capacity development for partner organisations;
- further strengthening the continuum from the emergency onset to early recovery and development (where feasible) using the LRRD approach, in particular within rapid response teams (i.e. in public health, preparedness and early recovery).

2 Context and challenges for the SRC

2.1 Impact of disasters on health

The importance of health in emergencies becomes clear when one looks at the diverse and serious effects that disasters have on health and health systems:

- Possible breakdown of local health systems, depending on the magnitude of the disaster and local capacities/preparedness;
- Lack of access to health facilities because facilities, roads and transport to the facilities are destroyed;
- Lack of adequate health personnel because health personnel themselves are victims of the disaster and the remaining staff may be unable to cope with the large volume of health needs;
- Lack of sufficient resources, such as medicines and consumables, to deal with the sudden magnitude of demand;
- Lack of access to safe drinking water and sanitation facilities;
- Lack of sufficient quantity and quality of food due to the destruction of livelihoods and lack of food stocks.

The above situations lead in turn to:

- Increased incidence of different types of diseases, in particular injuries and trauma;
- Increased probability of an outbreak of epidemics and communicable diseases;
- Increased nutritional deficiencies;
- Increased need for mental health and psycho-social support following the sudden onset of a disaster;
- Increased need for medication and medical supplies for people who suffer from non-communicable diseases and require constant care (e.g. diabetes).

2.2 Global trends

With the emphasis being on hazards and vulnerability, the SRC considers the following global issues and trends to be particularly relevant.

- **Growing differences between rich and poor:** Disasters tend to have a much stronger (negative) impact on the poor and vulnerable than on the rest of the population as they do not have adequate resources to prepare for, cope and recover from shocks. Therefore, reducing poverty and enhancing preparedness are key factors in addressing vulnerabilities and are at the centre of the SRC's long-term programmes.
- **Population growth and increasing pressure on natural resources:** These two issues are key factors (among others) of gradual environmental degradation, resource shortfalls, price rises and increased tension, augmenting exposure to risks and weakening coping mechanisms, particularly among the poor.
- **Climate change:** Unpredictable and extreme weather puts a strain on food production and causes more frequent and severe natural disasters (i.e. droughts, floods, typhoons). The increased occurrence of droughts or floods, for example,

worsens the already precarious food security and leads to chronic hunger and malnutrition.

- **Fragile States:** An estimated one billion people live in fragile contexts. They are exposed to changing and nebulous conflict patterns that are becoming increasingly complex and longer lasting and involve non-State actors. The governments of fragile States are usually unable or unwilling to provide services and security, making large sections of the population particularly vulnerable to natural hazards and violence.
- **Migration and urbanization:** Domestic and international migration, including forced migration caused by conflicts (internal displacement and refugees), is on the rise and is the outcome of the above-mentioned (and other) issues. The affected people, both migrant and host communities, become more vulnerable. Much of the migration is into urban areas that are unable to absorb the large numbers of migrants. As a consequence, one in three urban residents lives in a slum, suffering from poor water, sanitation and hygiene, food shortages and the absence of basic health services. They often live in particularly risk-prone areas (subject to flooding, earthquakes and violence) as urban development has often outpaced safe planning.
- **Health and epidemic trends:** Injuries and trauma are the most prevalent and urgent health concerns that need to be addressed immediately after the sudden onset of a disaster. Lack of safe drinking water and the quick spread of communicable diseases as a result of dense living conditions after disasters lead to the outbreak of epidemics. However, new epidemics and viral strains such as the coronavirus and HxNx are emerging. They cause sudden public health disasters such as SARS, swine flu or bird flu, which affect animals and humans alike.

Epidemic trends and disease outbreaks can encompass diseases that a country may never have experienced before. Induced by climate change or a fragile context, these public health concerns are mostly of slow onset and require preparedness measures.

In recent emergencies, the above-mentioned trends have often occurred simultaneously. As a result, disasters are becoming increasingly complex, involving the combination of natural hazards with an adverse socio-economic environment (e.g. economic crisis, armed conflict, poor governance, corruption, organized crime and social unrest). The challenge of enhancing development and protecting people from disaster becomes increasingly daunting for most developing countries and for virtually all fragile states.

