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Resilient India - Disaster Free India

Sphere India
National Coalition of Humanitarian Agencies in India

Health

HANDBOOK OF MULTI-SECTOR COORDINATION FOR EMERGENCY RESPONSE IN INDIA

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Handbook Of Multi-Sector Coordination For Emergency Response In India

ROLES AND FUNCTIONS

INTRODUCTION

STAKEHOLDER ANALYSIS AND COORDINATION

ASSESSING AND MONITORING THE SECTOR SITUATION IN INDIA

GUIDING PRINCIPLES AND STANDARDS

SECTOR STRATEGY AND AGENDA

RESOURCE MOBILIZATION

BENCHMARKS AND INDICATORS

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The National Institute of Disaster Management (NIDM) is one of the pioneer institutes under the Ministry of Home Affairs, Government of India which has been mandated to promote capacity building interventions in Disaster Risk Management (DRM). Since its inception, the Institute has been proactive in raising the level of awareness and preparedness in dealing with disasters and emergency situations in the country, as well as making DRM education accessible to people across different level of stakeholders.

Sphere India: Sphere India, is a national coalition of humanitarian agencies in India with a vision to build a disaster resilient India by promoting quality and accountability in humanitarian action through processes of collaborations at various levels. The members include key nodal agencies from Govt. of India, UN agencies, INGOs, NGO networks and national NGOs. Sphere India facilitates inter-agency coordination, training and capacity building, knowledge management and collaborative advocacy to protect the rights of the people affected by disasters and other humanitarian crisis.

Preface

Our aim is to enhance capacities and knowledge management system for emergency preparedness and response to improve quality of humanitarian action. In this handbook, we have sought to include practical guidance and advice on how different stakeholders and sector actors (NGOs, CSOs, UN Agencies and India Government) can come together to strategize sector preparedness and response in emergencies. It highlights key principles of humanitarian action and how coordination and joint efforts can increase the effectiveness and efficiency of interventions and promote better outcomes.

This handbook was drafted after numerous consultative meetings and write shops with sector experts from local and national organizations working in the field of WASH. Extensive research and discussions have taken place between authors of the sector before finalising the handbook. Inputs have been collected and collated from various experts across the field throughout the handbook drafting process. Sector wise consultative meetings were also organized to invite inputs from the Government and wider membership.

Sphere India would like to thanks Oxfam International, UNICEF, World Vision, Water Aid and all who have contributed their knowledge, expertise and time to make this edition of handbook, a possible venture. We are also grateful to collaborative partners and other CSOs, FBOs, CBOs, corporations, institutions, government departments and officials for their continued support and active participation in various consultations which helped us in facilitating the handbook.

Vikrant Mahajan
CEO, Sphere India

Sphere India
National Coalition of Humanitarian Agencies in India

Foreword

Disasters and disaster risks are on the rise. They negatively impact children's and women's rights, disproportionately affect poor countries, and erode development gains and are a set back for progress. Disasters, thus exacerbate already existing vulnerabilities and inequalities of boys, girls, women and men. As disasters are a function of hazard, vulnerability, exposure and capacity, they are both a humanitarian and a development concern. With a mandate of combining humanitarian and long-term development action, UNICEF recognises its crucial responsibility to integrate disaster risk reduction across its work. This calls for a concerted effort on the part of several sectors, including national, state and local governments, activists, NGOs, at-risk communities, etc.

Partners can support state governments to strengthen the capacity of the community-based health workforce as well as other levels of the system by promoting risk-informed actions from development systems; advocating for resource allocation and making investments (e.g. funding, technical support, human resources and supplies) for prevention, mitigation, preparedness and response actions addressing at household, community, and facility, safety and security level; supporting institutionalization of capability to enable continuity of access to social-sector services during emergency and eventual early recovery of services. UNICEF is committed to support the governments and CSOs to define and acquire the core competencies for emergencies, and the development of necessary guidance, training materials and tools; making use of the capacities and capabilities of the existing actors in this workforce, and promoting partnerships to link humanitarian and development domains.

This handbook is a resource that can be extensively used by all concerned authorities in the field of disaster risk management, which shall act as an operational manual for coordination during preparedness as well as response phases of emergencies.

Tom White
Chief DRR
UNICEF India

unicef

Foreword

The year 2020 was full of challenges, as the global health crisis brought humanity to a virtual standstill and changed the operational style of organizations. The difficult times also led to the emergence of a new emerging socio-economic order.

The role of CSR has become more relevant than ever, as corporates played a crucial role in supporting the nation in the fight against the pandemic and other disasters witnessed last year. HCL Foundation, along with partner organizations, has been working significantly to mitigate the humanitarian crisis. Through its various flagship programmes and special initiatives, it has positively impacted 2.14+ million human lives, spanning 21 states and 2 union territories of India.

It was the commitment and resilience of our communities, teams and partners that helped us navigate through the situation, and keep our efforts sustained. Going forward, I feel that organizations must start working towards strengthening of preparedness and unified emergency response systems. At HCL Foundation, we remain committed to addressing the socio-economic concerns while focussing on humanitarian aid and assistance. Our CSR programmes have the potential to bring value to the preparedness, response, and recovery systems by aligning corporate citizenship efforts to sustainable development processes.

The formulation of ***Handbook of Multi-Sector Coordination for Emergency Response in India*** (WASH), through joint efforts of Sphere India and partner organizations, shall act as an operational manual for coordination during emergencies and help improve the disaster management in the country and thus, mitigating the disaster risks.

Nidhi Pundhir
Director, HCL Foundation

HCL FOUNDATION

From Director's Desk

The traditional focus of the health sector has been on the response to emergencies. The ongoing challenge is to broaden the focus of disaster risk management for health from that of response and recovery to a more proactive approach, which emphasises prevention and mitigation, and the development of community and country capacities to provide timely and effective response and recovery. Resilient health systems based on primary health care at community level can reduce underlying vulnerability, protect health facilities and services, and scale-up the response to meet the wide-ranging health needs in disasters.

The health sector plays an important role in national and community-based multi-sectoral disaster risk management systems, integrating actions to reduce risk and prepare for emergencies. The health sector can also provide valuable input to local and national risk assessments through information on community health hazards such as epidemics or pandemics and vulnerabilities and capacities of the health system at all levels. Closer links and mutual support between health and national, and community-based disaster risk management systems are needed.

This handbook provides guidance for health workers engaged in disaster risk management and for multi-sectoral partners to consider how to integrate health into their disaster risk management strategies, and to efficiently coordinate with each other in an event of a disaster.

Major Gen. Manoj Kumar Bindal
Executive Director
National Institute of Disaster Management

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Acknowledgement

The chapters in this Sphere India's Multi-Sector Handbook (dedicated to Health sector) are result of a diverse consultation process amongst health sector experts in India and globally. Sphere India gratefully acknowledges the scale and breadth of the contributions made by: Doctors For You, UNICEF, Child Fund and Emmanuel Hospital Association (EHA). The working process to develop this handbook was coordinated by Sphere India via several online zoom meetings. We sincerely thank Shri Anil Kumar Sinha- IAS (retired) supporting and moderating these sessions. Most of the writeups were put forward by authors of their organizations, dedicating their time and effort as an in-kind contribution to the sector. Sphere India acknowledges the valuable contribution made between June 2020 and December 2020.

Sphere India also extends special thanks to Major General Manoj Kumar Bindal (Executive Director- NIDM) and Nidhi Pundhir (Director, HCL Foundation) for overall guidance and to. Anil K. Gupta (Professor- NIDM) and. Santosh Kumar (Professor- NIDM) for their critical editorial inputs.

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About Sphere India

Sphere India is a national coalition of humanitarian agencies in India. The members include key nodal agencies from Govt. of India, UN agencies, INGOs, NGO networks and national NGOs. Sphere India facilitates inter agency coordination, training and capacity building, collaborative advocacy, and information knowledge and learning management through a collaborative process for quality and accountability.

	Right to live with dignity.
	Right to assistance and protection.
	Principles of humanity impartiality, neutrality, independence, and other principles of Red Cross Code of Conduct.
	Inclusion.

The above mentioned points are grounded in Sphere India's commitment to the Article 21 of Indian Constitution on *Right to Life* and its interpretations in various judicial proceedings, Universal Declaration of Human Rights, International Humanitarian Law, Refugee Law and the associated treaties and covenants.

