

# THEMATIC HEA & Advocacy BRIEFING

World Vision

## health in emergencies

Prepared by WVI HEA and Policy & Advocacy, Thematic Briefings are designed for World Vision staff who may be called upon to provide a "World Vision response" on emergency-related advocacy issues. If a more detailed or nuanced response is needed, please contact Jan Butter, Public Policy Communications Manager, or the people listed at the end of the Briefing.

**Health and nutrition are critical determinants for survival in the initial stages of a disaster, and as such form part of World Vision's emergency response, with close links to related sectors such as water, sanitation and hygiene (WASH), shelter, and protection. The priority of World Vision's programming and advocacy is to save lives by addressing the health and nutrition needs of affected populations and to contribute to improved health outcomes for children.**

### overview

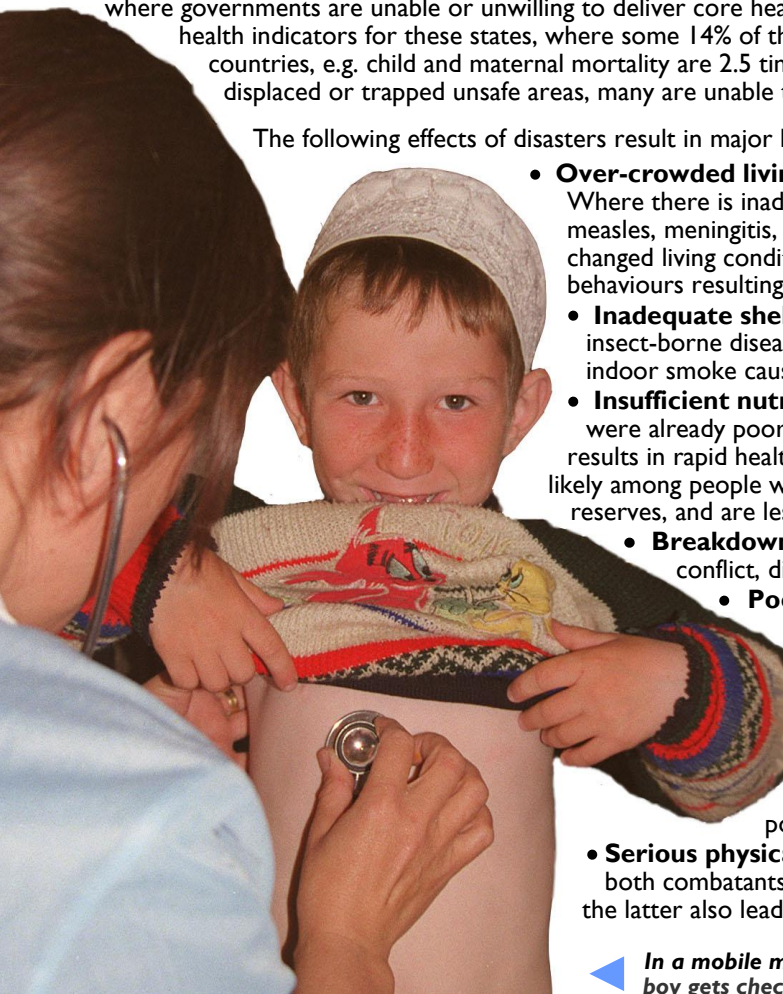
The number and impact of disasters is increasing. In 2008 there were 750 natural disasters including earthquakes, floods and storms with a combined death toll exceeding 220,000 (135,000 in Myanmar and 70,000 in China alone), over one billion people affected, and damage valued at over US\$200 billion.<sup>1</sup> Survivors of such disasters face trauma, injury and the threat of disease, as well as lack of support for ongoing and chronic health conditions due to breakdown in basic services. More broadly, climate change and food insecurity are resulting in changed health status (increase in communicable and mosquito-borne disease, malnutrition) of communities.