2.3 Challenges for humanitarian actors

The SRC takes into account the key challenges facing humanitarian action and its players.¹

- **Proliferation of humanitarian players:** The number of organisations involved in providing humanitarian aid has risen significantly in recent years. As a result, disaster relief has become much more competitive. Health is one of the most competitive sectors and not all competitors are willing or able to adhere to agreed humanitarian standards. On the donor side, a growing number of trusts, companies and foundations are developing their own humanitarian components, approaches and strategies. This privatisation of humanitarian aid holds potential but also presents a challenge.

¹ The challenges are defined in Chapter 2.2 (p. 6) of the Disaster Management Concept.

- **Human resources:** Disaster response requires the deployment of experienced staff at very short notice. Experienced health personnel need to keep up to date with rapidly evolving medical standards as well as to gather practical experience in the field and in emergency situations. This applies, in particular, to major and complex disasters. In the wake of disasters, job markets dry up very quickly and finding people with the right background, expertise and experience is a key issue. This phenomenon of scarce human resources applies both to the country affected by the disaster and to the country wishing to engage in humanitarian assistance.
- **Access, acceptance and security:** Humanitarian access is a precondition for humanitarian action. In recent years, access to conflict or disaster-affected populations has been increasingly subject to many types of constraints. These include security concerns, bureaucratic red tape, the marginalisation of affected population groups based on their ethnic, religious or other status, the diversion of aid, interference in the delivery of relief and the implementation of activities, and politically and/or economically motivated attacks on humanitarian personnel. Furthermore, the local perception of humanitarian organisations or understanding of humanitarian aid may present additional obstacles to effective humanitarian assistance.
- **Forgotten disasters:** Attention and funds tend to be directed towards major natural disasters. Ongoing emergencies and complex, slow-onset disasters are often neglected and underfunded. This tendency is intensified by the media, which have an enormous influence on audience interest and solidarity and hence a strong impact on the level of disaster response.

3 Guiding principles

The SRC health in emergencies programmes follow the guiding principles of the SRC Strategy 2020 for International Cooperation, those of the concept for disaster management and the health policy.

Focus on particularly vulnerable and deprived groups of people: The SRC programmes strive to meet the health needs of those who have been most affected by the disaster in terms of having lost access to health services and being exposed to public health hazards triggered by the disaster. The SRC programmes ensure that access to health services is restored and that services are affordable for the population, in particular for the most disadvantaged people such as women, children, the elderly and the disabled. The services are designed to give priority to meeting those needs and special requirements, for example in terms of nutrition and sexual and reproductive health.

Realizing the right to health: Although each human being has the right to health throughout his or her lifetime, exercising this right to health may be disrupted by the unavailability of services or the lack of physical access in an emergency. SRC health in emergency interventions help reinstate health service provision in the affected area and thus ensure that each person can exercise his or her right to health as quickly as possible after the onset of a disaster.

Empower communities and individuals to take self-determined action and reinforce self-help capacity: The SRC carefully assesses the availability and functionality of health services after a disaster based on the health systems building blocks model (see Annex 1). It strives to support services which are still functioning or partly functioning. The SRC uses

existing local resources in terms of health care infrastructure and local human resources in order to strengthen existing capacities. Local Red Cross volunteers or other community volunteers can play an important role in promoting the health services and in identifying patients who require outreach services. The volunteers are the link between provider and community and provide valuable services to the people. The retention of volunteers is enhanced through regular capacity building, motivation and small incentives. Building on local strengths helps to increase the self-help potential of the communities and the State and enables them to gradually take over and rebuild their own health system.

Cooperate in partnerships, promote alliances and participate in networks: The SRC works with local partners, in particular the local Red Cross or Red Crescent Society and the Ministry of Health. In all interventions, the SRC follows the national health policies or WHO guidelines. The capacity of the local partner organisations is strengthened with the aim of enabling them to manage health services independently again and even better than before the disaster. The SRC also works with international partners and participating National Red Cross and Red Crescent Societies (PNS).² In disaster response activities, this includes, for example, working with PNS which operate field hospitals or basic health care emergency response units (ERUs). Within the network of partners and alliances, a functional referral system is established to refer patients to the appropriate secondary or tertiary provider as considered necessary.