Composition of Sector Committees

SPHERE INDIA SECTOR COMMITTEE MEMBERS		
WASH	**SHELTER**	**FOOD & NUTRITION**
Oxfam India (Lead) UNICEF (Co-Lead) Water Aid CARE India EFICOR PGVS GIWA Wash Institute REDR ADRA India Plan India HI Ambuja Cement Foundation	HCL Foundation SEEDS Habitat for Humanity India (Lead) CARE India (Co-Lead) AIDMI NCDHR UNNATI HCLF	WFP (Lead) UNICEF India (Lead) CFNS (Co-Lead) CARE India EFICOR IGSSS World Vision India Oxfam World Animal Protection ACF Save the Children HCL Foundation
HEALTH	**PROTECTION**	**EDUCATION**
WHO (Lead) Doctors For You (Co-Lead) Handicap International CARE India ADRA ChildFund Water Aid HCL Foundation Cipla Limited Cipla Foundation Adani Foundation World Vision India UNICEF Save the Children ICRC OXFAM India PCI IPPF EHA Americares India	Caritas (Proposed Lead) OXFAM (Proposed Lead) NCDHR CARE India Child Fund Islamic Relief IGSSS CRS Handicap International IPPF ADRA TDH UNNATI WV Change Alliance Save the Children IPPF SAFA HCL Foundation	Save the Children (Sector lead) UNICEF (Co-Lead) CARE India ChildFund India World Vison India Oxfam RTE Forum HCL Foundation Sterlite EdIndia Foundation Bharti Foundation DLF Foundation

About the Handbook

This Health Sector Coordination handbook provides practical guidance and advise on how different stakeholders and health sector actors (NGOs, CSOs, UN Agencies and Government) can come together to strategize health sector preparedness and response to health, during emergencies. It highlights key principles of humanitarian health action and how coordination and joint efforts among health and other sector actors can increase the effectiveness and efficiency of health interventions to promote better health outcomes.

Process of Drafting the Multi Sector Coordination Handbook

The handbook has been drafted under the *Network Approach to Emergency Preparedness for Response*, after numerous consultative meetings and write shops with sector experts from local and national organizations working in the fields of education, health, food and nutrition security, WASH, shelter, and protection.

After initial consultations with sector leads, starting from the month of January 2020, the outline of the handbook was developed and discussed in the sector committee meetings of six sectors held in February 2020. Interest from sector committees and other sector experts was sought and nominations were completed by April. The inception of the handbook began in the first week of May 2020. Introductory meetings were held with each of the six sector committees wherein Sphere India presented a prototype of the handbook to elucidate the desired chapters and content to be produced.

Following this, lead authors, section authors with support from Sphere India secretariat began drafting the handbook. Sector-wise meetings as well as multi-sector meetings were held for discussions. During the handbook drafting process, three multi-sectors write shops and consultations with multi-sector strategic leads were held along with 24 sector authors meetings.

Extensive research and discussions have taken place with authors of the sector before finalising the content. Inputs have been collected and collated from various experts across the field. sector wise consultative meetings were held inviting inputs from the Government and its wider membership.

Contents

A LIST OF TABLES

A LIST OF FIGURES

Roles and Functions of the Sector Committee

ROLES AND FUNCTIONS

Roles and Functions of the Sector Committee

1. Humanitarian coordination during disasters and preparedness.
2. Recovery coordination.
3. Coordination for DRR activities of Sphere India members.
4. Coordination with IAGs at district and state levels for the above roles/ situations.

Roles of the Sector Lead

1. Use the lead agency's existing working relations with the national authorities and non-state actors active in the sector, to facilitate their participation in the sector.
2. Maintain appropriate links and dialogue with national and local authorities, CSOs, and other stakeholders.
3. Make the technical expertise of lead agency available for sector and inter-sector assessments.
4. Participate actively in strategy development.
5. Ensure that sector plans take appropriate account of national sector policies.
6. Ensure that all sector committee members are aware of relevant policy guidelines and technical standards.
7. Promote/ support training of sector members.
8. Hold regular coordination meetings.
9. Collect information from all partners on Who's Where, since and until When, doing What, and regularly feed the database managed by Sphere India.
10. Represent the sector in inter-sector coordination mechanisms.
11. Assess and monitor available sector resources.
12. Mobilize sector partners to contribute to establishing and maintaining appropriate "Early Warning System".
13. Ensure that sector needs are identified by planning assessments.
14. Head and contribute to sector analysis of information and data leading to identification of gaps in sector response.
15. For recovery planning, or in protracted crisis, ensure incorporating building back better, and risk reduction measures.
16. Lead sector contingency planning.
17. International NGOs and CSOs to utilize their networks in a comprehensive manner for provide guidance to the government.

Roles and Responsibilities of the Sector Coordinator (Sphere India Secretariat)

1. The Sector Coordinator, commonly known as Focal Point shall coordinate for execution of the annual plan under the guidance of committee, Chair, Co-chair of committee and CEO/SPM (Senior Program Manager) of Sphere India.
2. The Focal Point shall have monthly meetings with the Chair and the CEO/ SPM to update and seek guidance on developments on processes, projects, new initiatives taken and individual development.
3. The Focal Point shall have frequent meetings with members, individually.
4. The Focal Point shall share the monthly report with the Chair and the CEO/ SPM.
5. The Focal Point shall take minutes of all the committee meeting and circulate it to members.

Main Functions of the Committee

1. To draft the long-term strategic plan for the sector.
2. To approve annual plan of actions with programmatic and financial details.
3. To review the progress on plan implementation and utilization of budget quarterly.
4. To guide and support executive team for collaborative advocacy.
5. To elect chair and vice-chair for the committee

Meetings of the Committee

1. The committee shall meet once every quarter. The dates should be fixed in advance falling under first week of the months of February, May, August and November.
2. The special meetings of the committee meeting can be convened as required.
3. The committee meetings should be professional with agenda approved by the subcommittee chair and the CEO/SPM.
4. The member organizations shall appoint a point person to attend the meetings and represent in committee.
5. All important decisions including election of the chair, approval of plans and activities shall be final only if there is a minimum quorum of the 50% of the committee strength in the meeting.

Sector Committee Composition

1. The composition of the sector committee must be diverse. Efforts are made to have an inclusive committee with prominent representation from local NGOs, all caste groups, different genders and different regions.
2. In order to enhance local representation, the sector committee must ensure that either the Sector Lead or Co Lead is a member of a local organization.

Formation of the Sector Committee

By following a participatory process, the formation of sector committee is carried out. Sphere India Secretariat sends out an email to all its members inviting them to be a part of sector committee. Furthermore, members are requested to nominate sector specialists or focal persons for the sector within their organizations. Terms of reference of the committee are also sent along with this email. The desired committee size is 8-10 members however, in the event that more nominations are received, preference is given to members who were not a part of the sector committee in the previous year. Nominations for the Chair/Co-Chair are received and finalised based on consultations with the CEO or the Chair/Vice- Chair of Excom.

Introduction: Health Sector

INTRODUCTION

The health sector plays a key role in emergency and disaster preparedness and response. Timely and efficient intervention to the healthcare needs of the populations affected, by a disaster is one of the highest priorities in the overall management of major emergencies and disasters.

The objective of disaster preparedness is to guarantee that systems, procedures, and resources are readily available to provide rapid and effective assistance to victims. Thus, facilitating relief activity and the restoration of services.

Disaster risk management for health is multisectoral and refers to: the systematic analysis and management of health risks, posed by emergencies and disasters, through a combination of

1. hazard and vulnerability reduction to prevent and mitigate risks,
2. preparedness,
3. response and
4. recovery measures.

The traditional focus of the health sector has been on the response to emergencies. The ongoing challenge is to broaden the focus of disaster risk management for health from that of response and recovery to a more proactive approach which emphasises prevention and mitigation, and the development of community and country capacities to provide timely and effective response and recovery. Resilient health systems based on primary healthcare at community level can reduce underlying vulnerability, protect health facilities and services, and scale-up the response to meet the wide-ranging health needs in disasters.

Stakeholder Analysis and Coordination

STAKEHOLDER ANALYSIS AND COORDINATION

Identifying Key Stakeholders, Managing Sectoral Coordination and Information

Understanding existing structure and who are the key actors, how do they coordinate, identifying and detailing the role of the various GO-INGO- NGO in DRR and sector coordination, while also referring to the National Disaster Management Plan, is the key. Almost all disaster relief operations impart lessons to be learned,which can be applied in an another similar event. Disaster management is a complex issue, and so is coordinating with various stakeholders in multi-sectoral preparedness and response. But it is achievable and doable by identifying and pooling in all potential stakeholders, skills and scarce resources, when they are needed the most.

Such coordination for preparedness can be further strengthened by improving government-corporate ties led by sharing human resource, the corporate professionals to work with government departments on Disaster Management and government departments to make use of modern technology and equipments of private sector. Furthermore, coordination among non- government organizations and agencies to include a standardised planning approach is very useful for increasing cohesion and reducing individualism.

Preparedness is a continuous process of upscaling skills, capacity, action plan for overall effective, efficient and timely response and recovery, while constantly enhancing communication from ground level. Lack of pro-active planning in disaster preparedness would only ensure continuity of mistake and no course correction. Existing structure: In India we have Disaster Management 2005, NDMA, NIDM, NDRF, SDRF, etc.