There are also acute and chronic humanitarian emergencies caused by political instability and conflict – many occurring in "fragile states" where governments are unable or unwilling to deliver core health services to their people. According to the NGO Health Unlimited, health indicators for these states, where some 14% of the world's population lives, are worse than for other developing countries, e.g. child and maternal mortality are 2.5 times higher. In areas of conflict where large numbers of people are displaced or trapped in unsafe areas, many are unable to access even the most basic of services.<sup>2</sup>

The following effects of disasters result in major health risks:

- **Over-crowded living areas as affected populations congregate in unsafe locations.** Where there is inadequate personal space and lack of privacy, diseases such as pneumonia, measles, meningitis, tuberculosis and cholera spread quickly. In addition, insecurity and changed living conditions can lead to greater risk of sexual violence and risk-taking behaviours resulting in sexually transmitted infections, HIV and AIDS.
- **Inadequate shelter** can result in dehydration or cold-related illnesses, exposure to insect-borne diseases as people sleep in the open, and respiratory disorders because of indoor smoke caused by inadequate ventilation.
- **Insufficient nutrition intake** Often the most vulnerable to disaster are those who were already poorly nourished and deficient in micro-nutrients, so further food insecurity results in rapid health deterioration. Epidemics of measles or diarrhoeal diseases are more likely among people with lower immunity. Children are the most affected as they have fewer reserves, and are less likely to eat if sick.
- **Breakdown of health (including vaccination) services** during extended conflict, displacement or over-crowding raises the likelihood of disease outbreak.
- **Poor water, sanitation and hygiene** can result from contamination of water at source or in storage, unsafe food preparation or lack of hand-washing behaviours, while inadequate sanitation services for crowded conditions accelerate spread of diarrhoea and insect-borne disease.
- **Delayed or ineffective treatment**, due to the affected community's limited access to affordable treatment or a lack of resources and trained health workers, can result in death or disability, accelerate degeneration in the case of chronic diseases, and pose danger for women in childbirth.
- **Serious physical injuries** incurred during natural disasters; conflict-related injuries in both combatants and non-combatants from guns, landmines, rape and sexual violence; the latter also leading to unwanted pregnancy or exacerbating the spread of HIV and STIs.

◀ *In a mobile medical clinic assisting displaced Chechen people in Ingushetia, a young boy gets checked for signs of respiratory disorders. Photo: Ben Negus/World Vision*



- **Disaster trauma and lack of community support networks** can exacerbate existing mental illness, cause new incidences of mental illness and lead to psycho-social distress. Many disaster-affected areas have limited access to mental health services, and disasters result in large numbers of people living without their normal support mechanisms. In addition lack of safety and family separation can place certain members of society at greater risk of violence, exploitation and isolation, all affecting people's psycho-social well-being.
- **Severe strain on existing health services** due to the large number of injuries/illnesses incurred during the disaster.

## Operational definition and legal framework

The World Health Organisation in 1948 defined health as a state of complete physical mental and social well-being and not merely the absence of disease or infirmity.<sup>3</sup> This has been expressed in numerous legal codes, global conventions and charters:

- The 1948 **Universal Declaration of Human Rights** (Article 25) states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, and housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."
- The 1949 **Geneva Conventions**, which apply during times of war or armed conflict, assert the rights of the wounded and sick (combatants or non-combatants) to health care; the protection of health workers and facilities (First Convention); and the responsibilities of occupying powers to provide for the population's basic needs including health care (Fourth Convention).
- The 1966 **International Covenant on Economic, Social and Cultural Rights** (Article 12) comprehensively states "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", and binds States Parties to work towards "provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child; improvement of all aspects of environmental and industrial hygiene; prevention, treatment and control of epidemic, endemic, occupational and other diseases; and the creation of conditions which would assure to all medical service and medical attention in the event of sickness."
- The 1966 **Convention on the Elimination of All Forms of Racial Discrimination** (Article 5) prohibits discrimination in the enjoyment of the right to public health and medical care.
- The 1979 **Convention on the Elimination of All Forms of Discrimination Against Women** (Articles 11, 12 and 14) cover the right to the protection of health in the workplace; reproductive health rights; equal access for women to health services; and access to services and adequate nutrition during the pre- and post-natal period.
- The 1989 **Convention on the Rights of the Child** (Article 24) obliges States to: ensure for all children the right to health and access to health care; diminish infant and child mortality; develop primary health care; combat disease, malnutrition and environmental pollution; provide adequate health education and information; develop preventive health care programmes; abolish traditional practices prejudicial to children; and promote international co-operation to enable the progressive realisation of children's rights.
- The 2006 **Convention on the Rights of Persons with Disabilities** (Article 25) covers the right to the enjoyment of the highest attainable standards of health without discrimination.