Do no harm and take conflict-sensitive action: Before health services are provided after a disaster, an assessment of the needs and the context is first carried out. The SRC always considers the unintended negative effects of its work (do no harm). Conflict-sensitive project management is therefore a fundamental component of project management in all areas. The SRC carefully assesses the connectors and dividers in a community and provides services equally for all segments of the population, with a special focus on the most vulnerable. Together with the other stakeholders, intervention areas are carefully selected to ensure the best possible service coverage with equal access for all.

4 Objectives and implementation

4.1 General objective

In emergencies, the SRC aims to save lives and alleviate suffering by responding to the basic health needs of vulnerable people affected by disasters.

Health in emergencies is provided in rural and urban settings with the objective of providing basic health services in which the emphasis is on prevention, health promotion and universal access to health as well as on controlling epidemics in sudden and in slow-onset disasters. In emergency situations, this means supporting the local health system in providing services or acting as a substitute for them if they have been significantly disrupted. In particular, the SRC engages in the following building blocks of a health system: service delivery, medicines, and technology, human resources and financing (see Annex 1). The

² In particular, the SRC has an agreement with the German Red Cross which provides that in case of a deployment of the Basic Health Care ERU or field hospital, SRC delegates will be part of its staff.

interventions depend on the magnitude of the disaster and the needs expressed by the affected country's health system.

4.2 Specific objectives

The SRC provides health in emergency in relief situations following a disaster as well as includes preparedness for health in emergencies at the local level in its long-term development programmes. SRC support may be complemented by measures in the sectors of shelter, food security/nutrition and WASH. Their application to health in emergency is elaborated in the individual thematic concepts.

The following specific objectives apply for health in emergencies:

- a) *Mechanisms within Switzerland and the Red Cross Movement are functional and enable immediate action and reaction in health emergencies ensuring that*
 - Access to basic health services is gained

Depending on the magnitude of the disaster and the capacity of the remaining health structures, the SRC replaces, substitutes or supports the local health services. From the outset, the local health system and health provider staff are integrated and supported.

In an emergency, SRC specialists diagnose, treat and care for injuries and trauma, communicable and non-communicable diseases (NCDs) as well as maternal and neonatal child health (MNCH) including safe delivery and the integrated management of childhood illnesses (IMCI). Health care is provided in collaboration with the existing local health structures and in joint operation with the local and international Red Cross or Red Crescent partners. Depending on the needs of the country, health care interventions can take place at different levels within the health care system. For example, this can be at primary health care level, providing basic health services through a basic health care ERU. In another situation, the SRC specialists may work in a field hospital, providing secondary or tertiary level care. Depending on the situation, the level of health care may exceed basic health care services. Annex 2 presents the different health services provided by SRC specialists.

SRC supports the repair and construction of temporary health infrastructures or supplies large tents for intermediate use until the health services have been rebuilt and are fully operational. The repair and reconstruction work includes the provision of water and sanitation facilities.

SRC programmes ensure that the health care system has access to necessary medicines and equipment. Depending on the needs in the specific emergency, the SRC purchases and delivers specific medicines or equipment. The health and epidemiological profile of the affected population may require context specific consumables and medicines including anti-retrovirals and post-exposure prophylaxis in a HIV high-prevalence country and medication for NCDs (diabetes, high blood pressure) in order to counteract the interruption of treatment caused by the disaster. Depending on the availability and the local rules and regulations, those items are purchased locally or delivered from abroad.

Alternatively, the SRC may use a “cash for health” approach to ensure that the beneficiaries have access to health services in a country where services are still functional.

- Epidemics are controlled

The SRC works on the prevention, control and treatment of infectious diseases. In case of an outbreak of an epidemic (e.g. cholera, meningitis, viral infections), SRC specialists provide preventative interventions and treatment. Health and hygiene messages are also transmitted through the National Society's volunteer network in support of the local authorities and WHO.