Handbook, IASC Sector approach was adopted in 2005. It ensures that international responses to humanitarian emergencies are predictable and accountable and have clear leadership by making clearer the division of labour between organizations, and their roles and responsibilities in different areas. It aims to make the international humanitarian community better organized and more accountable and professional, so that it can be a better partner for affected people, host governments, local authorities, local civil society and resourcing partners.

Who Are the Key Actors?

- State governments are primarily responsible for providing humanitarian assistance to people under their jurisdiction. NDMA, NIDM, Disaster

Management Division of the Ministry of Home Affairs, MoHFW, Police, Fire services, Hospital, PHC, CHC, Panchayat Raj Institute.

- UN agencies
- INGOs, NGOs, and the Red Cross/Red Crescent
- Corporate
- CSO
- Grassroots organization
- Faith-based organization
- Healthcare institution
- Educational institution
- Local community
- Logistic – Taxi, driver union
- Club, Union, SHG, etc.
- Community leaders- NGOs, CBOs, CSOs, FBOs
- Volunteers
- Inter-Agency Groups
- Suppliers of essential goods, vendors
- Other potential stakeholders like traders & suppliers, transport, blood banks, etc.
- Professionals- DPOs, trained volunteers, emergency medical practitioners, disaster manager, health, nutrition, WATSAN, shelter, gender, RCH/MISP, etc.

Table 2: Conceptual Framework of Assessment Process

Section	Stakeholders	Expected Roles
Preparedness	Govt, I/NGOs, CSOs, FBOs, corporates, local volunteers, community, hospital.	Training, capacity building, equipment, awareness & sensitization program, mock drill.
Relief response	Govt, NDRF, SDRF, DM/DC I/NGOs, CSO, hospital, FBO, corporate, local volunteers, community first responders.	Search & Rescue, injury management, mass casualty, relief, shelter, food, medicine, WASH.
DRR	Govt, DM, PRI, Health Dept, Forest Dept, I/ NGOs, hospital, CSO, FBO, corporate, local volunteers, community.	Livelihood, training, Village DMP, policy, advocacy, safety guidelines, codes.

How do they Coordinate?

- Pre-mapping of local stakeholders.
- Identify the potential stakeholders.
- Have some understanding/ToRs/MoU with the relevant stakeholders for mutual understanding of roles, responsibilities, and accountabilities.
- Organize meeting, seminar, workshop to get to know each other's strength, potential area of collaboration during emergency, etc.

- Sharing information, resources, database of volunteers, professionals, resources, etc.
- Announce disaster warnings and pre and post disaster related updates.
- Risk communication for avoiding miscommunication.

Identifying and Detailing the Role of the various GO-INGO-NGO and Local Communities in DRR

- Government departments and local authorities in coordination with universities and research organizations can gain insight to strengthen health sector strategy and disaster response. Mapping capacities of local responding organizations including the State departments enable local administration, which provides the ultimate leadership for a quick and effective response. Creating a database of pool of professionals and skilled and trained volunteers is essential for effective disaster emergency response. Incentives to youth can be given for participating in capacity building trainings.
- For preparedness to handle emergency situations and outbreaks. The provided incentives will encourage the involvement of health responders in non-health disasters. This will also lead to creation of a collaborative coordination mechanism from all local potential stakeholders.
- Inclusion of localities and volunteers in training results in smoother evacuation and response, and also enables to improve the communication to communities in non-disaster and pre- disaster days through the volunteers to tackle the issue of lack of awareness of policies for the affected population and henceforth the implementation.

National authorities have the primary responsibility for preparedness. It is also their responsibility to strengthen existing practices of announcing disasters, communicating updates on pre and post disaster situations and relief operations. Cultural and linguistic barriers sometimes create barriers in evacuation and rescue operations.

However, all stakeholders have a responsibility to ensure that the humanitarian system is in a position to support national actors and is equipped to respond to a crisis. NGO's should also to the best of their abilities try to reduce the cultural and linguistic barriers in evacuation and rescue operations by NDFR. Therefore, each agency has to operationalize emergency response preparedness (ERP) in their respective sectors and monitor its quality and comprehensiveness. In preparing for and responding to an emergency, international humanitarian actors are expected to cooperate with national authorities and support national capacity wherever it is feasible and appropriate to do so.

Interfaith leaders are widely followed by communities and religious followers, so inspiring them to include DRR principles in their sermons will prove instrumental in reaching a wider section of population.

Figure 1: Example: Odisha Case Study - Active Role of Community in Evacuation Operations

Disaster preparedness at the community level is conducive for speedy dissemination of alerts and mobilization of the people necessary for effective implementation of evacuation operations-one of the primary reasons behind Odisha's success in disaster management. As the World Bank puts it, Odisha has a good community outreach system through which people can be contacted on time. There is a network of 450 cyclone shelters and each shelter has a maintenance committee trained in rescue and relief activities. Through a network of these shelters and committees, the state has involved the entire community, making it easy to disseminate warnings and evacuate people.

Recent disasters bear testimony to Odisha's prowess in conducting evacuation operations. During Cyclone Amphan, one of the strongest cyclones ever to have been recorded in the Bay of Bengal, nearly 200, 000 people were evacuated in the state. Cyclone preparations began as soon as the alerts were issued by the Indian Meteorological Department and restoration efforts were undertaken on a war footing so that by the time the cyclone steered away from Odisha towards West Bengal more than 85 percent of the power restoration work was already done. Heading the central team to assess the post Amphan damage in Odisha, Joint Secretary of Union Home Ministry, Shri Prakash, stated that "community involvement" in the process of disaster management had been one of the "achievements of the Odisha government."

Altogether, organizations active for emergency preparedness for response should take measures for decentralised work on the field through a central coordination protocol. During such coordination, emergency protocols should write over internal department protocols for rapid response, this can be achieved by unanimously finalising the strategic planning decisions between agencies. To ensure effectiveness of strategic planning, local leaderships to hold representation in state inter agency platforms and form smaller emergency alliances based on compatible skill set for following multi stakeholder preparedness and response strategy.

Besides this, the small NGOs to receive support from international and other big NGOs to ensure better reach, representation and visibility in all districts of the state. This in turn will help INGO's by leveraging the rapport built by local NGO's for a more cohesive response in emergencies to work jointly with other Sectors for enhancing cross-Sector synergies and reducing demands on time.

Sector Coordination

The main purpose of coordination is to meet the needs of affected people by means that are accountable, relevant, reliable, effective, inclusive, and respect humanitarian principles while also referring to the National Disaster Management Plan, Disaster management Act 2005 and others.

Assessing and Monitoring the Sector Situation in India

ASSESSING AND MONITORING THE SECTOR SITUATION IN INDIA

Assessments are time-bound exercises that provide information on the status at any particular point of time; expected evolution of the situation is analysed, identifying the potential risks associated with it. Whereas, monitoring or surveillance is a continuous process that registers information on a regular basis for situation update and analysis, helping in identification of trends and detecting any new threats. Cluster partners should agree on a coherent, coordinated set of assessment and situation monitoring activities adapted to the local setting that identifies priorities and provides timely information to decision- makers in relation to both humanitarian and early recovery needs.

Key Health Information Needs, Processes, and Tools

Good, shared information is essential for overall health response and some of its basic principles are as followings:

- Secondary data should be obtained from reliable sources, its relevance to current situation should be considered along with time periods to which they relate.
- The data should be segregated according to its use into various categories.
- Local professionals who know the context must be mobilized to contribute to the assessment and analysis process.

Data need to be collected and systematically analysed on these three core aspects.

1. **Health Status and Risks:** The current health status of affected population groups (e.g. mortality, morbidity and their major causes) and health risks (e.g. potential outbreaks or further interruption of services or critical disease control programmes).
2. **Health Resources and Services Availability:** Initial focus on the facilities, personnel, supplies and services of national health authorities, other national and non-state actors, and international partners. Later, once the initial, acute phase is over and especially when seeking to promote recovery, the analysis should cover other health system components for the target (management systems, financing, etc).
3. **Health System Performance:** The coverage and quality (effectiveness) of the services currently available; the access (physical and temporal access) that men, women, boys and girls have to those services and their utilization for them.

Additionally, information is needed on the context which includes political, social, economic and security conditions, to recommend actions to address priority health

problems and gaps in services. Assessments should be carried out to ascertain the resource capacity of hospitals and pre-hospital care before giving emergency responsibilities. Also lessons from responses to previous crisis in the country, or in neighbouring countries, give a reference in order to be able to build on successes and avoid repeating mistakes

Various tools available globally for the collection, collation and analysis of data on these core aspects are as followings:

1. The multi-cluster/multi-sectoral Initial Rapid Assessment (IRA).
2. The global health cluster Health Resources Availability and Mapping System (HeRAMS).
3. The WHO/global health cluster Early Warning and Response System (EWARS) and the HINTS software produced by the health and nutrition tracking service.
4. Regular Health Information System (HIS).
5. Tools/database available in India include: National Health Profile, National Health Systems Resource.