At regional level, the 1981 **African (Banjul) Charter of Human and People's Rights** (Article 16), obliges States to take measures to protect the health of their people and ensure they receive medical attention when they are sick; the 1988 **Charter of the Organisation of American States** (Chapter VII, Article 34) discusses the need for provision of health services and adequate nutrition for all people; and the 2004 **Arab Charter of Human Rights** (Article 39) establishes the right of all people to have access to health care without discrimination and (Article 40) specifically refers to the rights of people living with disabilities.

While 121 countries include the right to health or access to health services in their constitutions<sup>4</sup> and most countries have signed onto at least one international charter that ensures this right, in times of emergency governments are not always able or willing to meet their obligations. Non-governmental organisations may be asked or compelled to assist governments to meet their obligations in order to reduce excess mortality.

**Sphere and the Humanitarian Charter:** The Sphere Project, taking as its basis the legal imperatives of the right to life with dignity and the right to assistance, has consolidated and adapted knowledge and practice in disaster response to define minimum standards for disaster assistance. The 2004 edition has standards for health services and nutrition that are closely linked to other sectors of operation.<sup>5</sup> World Vision strives to meet the Sphere standards in health and nutrition activities.<sup>6</sup>

## World Vision programmes

World Vision Humanitarian and Emergency Affairs activities aim to protect and improve the health and nutrition of women and children during emergency responses, and to build resilience in communities to deal with shocks. World Vision seeks to support rather than replace the government in health service delivery, but in sudden-onset emergencies it may be necessary to engage in direct implementation in order to save lives. Within the breadth of health service needs, we focus on primary health services (including provision of basic medical supplies and nutritional interventions) to ensure that lives are saved and communities have access to health care. All responses are based on recognised international standards and best practices and are co-ordinated with the government, partners and other NGOs. In slow-onset emergencies responses we focus on establishing community-based preventive health and nutrition activities to address the underlying causes of maternal and child morbidity and mortality.

The nature of any emergency response depends on the context, situational assessment and community priorities, but key areas of World Vision health intervention include:

- **control of communicable diseases**

including health and hygiene promotion; disease surveillance and early warning; epidemic response; communicable disease prevention (e.g. insecticide-treated nets for malaria control, vaccination against measles and other childhood illnesses); and HIV&AIDS and STI awareness, prevention and support;

- **maternal and child health**

including community-based management of common childhood illnesses (e.g. acute respiratory tract infections, diarrhoea, malaria) through training and support of community health workers; safe assisted delivery (supporting birth attendants with training and delivery kits); promotion and support to essential newborn care practices; creating demand for birth spacing and family planning;

- **nutrition**

including promotion of optimal infant and young child feeding practices; micro-nutrient supplementation; implementing the community-based management of acute malnutrition (CMAM) approach; nutrition and early childhood feeding education including breast-feeding, complementary feeding and preparing balanced diets.

Additional areas of focus include psycho-social and mental health support; and links with other sectors such as water and sanitation, food security, and HIV&AIDS care and prevention.

<b>Examples of World Vision health and nutrition activities in emergency responses</b>	
<b>Darfur</b>	<i>Malaria epidemic response and preparedness, through the provision of mosquito nets to pregnant and lactating mothers, surveillance of outbreak of diseases, and health education to train mothers to recognise signs of disease and the importance of taking the patient for treatment</i>
<b>Niger</b>	<i>Community-based therapeutic feeding programme providing treatment for children with severe acute malnutrition, and a supplementary feeding programme for children with moderate malnutrition</i>
<b>Liberia</b>	<i>Improving access to primary health care by supporting primary health care clinics with medical supplies, training health workers, and facilitating outreach activities by providing transport</i>
<b>Zimbabwe</b>	<i>Responding to cholera outbreak by supporting the Ministry of Health with cholera treatment kits and medical supplies; community mobilisation and health education campaigns; and improvement of water and sanitation infrastructure. All these are accomplished in co-ordination with the government and humanitarian partners.</i>
<b>Somalia</b>	<i>Provision of primary health care through infrastructure development of primary health care units (PHCU), capacity building for PHCU staff, training for Traditional Birth Attendants, and provision of EPI services.</i>

## World Vision advocacy

The overall objectives of humanitarian action are to save lives and alleviate suffering, and the humanitarian imperative holds that disaster-affected people have the right to protection and assistance. These principles underpin World Vision's advocacy around health in emergency situations. Specific advocacy messaging is guided by the context, but general messages apply to particular target groups:

### to governments:

Recognising governments' role in ensuring their populations' right to health, especially during emergencies, we advocate that they act to: **(before and after a disaster)**