The SRC also targets root causes of epidemics, particularly if they are water-borne. WASH interventions extend from ensuring a supply of safe drinking water through water trucking, water point cleaning and repair and water purification to the construction of public latrines and the dissemination of hygiene messages.

Public health in emergency programmes are particularly geared to preparation for epidemic outbreaks. While preparedness has so far focused on the outbreak of water-borne and vector-borne diseases, an expansion to incorporate the integrated management of epidemic diseases as well as global alert and response for newly emerging epidemics such as SARS, bird flu, swine flu, etc. requires further consideration and development.

b) Local preparedness mechanisms for health emergencies are established

In order to better understand the synergies between disaster and health, the SRC has started a learning and screening process of its programmes in countries recurrently affected by disasters. The aim is to enhance the emergency preparedness in focus countries. Each country will elaborate its own emergency preparedness plan, which will cover the local partners and their responsibility as well as the responsibility of the SRC programme in a health emergency.

A long-term development programme can enhance the preparedness and the ability of a health system or of a local Red Cross or Red Crescent Society to react immediately in a health emergency (e.g. outbreak of a cholera epidemic). Specific preparedness programmes for health emergencies may have a public health in emergency focus, preparing a Red Cross or Red Crescent Society to act and react in public health disasters or to work with the Ministry of Health to equip health centres and to build the capacity of health personnel so that they are able to react appropriately in health emergencies.

Likewise, preparedness for disasters and health emergencies is an integral part of the SRC blood security concept. The concept outlines how national blood transfusion systems engage in disaster preparedness by having a contingency plan, by ensuring that the national blood transfusion services remain functional and accessible in all types of disaster and that blood centres have sufficient stocks to provide for trauma surgery.

5 Implementation

In order to implement the above-mentioned objectives, the SRC has the following instruments and cooperation mechanisms at its disposal:

5.1 Multilateral cooperation

In major disasters, the SRC generally operates within the Movement framework during the emergency relief phase. Multilateral cooperation is usually led by either the IFRC or the ICRC, depending on the type of disaster. Movement coordination includes information gathering, crisis management, decision-making processes and the coordination of operations. The SRC's rapid response tools for health in emergencies contribute to the following:

- **Basic Health Care Emergency Response Unit (BHU-ERUs):** Drawn from the SRC pool of health experts and usually deployed as SRC secondments to the field hospital or basic health care ERUs of other National Societies.
- **FACT/RDRT/RDU:** The SRC develops a pool of medical and public health experts participating in global or regional deployment in the field assessment and coordination team (FACT), the regional disaster response team (RDRT) or rapid deployment unit (RDU).
- **Operations managers:** The SRC develops a pool of medical and public health experts for IFRC programmes.
- **Contributions to appeals:** Contributions to IFRC or ICRC appeals/operations, earmarked for health in emergency response operations.
- **Purchase/supply of relief items:** Contributions of medical items to Movement operations.

5.2 Bilateral cooperation

In SRC focus countries, health in emergencies activities are usually carried out together with the partner organisation (National Society or non-governmental organisation) in a direct, bilateral approach. In other countries, the SRC may also work directly with the host National Society from the outset of a disaster, supporting emergency operations carried out by national teams with or without SRC staff. Furthermore, the SRC switches to bilateral cooperation as soon as the response to major disasters moves into the early recovery phase. Under this approach, the SRC usually builds up its own structure but coordinates closely with the IFRC and the United Nations clusters concerned and aligns its interventions at programme level. In bilateral operations, the SRC assumes the tasks of information gathering, crisis management, decision-making and operations in close coordination with the local partner. Rapid response tools include:

- **Emergency response team (ERT):** Experts from the global pool and/or staff of SRC delegations, with expertise in basic health care, epidemics and/or public health;
- **Swiss Rescue:** Liaison person for coordination with the Movement; health delegate;
- **Cash contributions:** Earmarked contributions to host National Society health in emergency operations;
- **Purchase/supply of medicines and/or medical equipment:** Contributions to host National Society operations.