Figure 2 : Data Collection and Analysis Processes

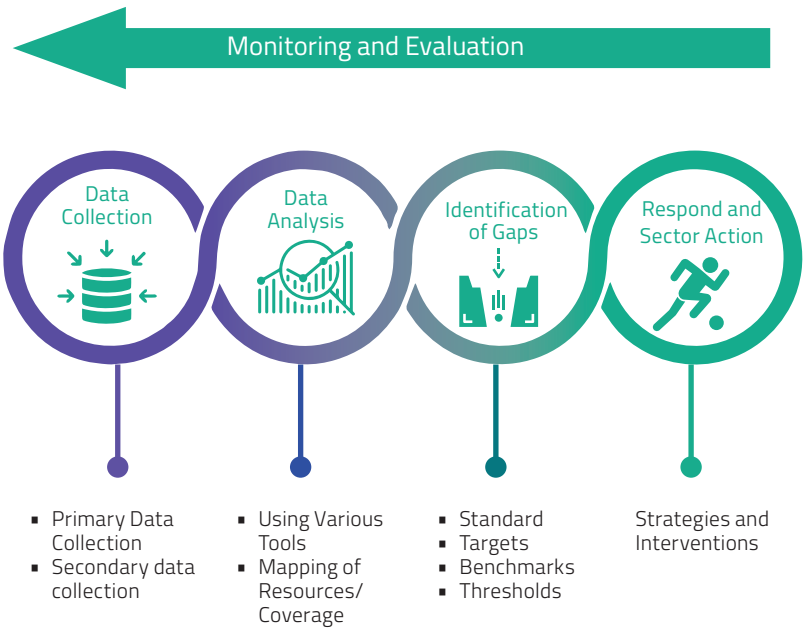

Table 2: Conceptual Framework of Assessment Process

Phase 1 (0-3 days)	Phase 2 (4-10/15 days)	Phase 3 (15-30/45 days)	Phase 4 (30/45+ days)
Assessment Methods			
Expert interpretation of initial reports & remote data of a Few site visits.	Rapid appraisal methods only (KI, O & GD). Purposive sampling.	Household level survey + rapid appraisal methods. Representative sampling	Household level survey + rapid appraisal methods. Representative sampling
Information Outputs			
Preliminary working scenario.	Identification of main problems, risks and gaps – initial planning scenario.	Initial analyses of problems, risks and gaps – updated planning scenario.	Comprehensive and updated analyses and planning scenario (ongoing, regular).
Use of the Information			
Preliminary health crisis response strategy (for response in the first few days).	Initial health crisis response. Flash appeal. Adjustment of initial responses. Specific project, proposals.	Initial health crisis response strategy. Adjustment of initial responses. Specific project, proposals.	Updated health crisis response strategy, projects and appeals.

Organizing Follow-Up Assessments and Surveys

Depending on the outcomes of initial assessment, the context and type of crisis, detailed follow-on assessments or sample surveys may need to be undertaken in particular localities in relation to some or all of the following:

- Mortality rates (CMR and U5MR) and morbidity rates.
- Main causes of death, injury and disease and their distribution among different population groups (disaggregated by age, sex, geographic area and other locally relevant characteristics).
- The psychological impact on the population and on health and relief workers.
- The impact on disease vectors and vector control programmes.
- The impact on the ability of men, women, boys and girls to access health services.
- Damage to health facilities – detailed surveys by competent technicians and engineers to prepare specific plans and cost estimates for repair/ reconstruction.

- Damage to facilities that the health facililties are dependant upon – e.g. feeding electricity grid, oxygen generators, road connectivity, etc.
- The human and other resources and capacity to assure health services in the medium term.
- Other health system components: policies, infrastructure, financing, supplies and management.

Follow-on assessments and surveys need careful planning, as it often requires considerable resources (human, financial and logistic) for the results to be reliable and usable. Additionally, it may sometimes be politically sensitive too. Be cautious to not to over-load a survey by trying to respond to too many disparate demands for data.

Guiding Principles and Standards

GUIDING PRINCIPLES AND STANDARDS

Humanitarian principles are at the core of all humanitarian work. They guide humanitarian action and their application is essential to distinguish humanitarian action from other forms of activities and action. The principles' centrality to the work of Sphere India and other humanitarian organizations is formally enshrined in two General Assembly resolutions. The first three principles (humanity, neutrality, and impartiality) are endorsed in General Assembly resolution 46/182, which was adopted in 1991. This resolution also established the role of the Emergency Relief Coordinator. General Assembly resolution 58/114 (2004) added '***independence***' as a fourth key principle underlying humanitarian action.

Table 3: Key Principle Underlying Humanitarian Action

Humanity	Neutrality	Impartiality	Independence
Human suffering must be addressed, wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings.	Humanitarian actors must not take sides in hostilities or engage in controversies of political,racial, religious or ideological nature.	Humanitarian action must be carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of nationality, race, gender, religious belief, class or political opinions.	Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented.

In situations of emergencies, the principles of Disaster Risk Management to be used for building sector synergy among all developmental areas. Sphere India also adheres to other internationally recognized principle of "do no harm," which obliges Sphere India to prevent and mitigate any negative impact of its actions on affected populations. Equally important is Sphere's commitment to rights-based and community-based approaches that include efforts to engage and empower concerned persons with decisions that affect their lives.

For operations in India, Sphere India adheres to the Fundamental Rights as the basic human rights of all citizens as enshrined in the Indian constitution. These rights are defined in Part III of the Constitution irrespective of race, place of birth, religion, caste, creed or sex. These include Article 14-18: Right to Equality, Articles 19-21: Right to Freedom, Articles 23-24: Right against Exploitation, Article 25-28: Right to Freedom of Religion Cultural and Educational Rights, Article 32: Right to Constitutional Remedies.

On practical terms the guiding principles translates to:

- Every person in the midst of any emergency has the same needs and rights as in person who are not in the midst of the emergency.
- The right to rescue, relief, and rehabilitation is the same for everyone, irrespective of gender, caste, religion, ethnicity, geographies.
- The emergency response will build on the existing activities and partnerships developed through country/state/district cooperations.
- The response will be based on national/ state/district level defined priorities and 'Sphere partners' comparative advantage.

People are at the heart of humanitarian action. The primary motivation of any response to crisis is to save lives, alleviate human suffering and to support the right to life with dignity. Humanitarian organizations recognize that the humanitarian imperative comes first and seek, therefore, to provide humanitarian assistance wherever it is needed. Such effort from humanitarian organisations or individual field actors should be duly recognised through awards and motivation programmes.

Ultimately, States have the primary responsibility to protect and assist persons in their territories who are affected by disasters, armed conflicts or violence. Humanitarian action is designed to complement and support States in fulfilling those responsibilities; it should neither undermine nor supplement state responsibility.

Quality Standards

Quality standards is as essential as the main aim of emergency health response, is to decrease mortality and morbidity. For example, if measles vaccination campaign does not achieve 95 percent coverage, with appropriate cold chain standards, then it would fail to prevent the risk of a measles outbreak. Thus, quality standards is one of the key determinants of health emergency response.

The services and activities of all health actors will be normally in accordance with national and/or state treatment policies and guidelines; but if these are not available or not in line with latest global evidence, then Sphere India will facilitate dialogue among all stakeholders to agree on relevant policies and guidelines.

Table 4: Minimum Quality Standards, Indicator, Benchmark and Inter-sectoral Coordination for Health Sector

Minimum Quality Standards for Health Sector		Indicators	Benchmarks	Inter-sectoral Coordination
General healthcare services	At least one basic functional health unit (from Government or formal private health service provider) per 5000 population, by administrative unit.	Average population covered by functioning health unit (from Government or formal private health service provider).	5,000 for one health unit (either a sub-health center or health and wellness center) 30,000 for primary health centre 100,000 for community health centre.	Allocation of land for establishment of health unit. Approachable ProtecQWted from local natural disasters. Facilities to health unit.
	A strategy to reach remote scattered communities and inaccessible displacement camps.	Number of health work-force (doctor, nurse, ANM) per 1,000 population, by administrative unit (%m/f).	More than 22.	Identification of vacancies.
	A strategy to reach remote scattered communities and inaccessible displacement camps.	Number of ASHAs per 10,000 population, by ad-ministrative unit.	More than 10.	Identification of remote scattered communication and inaccessible displacement camps.
	More than 10 hospital beds per 10,000 population.	Number of hospital beds per 10,000 population (in patient and maternity), by administrative unit.	More than 10	Oversee the allocation.
	More than one new outpatient visit per person, per year.	Number of outpatient consultations per person per year, by administrative unit.	More than one new visit/per person per year.	Oversee during meetings of Rogi Kalyan Samiti.
	Less than 50 consultations per doctor per day.	Number of consultations per doctor per day, by administrative unit.	Less than 50 per doctor per day.	Oversee during meetings of Rogi Kalyan Samiti.

Minimum Quality Standards for Health Sector		Indicators	Benchmarks	Inter-sectoral Coordination
	Role of ASHA, ANMs, CHOs, nurses, doctors enhanced in provision of curative health services as per the local health/disease context.	Percentage of health work force trained as per the local health/ disease context, disaggregated by cadre.	More than 90 percent of health work force trained as per the local health/disease context.	Venue selection. Transport to and fro venue. Food and night shelter for trainers and trainees.

Minimum Quality Standards for Health Sector		Indicators	Benchmarks	Inter-sectoral Coordination
General healthcare services	Risk assessment for disease outbreaks, case fatality rate.	Number of cases or incidence rate of selected diseases relevant to the local context (cholera, measles, acute encephalitis, etc). Measure deaths or mortality rate of selected diseases relevant to the local context.	Measure trends < 1 % case fatality rate	Tracing contacts. Crematorium vigil.
	Proportion of people exposed to hazard/s.	Proportion of people with less than 15 liter of water/ day. Proportion of families using fossil fuel for cooking. Proportion of people at risk of exposure to natural/ human-made disasters.	Measure trends	Alert and inform. Usher in government schemes to local people.
	Referral transport system mapped for each geography.	Number of BLS and ALS ambulance available per 1,000,000 population.	10 BLS 1 ALS	Provision of ambulance. Training of paramedics.
	As per the risk profile, emergency stocks of medicines and equipment available for at least three months duration.	Percentage of health facilities without stockout of selected essential medicine or equipment.	100 percent	Oversee during meetings of Rogi Kalyan Samiti.
	Antenatal care, skilled attendance at birth, newborn care.	Percentage of pregnant women and adolescent girls receive scheduled Antenatal Care (ANC) in line with coverage of 4+ANC visits.	90 percent	VHNSD arrangements in AWW.

Minimum Quality Standards for Health Sector		Indicators	Benchmarks	Inter-sectoral Coordination
Maternal and newborn care	One Basic Emergency Obstetric Care (BEmOCs) health facility for 24 X 7 , available for every 30,000 population [(i) Administer parenteral antibiotics (ii) Administer parenteral uterotonics (iii) Administer parenteral anticonvulsants (iv) Perform manual removal of the placenta (v) Perform removal of retained products of conception (vi) Perform assisted vaginal delivery (vii) Perform neonatal resuscitation].	Number of BEmOCs.	One BEmOCs for every 30,000 population.	WASH facilities.

Inter-sectoral coordinations

Minimum Quality Standards for Health Sectors		Indicators	Benchmarks	Inter-sectoral Coordination
Maternal and newborn care	One Comprehensive emergency obstetric care (CEmOC) health facility for 24 X 7 available for every 50,000 population but, in a conflict setting, services should be available as near to the population as possible as referral might be impossible. [In addition to the above (viii) Perform cesarean and laparotomy under anesthesia and (ix)Perform blood transfusions].	Number of CEmOCs	One CEMOC for every 50,000 population.	WASH facilities. Blood donation camps.
	Availability of referral transport mechanism to BEMOC and CEMOC.	Number of BLS and ALS ambulance available per 1,000,000 population.	10 BLS 1 ALS	Provision of ambulance. Training of paramedics.
	Counseling using the mother and child protection card for antenatal care, birth preparedness, postnatal care, neonatal care.	Percentage of households with pregnant women or lactating mothers or newborns having mother and child protection card.	> 90 percent	Counselling on allied topics of Mother and Child Protection Card.
	Aim to increase proportion of clean deliveries at facility level.	Percentage births assisted by skilled attendant.	> 90 percent	WASH facilities.

Inter-sectoral Coordination

Minimum Quality Standards for Health Sector	Indicators	Benchmarks	Inter-sectoral Coordination
Caesarean section rate.	Percentage expected deliveries by Caesarean section, by administrative unit.	>= 5% and <= 15%	WASH facilities.
Immediate postnatal (matenal & newborn) care within 24 hours after delivery by healthcare providers (or trained community health workers).	Number of mothers/ newborns who received postnatal within 2 days of childbirth (regardless of place of delivery)—for all births.	> 90 percent	WASH facilities.
Newborn Care Corner (NBCC) and Newborn Stabilization Unit (NBSU) functional with equipment and adequately trained staff available at BEmOC and CEmOC facilities respectively.	Whether functional NBCC available at BEmOC. Whether functional NBSU available at CEmOC. Percentage of small and sick newborns have access to inpatient level 2 special newborn care within two hours of travel time.	Functional NBCC available at all BEmOC Functional NBSU available at all CEmOC 80%	WASH facilities.

Minimum Quality Standards for Health Sector		Indicators	Benchmark	Inter-sectoral Coordination
Child health	ASHA and ANM capacitated for provision of curative care for childhood illness e.g. Community-case management of pneumonia.	Percentage of ASHA trained on module 7. Percentage of ANMs trained on IDCF and SAANS.	> 90 percent	Arranging training of ASHA and ANM.
	Children with pneumonia provided with pre-referral dose of Amoxicillin by ASHA and / or ANM within 24 hours of symptoms and referred.	Percentage of cases of childhood pneumonia who received pre-referral dose of Amoxicillin.	> 50 percent	Arrangement of referral transport.
	Oral rehydration salts available at home level.	Percentage of households with under-five children having oral rehydration salts.	> 80 percent	Communicating with families of under-five children.
	Zinc supplementation for treatment of childhood diarrhoea.	Percentage of under-five children with diarrhea who received Zinc supplementation.	> 80 percent	Communicating with families of under-five children.

Minimum Quality Standards for Health Sectors		Indicators	Benchmarks	Inter-sectoral Coordination
Child health	Vitamin A supplementation for all children under five.	Percentage of children 9 to 59 months who received bi-annual doses of Vitamin A.	> 80 percent	Communicating with families of under-five children.
	In malaria endemic areas, families sleep under insecticide treated bednet.	Percentage of children under five years of age , who slept under an insecticide-treated nets the previous night in malaria endemic area.	> 80 percent	Communicating with families of under-five children.
Immunization	Children should be immune against measles.	Coverage of measles vaccination (6 months-15 years).	> 95% in camps or urban areas > 90% in rural areas	Communicating with families of under-five children.
	Children should be immune against diphtheria, pertussis and tetanus.	Children should be immune against diphtheria, pertussis and tetanus.	> 95 percent	Communicating with families of under-five children.

Minimum Quality Standards for Health Sectors		Indicators	Benchmark	Inter-sectoral Coordination
Nutrition	Management of cases with severe acute malnutrition at health centre level.	Recovery of severe acute malnutrition cases.	> 75 percent	If acute malnutrition level is above national standard or >10 GAM and >1 SAM – coordinate with Nutrition Cluster for possible initiation of community case management of acute malnutrition.
	Data collection from service providers through the Integrated Disease Surveillance Programme (IDSP), its analysis for early warning and dissemination to enable mounting a response system.	Early warning detection rate.	90 %	Alert and reporting of increase in number of infectious cases and/or deaths.

Minimum Quality Standards for Health Sectos		Indicators	Benchmarks	Inter-sectoral Coordination
Communicable diseases	Outbreak response initiated within 24 hours of index case reporting of new infection or clustering of cases.	Percentage of outbreak response initiated within 24 hours of index case reporting of new infection or clustering of cases.	100 %	Preventive measures, reporting cases.
	Case fatality rate during any infectious outbreak particularly acute watery diarrhea and measles.	Outbreak specific case fatality rate.	< 1 %	Reporting deaths. Appropriat cremation.
	Rapid field assessment of vaccination coverage by ASHA and ANM followed by vaccination of unvaccinated pregnant women and children with respective vaccines.	Dropout rate between TT1 & TT2 / B for pregnant women and BCG & measles for children.	< 5%	Assistance in assessment.
	Efficiency of laboratories.	Reporting within standard set for each infectious disease.	> 80% samples	Green coordinator for transportation of samples.
Gender based violence	Clinical management facilities.	Percentage of health facilities with availability of clinical management of rape survivors + emergency contraception + PEP available.	100 percent district. Government health facility 50 percent block health facility.	