5.3 Partnerships and alliances

Partnerships and alliances with the relevant stakeholders are essential to the provision of efficient and effective health services in emergencies. Working in partnerships also means anchoring the activity in the local context over the long term.

The SRC involves and maintains alliances with different stakeholders at various levels:

- **National authorities:** The SRC seeks the permission of and cooperation with the national authority in charge of ensuring health care during emergency situations. The SRC intervention adheres to the policies, rules and regulations of the host country;
- **International Red Cross and Red Crescent Movement:** Strategic and operational partnerships with host National Societies, alliances of like-minded National Societies, Participating National Society cooperation for joint operations or co-funding of SRC operations, ICRC secondments for relief operations in conflict settings (e.g. RDUs);
- **Swiss Agency for Development and Cooperation (SDC) /Humanitarian Aid:** Joint deployments, joint missions, member of Swiss Rescue, general coordination, collaboration and exchange of expertise and resources (while strictly adhering to the Movement's Fundamental Principles and Code of Conduct);
- **Multilateral organisations and local non-governmental organisations (NGOs):** The SRC follows the guidelines of MSF and coordinates its activities with the health cluster and other organisations active in the health sector. Occasionally, the SRC may engage in an ad hoc partnership with WHO and/or local NGOs in the health sector to implement a response project.
- **Alliances with Swiss NGOs:** Strengthening partnerships and building synergies in niche areas, for operational and communication purposes and for cooperation in key sectors;
- **Institutionalised partnerships with the private sector:** For sponsoring, training, human resources, technical support or specific purposes (e.g. preparedness, provision of medicines).

6 Quality Management

Quality management standards for all SRC interventions are specified in the SRC Strategy 2020 for International Cooperation. At the operational level, these are reflected in Quality management manuals for the field and for SRC headquarters, which cover all health in emergency interventions.

The SRC is committed to fulfilling the following specific quality standards in health in emergency programmes:

Quality of care: SRC interventions place an emphasis on the provision of good quality services. Only expatriate health staff with appropriate qualifications and specific expertise are included in the senior health delegate pool. In order to develop the capacities of less experienced staff, the SRC may recruit and deploy junior health delegates together with a senior delegate. In order to meet the exceptional needs in a disaster situation, the staff in the health pool are regularly trained and re-trained using field context simulations. The training is conducted by an experienced physician from the SRC, IFRC or a PNS. The Public Health Guide in Emergencies is a comprehensive compendium on health in emergencies and

provides standards and guidelines for health personnel. Likewise, BHC ERUs and field hospitals operate in line with guidelines developed by MSF and WHO. During field missions, existing local quality of care guidelines are taken into account when providing care. Even under difficult circumstances, the highest possible international standards are maintained. This also applies to hygiene and sterilization procedures as well as to the procurement of quality medicines and material from reputed companies. The SRC procures medicines on the basis of the essential medicines list of the intervention country and in line with WHO recommendations and requirements. If quality criteria cannot be met with local products, if there is a stock-out in the intervention country or in case of logistic shortcomings, medicines will be imported from the neighbouring countries or from Switzerland. Donations of medicines are screened to ensure that they are based on the good donation principles.

Staff health: The SRC human resource policy outlines the type of support given to SRC delegates during and after missions. Discussions of staff health as well as medical check-ups are an integral part of briefings and debriefings. The SRC makes sure that enough time for recovery is allowed during the mission and between missions. If SRC delegates wish, they may contact an independent psychologist to debrief about the mission and obtain follow-up treatment.

Knowledge management: The SRC is actively engaged in the knowledge management process of emergency operations within the International Red Cross and Red Crescent Movement. The local partners, the IFRC and other PNS regularly exchange experiences and lessons learned and develop or adapt guidelines for future operations. The institutionalised briefings and debriefings of delegates as well as the regular exchange of information within the Department of International Cooperation ensure the dissemination of knowledge and periodical adaptation of response.

7 Monitoring and impact measurement

The impact chain of the health in emergency programmes is depicted in the SRC's impact model (see Annex 3), which reflects the outputs and outcomes on which the monitoring framework is based. All SRC programmes establish a monitoring framework, against which the successes and drawbacks of the programme are analysed. The monitoring is done by applying internal monitoring standards in line with the standardised project management cycle.

After relief operations in countries and areas where no other long-term SRC projects are in place, outputs are measured and assumptions and conclusions drawn in relation to possible outcomes and impacts. In emergency situations where long-term SRC projects are already in place, outputs and outcomes are measured. In these projects, baseline data may be already available and outcomes can be measured from a long-term perspective that goes beyond the immediate disaster response interventions. In selected, longer and more complex projects, the SRC may choose to measure outcomes. Suggested indicators are provided in the toolbox in Annex 4.

8 Resources

8.1 Human resources

The required human resources are made available to ensure that health in emergency expertise can be institutionally embedded within the SRC:

- The SRC pool of senior and junior staff and experts for bilateral and multilateral health in emergencies, including capacity development training courses, comprises physicians, nurses, midwives, laboratory and public health specialists (see Annex 2);
- A physician with extensive experience in health in emergencies provides technical backstopping for the Disaster Management Unit and training for the pool members;
- The SRC health adviser for the Department of International Cooperation offers additional advice when requested;

The division of tasks and resources within the SRC is as follows:

- the Disaster Management Division within the Department of International Cooperation is in charge of SRC emergency relief operations - including health in emergency operations – for all large scale relief operations and for small and medium scale operations in non SRC focus countries;
- the geographical divisions are in charge of small and medium scale emergency relief operations in SRC focus countries in cooperation with the disaster management division;
- the geographical divisions are in charge for mainstreaming disaster risk reduction in SRC programmes;

The SRC encourages the inclusion of junior and less experienced health staff in the pool. They are deployed on missions with a senior partner, from whom they can learn and gradually gain senior status. Respecting the cultural and religious specificities of a country, the SRC will deploy personnel which best meet the professional and cultural requirements.

8.2 Financial and material resources

As other disaster management programmes, health in emergency responses are generally financed from the following sources:

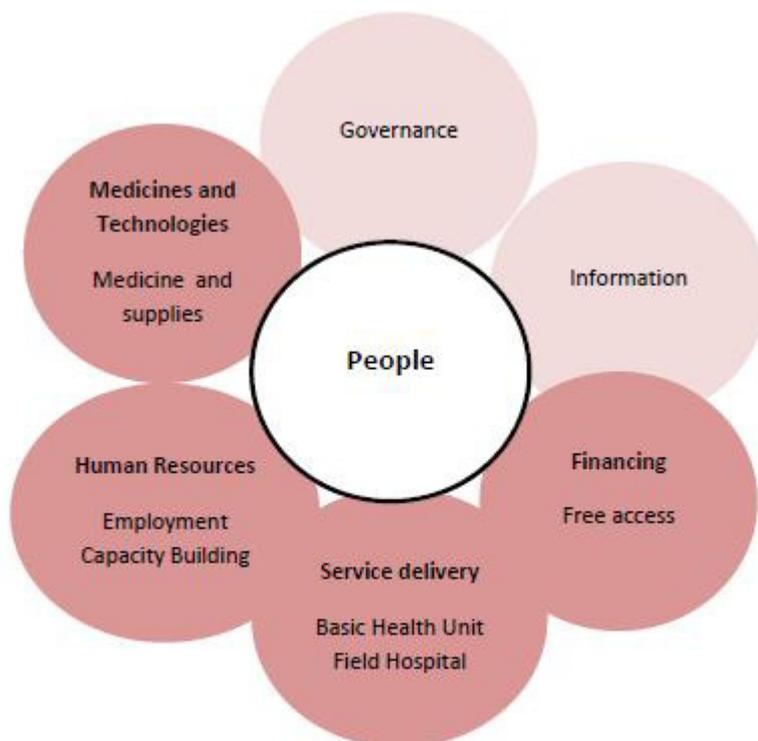
- Contributions from the Swiss government, in particular the Swiss Agency for Development and Cooperation;
- Contributions from Swiss Solidarity;
- Earmarked contributions from companies, public authorities, foundations and other institutions;
- Earmarked private contributions (in cash and in kind);
- SRC Disaster Relief Emergency Fund.