Minimum Quality Standards for Health Sectors		Indicators	Benchmarks	Inter-sectoral Coordination
Gender	Vulnerability measure	Number of cases or incidence of sexual violence.	Measure trends	
	Standard precautions at facility level to prevent exposure to or reduce the risk of transmission of pathogenic agents (including HIV) [includes education, training, personal protective equipment such as gloves, gowns and masks, hand washing, and employing safe work practices].	Proportion of health facilities who follow the standard precautions.	100 percent	Supply and logistic of equipment. Display of signages of standard precautions.

STIs & HIV/AIDS	Continuity of ARTs for those who are on treatment (restocking).	Proportion of people who were on ART and are currently receiving ART.	> 80 percent	Maintaining confidentiality.
	Safe blood transfusion.	Percentage of sero-prevalence of transfusion transmitted infections.	0 percent	Awareness about availability of blood banks and transfusion units.
	Free condoms available and accessible to the community.	Health facilities and ASHAs have condoms in stock.	80 percent	Awareness generation.
	Syndromic case management of STIs.	Proportion of district and block level government health facilities providing syndromic case management with appropriate laboratory tests.	50 percent	Maintaining confidentiality.
	Rapid test for syphilis as part of focused ANC.	Percentage of pregnant women tested for syphilis out of total ANCs registered.	80 percent	Maintaining confidentiality.
	Initiate PPTCT services in contexts where HIV/AIDS is the main cause of death.	Percentage of pregnant women tested for HIV out of total ANCs registered. Percentage of HIV positive pregnant women and lactating mothers receiving ARV .Percentage of infants born to mothers enrolled in PPTCT tested for HIV before eight weeks of age Percentage of infants exposed to HIV, initiated on ARV.	80 percent 80 percent 50 percent 95 percent	Maintaining confidentiality.

Minimum Quality Standards for Health Sectors		Indicators	Benchmarks	Inter-sectoral Coordination
STIs & HIV/AIDS	Number of district and block health facilities with availability of clinical management of rape survivors + emergency contraception + PEP available.	Percentage of district and block health facilities with availability of clinical management of rape survivors + emergency contraception + PEP available.	100 percent	NGOs for reporting to health facilities, police, counselling, Nari Niketan.
Non-communicable diseases, injuries and mental health	Rescue and evacuation, first aid, and surgical care needs are immediately available following natural disasters like earthquakes.	Mortality rate amongst the rescued and evacuated.	< 10 percent	Green passage for ambulance and healthcare personnel. Crowd control.
	Re-stocking of supplies for chronic diseases in circumstances of high burden.	Proportion of healthcare facilities that have adequate medication. To continue the pre-emergency treatment, including pain relief, of individuals with NCDs.	80 percent	Identification of individuals on medication for chronic diseases. Linking these individuals to the health facilities.
	Protect and care for people with mental disorders and others in institutions.	Proportion of people with mental disorder who received mental health treatment in a given clinic.	80 percent	Identification of institutions that provide mental healthcare. Counselling. Follow-ups. Reminders.

Minimum Quality Standards for Health Sectors		Indicators	Benchmarks	Inter-sectoral Coordination
Environmental health	Safe sharp and medical waste disposal system in place in all facilities.	Proportion of health facilities having deep burial (2m X 2m X 2m, cemented or wire mesh lid) and sharp burial pits (1m X 1m X 1m with cemented lid).	100 percent facilities.	Construction of burial pits.
	24 X 7 power supply to health facilities for indoor admission facilities + delivery facilities + cold chain.	Proportion of health facilities having electrical cold chain equipment also having indoor admission facilities & / + delivery facilities, with hybrid solar power.	Atleast 50 percent	Electrical and solar engineers.

Sector Strategy and Agenda

SECTOR STRATEGY AND AGENDA

The health sector response strategy in crisis is the principal tool for ensuring that the actions of all health actors are coordinated and, in particular, the actions of external health actors are well coordinated with, and appropriately support, those of the national and local health authorities and other local actors. It provides a framework for planning health response throughout the affected area(s), including the allocation of resources.

Steps in Developing a Health Sector Response Strategy in a Crisis

Health strategy development should be based on situation analysis.

Defining Priority Areas

Define affected geographical areas in relation to the priority health problems and risks. They should focus on addressing the main causes of death and illness in the local context and the major constraints to delivery of and access to healthcare services. Initially the focus will be on ensuring that life-threatening humanitarian needs are met, while always looking for opportunities to promote recovery and rebuild systems. As soon as life- threatening needs are met, the focus should shift progressively towards re-building national systems and capacities while ensuring that any remaining humanitarian needs are met.

Defining Objectives

Objectives must address the priority problems and risks and should take into account:

i. The context, capacities and resources.
ii. Seasonal variation and expected evolution of overall situation.
iii. Any protection or human rights issues, access issues, constraints on people and services.

Identification of Strategies

Response strategies must be appropriate and address priority problems and risk effectively. These should be feasible in the local context and aim to build back better and should do no harm.

a. While identifying response options and strategies consider the advantages and disadvantages of each option.
b. Analyse options carefully to identify the most appropriate option.

c. Draw from experiences of similar crisis, or previous crisis in the same area. The following table can be used to analyse the available response options.

Table 5: Healthcare Response Option Template

Problem/ Risk/ Issue	Key Points from Situation Analysis	Specific Objectives	Response Options	Advantages	Disadvantages	Relevant Experiences
E.g. Epidemics	An outbreak of acute encephalitis syndrome has recently occurred in 5 districts of UP.	Ensuring efficient response to epidemic outbreak and relief with a caring approach towards the needs of the vulnerable sections of the society.	Training of stakeholders in disease surveillance and action.	Improved surveillance. Quick response action.	Requires a robust mechanism of coordination and collation of data.	Done by UP Government in 2006-07.

Actions of the Health Sector Committee

- If a Health sector contingency plan exists, review the objectives and strategies and adjust them to the current crisis situation. If no such contingency plan exists, develop objectives and strategies.
- Prepare a concise statement of goal and priority problems to be addressed in initial period (say 1 month), specific objectives and strategies.
- Once the assessment findings are available revisit the objectives and strategies and modify for 6-12 months.
- At regular intervals and after any significant change in situation, review the strategy and make adjustments ensuring that it is adapted as the context evolves.
- Committee to have women leadership along with community leadership for working together in responding, strengthening preparedness, prevention and response during humanitarian emergencies.
- Committee to have representation from dalit, tribal and minority groups.

What to Include in a Health Sector Response Strategy?

The document must present the priority areas, the objectives and response (activity-level) strategies and the rationale. The rationale must explain, concisely, the reasons – the justification – for the priorities and the chosen strategies.

This will be very brief for the preliminary strategy document, more detailed for subsequent ones.

It should provide a concise analysis of the situation including the prioritized list of the main problems and their underlying causes, and explain the choice of priority areas; present the objectives for each main area of intervention (e.g. prevention and control of communicable diseases, injury rehabilitation, surveillance, drug supplies management).

The proposed strategies need to achieve the objectives, showing how the objectives and strategies derive from the assessment findings and situation analysis; and highlight the operational constraints and inter-sectoral cross cutting concerns that have been identified as being particularly important for health in the current situation and explain how they have been taken into account, show how general emergency programming principles have been applied and provide ways to facilitate effective supply and distribution of essential emergency response materials/medicines to different geographies during disasters.

Key Components of a Health Strategy

- Priority health needs and risks.
- No more than 5 objectives with health indicators to measure progress.
- Activities under each objective.
- People in need/ affected and targeted.
- Sector Committee Strategic Response Plan (SCSRP).
- Monitoring plan for the achievement of objectives.
- Implications if the health strategy is not implemented.

The Following Template can be Used for Developing a Response Plan:

Table 6: Template for Healthcare Response Plan

Indicator	In need	Baseline	Target
Disaster affected people served by emergency PHC/ mobile services (E.g of indicator).	20 lakhs	2 lakhs	80%
(Write indicator).	(in need)	(baseline population).	(percentage).

Health Objective: For example, ensure access to essential basic and emergency for disaster affected areas.

Supporting Health System Recovery

Before the onset of a disaster, skill and capacity building of locals should be the focus of guidelines for effective support and reach in emergencies. Following the

sudden-onset disaster, the strengthening/re-building of local health systems and capacity can be initiated from day-1 by designing and implementing all emergency health programmes and activities in ways that contribute to the said objective. Increased local capacity can be used to do so. The recovery phase after a disaster, provides a window of opportunity for "building back better" – ensuring an appropriate, sustainable health system, building preparedness systems and capacity to deal with future crisis, and instituting vulnerability reduction measures.

The post-disaster or post-crisis period offers important opportunities. The enthusiasm for reconstruction may be high, the generosity of donors may be considerable, and resistance to change can be reduced. Gender roles and responsibilities may have changed during a protracted crisis and there can be opportunities for women's empowerment and increased levels of gender equality. If the health system before the crisis contained (as it is often the case) distortions and inequities, the recovery phase may offer the possibility of laying the ground for improvements. These opportunities must be seized through multi-sectoral approach to strengthen the overall health infrastructure and the overall district health infrastructure.