The SRC manages and maintains the following material resources, systems and capacities required for permanent organisational preparedness at the internal level:

- Global supply chain: global, regional and local purchasing capacity and expertise;
- Globally pre-positioned relief items in decentralised warehouses;
- Personal equipment of deployed health specialists.

Annexes

Annex 1: Areas of SRC intervention in the Health System Building Blocks



 SRC intervention areas

Annex 2: Health services provided by the SRC in emergencies

Referral hospital / Rapid deployment hospital

Area	Specific intervention	Staff	Partners and partnerships
General surgery, intensive care unit	Trauma patients Caesarean sections In-patients	Medical doctors Intensive care nurses Anaesthetists	IFRC German, Norwegian, Finnish, Canadian National Red Cross Societies
General medical care	In-patients NCD treatment Public health services	Nurses Public health specialists	
MNCH	Antenatal care/ Post-natal Care Delivery Newborn care	Paediatricians Midwives Nurses	
IMCI	Vaccinations Vitamin A Deworming Growth monitoring	Nurses Midwives	
Laboratory	Urine and stool Haematology Biochemistry Microbiology Serology	Laboratory technicians	
Water-borne diseases	Cholera tent, treatment Outreach activities (Hygiene promotion)	Nurses Public health specialists	
Vector-borne diseases	Outreach activities (prevention), vector elimination Detection, treatment	Laboratory technicians Public health specialists	
Nutrition	Monitoring, referrals	Nurses	
Management team, administration	Hospital management, administration	Senior medical officer, hospital administrator	

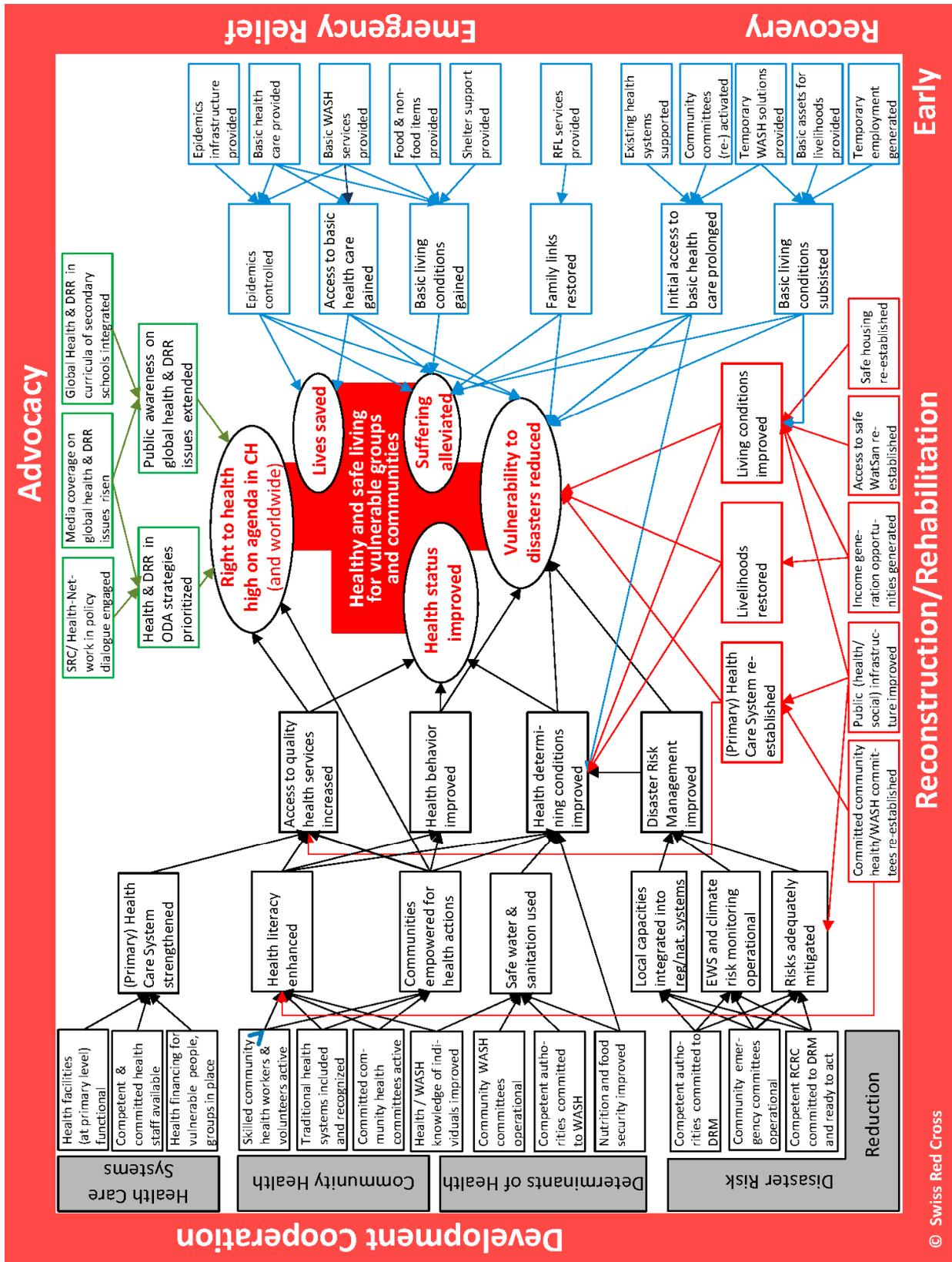
Basic health care (BHC) ERU

Area	Specific intervention	Staff	Partners and Partnerships
General medical care	Outpatient department Public health services Referral	Medical doctors Nurses Public health specialists	IFRC Canadian, Finnish, French, German Japanese, Norwegian, Spanish National Red Cross Societies
MNCH	Antenatal care/ Post-natal Care Delivery (normal vaginal deliveries) Newborn care	Paediatricians Nurses	
IMCI	Vaccinations Growth monitoring Vitamin A Deworming	Paediatricians Nurses	
Water-borne diseases	Treatment, water purification and hygiene kit distribution Outreach activities Hygiene promotion Sensitisation	Nurses Public health specialists	
Vector-borne diseases	Outreach activities, Detection, treatment	Nurses Public health specialists	
Nutrition	Monitoring, referral	Nurses	

ERT / bilateral operations

Area	Specific intervention	Staff	Partners and partnerships
Support of local health system	Medication supply Infrastructure support Staff support (training, salaries) Cold chain management	Public health specialists Logisticians Construction delegates	Host National Societies SDC Swiss NGOs
Access to health services	Cash for health (transport, access)	Public health specialists Cash delegates	
Water-borne diseases	Sensitisation, water purification and hygiene kit distribution Hygiene promotion	Nurses Public health specialists	
Vector-borne diseases	Vaccination Sensitisation	Nurses Public health specialists	

Annex 3: SRC impact model



Annex 4: Suggested indicator toolbox

Outcome 1: Access to basic health care gained

Utilisation rate of health care facilities served by the SRC
Number of health facilities renovated and made functional

Output 1.1: Basic health care provided

Number of SRC health personnel/ERT deployed
Number of materials sent
Number of medicines supplied
Number of beneficiaries who received medicines (other than for epidemic control)
Days of stock-out

Outcome 2: Epidemics controlled

Case mortality rate reduced
Crude mortality rate < 1/10,000 people/day
U5 Crude mortality rate < 2/10,000 people/day
Utilisation of hygiene kits by the beneficiaries

Output 2.1: Epidemics infrastructure provided

Number of health personnel deployed
Number of ERT teams equipped
Number of beneficiaries reached with epidemic control measures (health promotion)
Number of beneficiaries who received drugs

Output 2.2: Basic WASH services provided

Number of beneficiaries being sensitised to hygiene
Number of water purification methods and hygiene kits distributed

Endnotes

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