Figure 3 : Six Core Health Systems Building Blocks (WHO)

The six core health systems building blocks (WHO)- for recovery are given below:

- Leadership and governance (capacity building, formulation of policies and strategies, developing coordination platforms and, supporting decentralisation).
- Human resources (early establishment of HR database, early planning for HR development, salary issues and training).
- Financing (realistic assessment of cost of recovery activities, government budget, humanitarian funding, global funds, etc.)
- Medicines and technology (ensure supply of essential drugs).
- Information (Develop/Re-establish health information management system, epidemiologic surveillance and early warning systems must be mainstreamed into regular operations at local level).
- Service delivery (strengthen primary healthcare services, planning and restoration of service delivery).

Resource Mobilization

RESOURCE MOBILIZATION

During any humanitarian disaster, responding agencies require 4 major types of resources at their disposal, namely:

1. Financial Resources
2. Human Resources
3. Material Resources
4. Knowledge and Information Resources

As a part of the work plan of the sector committee, members would be undertaking joint programming and advocacy initiatives based on the pre-determined key priorities. Therefore, resource mobilization forms a key component of the sector committee to minimize avoidable mortality and morbidity.

Financial Resources

Within 5 to 7 days of the onset of a crisis, the sector committee should convene and release a joint flash appeal to mobilize resources for humanitarian response during the first three to six months. After the first month, the sector committee should reconvene and revise the flash appeal to include additional information, more details about early recovery projects and appeal for simpler methods of funding for grass root organisations.

Some other basic principles

- The flash appeal should contain an initial response plan-developed jointly with participation of government agencies.
- The initial response plan should focus on lifesaving needs and necessary early recovery projects, and include a response strategy, roles and responsibilities of stakeholders, and outline of proposed projects based on early estimates, JRNA report and other available information.
- While government agencies may not appeal for funds, they may acknowledge the need for resource mobilization through a statement in solidarity with civil society organizations.
- Action points to develop flash appeal.
- Bring together all significant stakeholders and analyse the available assessment information, discuss any projects proposed by member organizations, develop a consensual strategy to ensure that the appeal contains relevant, high- priority, coordinated and feasible projects.
- Consult with other Sectors, notably FNS and WASH to ensure complementarity of projects and avoid duplication.
- Consult with MoHFW, MWCD on the appeal, and keep donors informed about the process.
- Submit the draft within 5 days of the decision to launch the flash appeal to Sphere India Secretariat. However, the actual deadline may be specified during consultation meetings of the sector committee in each case.

Common Resource Pool for the Sector

The Common Resource Pool (CRP) is a standby fund to be established/ facilitated by the Sphere India Secretariat to enable response to help jumpstart critical operations or support under- funded emergencies, intended to complement – and not substitute for – flash appeals. The funds are intended to support emergency response in general, and if any member organization wants to seek access to the fund, a proposal for the project funding is to be submitted to the Sector Committee and the Sphere India Executive Committee.

Action points for CRP Funding

- While releasing the flash appeal, donors should be appealed to contribute for the CRP.
- Internally, the sector committee shall agree on the high-priority projects which are not attracting attention of donor agencies and develop a Guiding Note for the Sphere India Executive Committee.
- The Sector Committee to invite organizations to submit proposal to it and the Executive Committee.
- The Executive Committee of Sphere India to select the projects to be funded based on the Guiding Note and the project proposal, and to ensure that the procedure to transfer the CRP funds is clearly understood.

Financial Tracking System

Sphere India Secretariat shall develop a Financial Tracking System (FTS) dashboard to track needs and contributions against the health/shelter component of the flash appeals and funding from CRP. It shall provide quarterly reports on the FTS, analysing the crises-wise utilization of funding, and the additional funding required to fulfill the priority projects.

Forecast-based Financing

Implemented in multiple countries, ***Forecast-based Financing*** (FBF) enables access to humanitarian funding for early action based on in-depth forecast information and risk analysis. The goal of FBF is to anticipate disasters, prevent their impact, if possible, reduce human suffering and losses. With strong forecast systems in India, this system could be well integrated in the humanitarian response strategies.

A key element of FBF is that the allocation of financial resources is agreed in advance, together with the specific forecast threshold that triggers the release of those resources for the implementation of early actions. The roles and responsibilities of everyone involved in implementing these actions are defined in the Early Action Protocol (EAP). Applying this at district level to ensure preparedness measures and allocation of resources and action will lead to much efficient response and reduced losses and damages. This ensures the full commitment for implementation among the involved stakeholders.

Mobilizing Human Resource

Major emergencies require rapid increase in the resources and an effective surge capacity is a pre-requisite for emergency response. The National Disaster Management Act and Plan has developed protocols for deployment of the National Disaster Response Force (SDRF) and the State Disaster Response Force (NDRF) for immediate relief and rescue operations. A cadre of the first responders and emergency volunteers to respond in the golden period is created with active involvement of multiple stakeholders for including Indian Red Cross and IFRC.

Multiple international and national organizations including the UN maintain emergency roasters and standby teams. Local NGOs operating remotely work to mobilize manpower for assistance demanding situations. These volunteers of non-profit organization are provided modules through training sessions on emergency response. Techniques such as providing ID cards and workspace will improve the efficiency of volunteer management. Separate SOPs for government, international, national and local non-government organizations to be referred while mobilising work force at grassroots to avoid duplication. During pre-disaster phase, uninterrupted communication between state department and inter agency groups act as a founding step for implementing sector strategy and mobilizing man power.

The disaster preparedness and development of district and village level DMP's should detail out the availability of such resources, including ASHA workers, Aanganwadi workers, small and marginal farmers and make efforts to invest in building capacities for instilling DRR, creating a cadre of trained volunteers and the first responders. The sector strategy must make necessary plans for resource mobilization- both financial and human resource and invest in building capacities.

Resource Mobilization Strategy

The Sector Committee Lead, with support from the members, shall undertake efforts to increase the participation of donors in the sector committee meetings, visits to the projects sites undertaken through flash appeals and CRP, oversee communication to donor agencies on behalf of the sector committee, and link potential donors to the sector committee and its members, wherever required.

Similarly, the Sector Committee Lead, in consultation with the members shall prepare a Joint Report to be prepared for donors based on funding received from the flash appeal or CRP, including a joint narrative report and a separate financial report for each organization. Donor support should be provided for backing all disasters including block specific and invisible health disasters. Thereafter, the sector committee to work with CSR donor agencies to enhance their financial support in situations of delayed involvement by the government and extending additional support in wider range of crisis situations.

Benchmarks and Indicators

BENCHMARKS AND INDICATORS

The following section outlines the benchmarks and indicators to be referred during the process of data collection, recording, and detailed analysis, pertaining to sub-sectors within health services. The outcomes and identification of gaps, along with planning are discussed below.

Level of Healthcare Services

The level of healthcare services varies according to the population to be catered as well as the nature of diseases. Broadly, it can be classified into three categories, namely, Community Care, Primary Care and Secondary/Tertiary Care.

Table 7: Healthcare Service Typology

	Healthcare Services Typology (By Level of Care and Health Sub-Sectors)			
Area/ Sub-Sectors			**Health Services**	
Community Care	C0	Collection of vital statistics	C01	Deaths and births.
			C02	Others: e.g. population movements; registry of pregnant women newborn children.
	C2	Child health	C21	IMCI community component: IEC of child care taker + active case findings.
			C22	Home-based treatment of: fever/malaria, ARI/pneumonia,dehydration due to acute diarrhea.
			C23	Community mobilization for and support to mass vaccination campaigns and/or mass drug administration/ treatments.
	C3	Nutrition	C31	Screening of acute malnutrition (MUAC).
			C32	Follow up of children enrolled in supplementary therapeutic feeding (trace defaulters).
			C33	Community therapeutic care of acute malnutrition.
	C4	Communicable diseases	C41	Vector control (IEC + impregnated bed nets + in/outdoor insecticide spraying).
			C42	Community mobilization for and support to mass vaccinations and/or drug administration/ treatments.
			C43	IEC on locally priority diseases (e.g.TB self-referral, malaria self-referral, others).
	C5	STI & HIV/AIDS	C51	Community leader's advocacy on STI/ HIV.
			C52	IEC on prevention of STI/HIV infections and behavioural change communication.
	C6	Maternal & new-born health	C61	Clean home delivery, including distribution of clean delivery kits to visibly pregnant women, IEC and behavioural change communication, knowledge of danger signs and where/ when to go for help, support breast feeding.

	Healthcare Services Typology (By Level of Care and Health Sub-Sectors)			
Area/ Sub-Sectors			**Health Services**	
Community Care	C7	Non-communicable diseases, injuries and mental health	C81	promote self-care, provide basic healthcare and psychosocial support, identify and refer severe cases for treatment, provide needed follow-up to people discharged by facility based health and social services for people with chronic health conditions,disabilities and mental health problems.
	C8	Environmental health	C91	IEC on hygiene promotion and water and sanitation, community mobilization for clean-up campaigns and/or other sanitation activities.
Primary Care	P1	General clinical services	P11	Outpatient services.
			P12	Basic laboratory.
			P13	Short hospitalization capacity (5-10 beds).
			P14	Referral capacity: referral procedures, means of communication, transportation.
	P2	Child health	P21	EPI: routine immunization against all national target diseases and ade-quate cold chain in place.
			P22	Under 5 clinic conducted by the IMCI-trained health staff.
			P23	Screening of under nutrition/ malnutrition (growth monitoring or MUAC or W/H, H/A).
	P3	Nutrition	P31	Management of moderate acute malnutrition.
			P32	Management of severe acute malnutrition.
	P4	Communicable diseases	P41	Sentinel site of early warning system of epidemic prone diseases,outbreak response (EWARS).
			P42	Diagnosis and treatment of malaria.
			P43	Diagnosis and treatment of TB.
			P44	Other local relevant communicable diseases (e.g. Sleeping sickness).
		P5 STI & HIV/AIDS	P51	Syndrome management of sexually transmitted infections.

	Healthcare Services Typology (By Level of Care and Health Sub-Sectors)			
Area/ Sub-Sectors			**Health Services**	
	Sexual and reproductive health area		P52	Standard precautions: disposable needles / syringes, safety sharp disposal containers, personal protective equipment (PPE), sterilizer, P 91.
			P53	Availability of free condoms.
			P54	Prophylaxis and treatment of opportunistic infections.
			P55	HIV counselling and testing.

	Healthcare Services Typology (By Level of Care and Health Sub-Sectors)			
Area/ Sub-Sectors			**Health Services**	
Primary Care		P6	P56	Prevention of mother-to-child HIV transmission (PMTCT).
			P57	Antiretroviral treatment (ART).
			P61	Family planning.
			P62	Antenatal care: assess pregnancy, birth, and emergency plan, respond to problems (observed and/or reported), advise/counsel on nutrition & breastfeeding, self-care and family planning, preventive treatment(s) as appropriate.
	Maternal & new-born health		P63	Skilled care during childbirth for clean and safe normal delivery.
			P64	Essential new-born care: basic new-born resuscitation + warmth (recommended method: Kangaroo mother Care – KMC) + eye prophylaxis + clean cord care + early and exclusive breast feeding.
			P65	Basic Emergency Obstetric Care (BeMOC): parenteral antibiotics + oxytocic/anticonvulsivant drugs + manual removal of placenta + removal of retained products with manual vacuum aspiration (MVA) + assisted vaginal delivery 24/24 & 7/7.
			P66	Post-partum care: examination of mother and new-born (up to 6 weeks), respond to observed signs, support breast feeding, promote family planning.

	Healthcare Services Typology (By Level of Care and Health Sub-Sectors)			
Area/ Sub-Sectors			**Health Services**	
	Maternal & new-born health		P67	Comprehensive abortion care: safety induced abortion for all legal indications, uterine evacuation using MVA or medical methods, antibiotic prophylaxis, treatment of abortion complications,counselling for abortion and post-abortion contraception.
		P7 Sexual violence	P71	Clinical management of rape survivors (including psychological support).
			P72	Emergency contraception.
			P73	Post-exposure prophylaxis (pep) for STI & HIV infections.
	P8	Non-communicable diseases, injuries, and mental health	P81	Injury care and mass casualty management.
			P82	Hypertension treatment.
			P83	Diabetes treatment.
			P84	Mental healthcare: support of acute distress and anxiety, front line management of severe and common mental disorders.
	P9	Environmental health	P91	Health facility, safe waste disposal and management.

	Healthcare Services Typology (By Level of Care and Health Sub-Sectors)			
Area/ Sub-Sectors			**Health Services**	
Secondary and Tertiary Care	S1	General clinical services	S11	Inpatients services (medical, pediatrics and obstetrics and gynecology wards).
			S12	Emergency and elective surgery.
			S13	Laboratory services (including public health laboratory).
			S14	Blood bank service.
			S15	X-ray service.
	S2	Child health	S21	Management of children classified with severe or very severe diseases (parenteral fluids and drugs, O2).

	Healthcare Services Typology (By Level of Care and Health Sub-Sectors)			
Area/ Sub-Sectors			**Health Services**	
	S6	Maternal & new born health	S61	Comprehensive emergency obstetric care: BEMOC + caesarean section + safe blood transfusion.
	S8	Non-communicable diseases, injuries and mental health	S81	Disabilities and injuries rehabilitation.
			S82	Outpatient psychiatric care.
			S83	Acute psychiatric inpatient unit.

Table 8: Benchmarks and Indicators for Mortality Rate

		Indicators	Type	Data Collection Method	Benchmarks
Health Resources Availability	A.1	Average population covered by functioning Health facility (HF), by type of HF and by administrative unit.	Input, proxy	HerAmS	Sphere standards: 10,000 for 1 health unit, 50,000 for 1 health centre, 250,000 for 1 district/ rural hospital.
	A.2	# HF with basic emergency obstetric care/ 500,000 population by administrative unit.	Input,	HerAmS	>=4 BcMOC/ 500,000
	A3	# HF with comprehensive emergency obstetric care / 500000 population, by administrative unit.	Input	HerAmS	>=1 CeMOC/ 500,000
	A4	% of HF without stock out of a selected essential drug in four groups of drugs, by administrative unit.	Input	IRA	100%
	A.5	# HF of hospital beds per 10,000 population (inpatients & maternity), by administrative unit.	Input	HerAmS	>10
	A.6	% of HF with availability of clinical management of rape survivors + emergency contraception + pep available.	Input	HerAmS	100%
	A.7	# HF of health workforce (md + nurse + midwife) per 10,000 population, by administrative unit (%m/f).	Input	HerAmS	> 22

		Indicators	Type	Data Collection Method	Benchmarks
	A.8	# HF of CHWs per 10,000, by administrative unit.	Input	HerAmS	> 10
Health Services Coverage	C.1	# HF of outpatient consultations per person per year, by administrative unit.	Output	HIS/ EWArS	>=1 new visit/ person per year.
	C.2	# HF of consultations per clinician per day, by administrative unit.	Output	HIS	Less than 50/ day per clinician.
	C.3	Coverage of measles vaccination (6 months–15 years).	Output	HIS, survey	95% in camps or urban areas, 90% in rural areas.
	C.4	Coverage of dpt3 in <1 year, by administrative unit.	Output		95%
	C.5	% births assisted by skilled attendant.	Output		90%
	C.6	% expected deliveries by caesarean section, by administrative unit.	Output	Prospective HF-based surveillance.	>=5% and <=15%
	R1	# HF of cases or incidence rates for selected diseases relevant to the local context (cholera, measles, acute meningitis, others).	Outcome	EWARS, IRA, Prospective HF-based surveillance, Surveys.	Measure trends
	R.2	# HF of cases or incidence of sexual violence.	Outcome	Prospective HF-based surveillance, surveys.	Measure trends
Risks Factors	R3	CFR for most common diseases.	Outcome, proxy	Prospective HF-based surveillance.	Measure trends
	R.4	Proportional mortality.	Outcome, proxy		Measure trends
	R.5	# HF of admissions to SFT & TFC.	Outcome, proxy		Measure trends
	R.6	Proportion/ number of U5 GAM and SAM cases detected at OPD/ IPD.	Outcome, proxy		Measure trends

		Indicators	Type	Data Collection Method	Benchmarks
	R.7	Proportion of people with <15l of water/ day.	Outcome, proxy		Measure trends
Health outcomes	O.1	CMR	Output	HH survey	>=2x base rate OR >1/10,000 per day*
	O.2	U5MR			>=2x base rate OR >2/10,000 per day*

Source: *Üstün B, Kostanjsek N, Chatterji S, Rehm J (eds). Measuring health and disability, Manual for WHO disability assessment schedule, WHODAS 2.0. Geneva: World Health Organization, 2010 (in press).

Mortality being a dynamic data, there is a need to fix a standard population denominator and a standard time period, in order to calculate the mortality rate. In case of different population size during a certain time span, the arithmetic mean of the population should be used for calculation purposes. The mortality rate can be estimated in the following two ways:

Table 9: Methods to Estimate Mortality Rate

Situation	Usual Frequency of Data Collection	Calculation of Mortality Rate
Acute emergency period.	Each day, or every few days.	Deaths/ 10,000/ day
When the health situation has stabilised.	Once-a-month.	Deaths/ 1000/ month

References

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