- ensure equitable access to primary health care;
- ensure minimum standards of service to prevent disease transmission (e.g. safe blood transfusion, infection control);
- prevent violations or lack of human rights that increase health vulnerability or have poor health consequences (e.g. harmful traditional practices, slavery, torture, violence toward women or children);
- ensure that health care and treatment are provided in a way that comprehensively addresses people's right to health (e.g. psycho-social support, freedom from discrimination, health services, food and nutrition, education and housing);
- strengthen health service infrastructure and systems in areas where there is a risk of natural disasters so that they can continue to offer services during emergencies (e.g. the safe hospital initiative);
- ensure training so that health workers can diagnose and treat illnesses that may increase during an emergency, and understand humanitarian standards and protection;
- endorse community-based management of acute malnutrition (CMAM) as an appropriate methodology for treatment for severe acute malnutrition;
- ensure the highest attainable standards of health, including the right to adequate nutrition, for all children, as stated in the *Convention on the Rights of the Child*;
- maintain surveillance systems to monitor trends in disease and mortality, which will not only enable governments to maintain their health services but provide early warning for outbreaks and possible epidemics.

### **(during an emergency)**

- promote equitable access to health services for all (especially where discrimination or favouritism exists for one or more groups);
- ensure that appropriate and adequate health personnel, supplies and equipment are dispatched to disaster areas to provide back up to local health services and ensure that services are maintained;
- allow free access of appropriate medical aid and personnel to the affected communities.

## to United Nations bodies and NGOs:

- ensure that affected populations have access to quality services in a coordinated manner and support and build capacity with the local MoH to ensure sustainability (refrain from creating a parallel system);
- ensure that all health and nutrition interventions are based on international standards and best practices;
- ensure that the design and implementation of health programmes do not violate human rights (discrimination, confidentiality, etc);
- challenge governments to take responsibility for the coordination and facilitation of disease control (even if a country does not have the resources to respond, it must take responsibility in facilitating the delivery of humanitarian assistance by the international community);
- develop policy on infant and young child feeding practices including the promotion, support and protection of breast-feeding;
- partner with other organisations to ensure that surveillance outbreak control and minimum services are offered to the affected communities;
- publicise the needs of the affected population to ensure that government, donors and the humanitarian community respond in a timely manner;
- evaluate the impact of activities on the health outcomes of the community and engage in research in areas of emergency medicine, and disaster response.

## to donors:

- support the strengthening of health systems to respond to disasters;
- support preparedness activities for predictable and effective response;
- support the capacity building of health staff at all levels of the health system;
- uphold and promote the principles embodied in the International Code of Marketing of Breast Milk Substitutes, and subsequent relevant World Health Assembly resolutions in protecting, promoting and supporting breast-feeding and safe and appropriate infant and young child feeding practices;
- match funding strategies with identified needs in the response;
- recognise the national standard drug lists and only provide materials that are within MoH guidelines (as health staff may not be able to use products that are unfamiliar to them);
- finance humanitarian health and nutrition responses in a timely manner;
- fund research into best-practice activities for emergency health response.

## resources

### GENERAL

Beaglehole, M & Bonita, R (2008), "Global public health: A scorecard", *The Lancet*, vol 372, no 8, pp 1–9

Checchi, F. et al (2007), *Public health in crisis-affected populations: A practical guide for decision makers*, ODI, London

The Sphere Project (2004), *Humanitarian charter and minimum standards in disaster response*, Geneva, <http://www.sphereproject.org/>

Médecins Sans Frontières (1977), *Refugee health: An approach to emergency situations*, Macmillan, London

Waltman, R J (2001), "Prioritizing health care in complex emergencies", *The Lancet*, vol 357, pp 1427–1429

World Health Organization (2008), *The right to health*, Fact sheet no 31, Geneva, <http://www.who.int/hhr/activities/factsheets/en/index.html>

### KEY WORLD VISION REFERENCE DOCUMENTS

World Vision International (2008), *Emergency health and nutrition strategy*

World Vision International (2007), *Procurement and use of milk products*, revised policy \*internal document\*

World Vision International (2006), *Partnership policy on reproductive health* \*internal document\*

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<sup>1</sup> AlertNet, "Disaster-heavy 2008 raises pressure for climate pact, insurance", 9 January 2009, [http://www.alertnet.org/db/an\\_art/20316/2009/00/5-174834-1.htm](http://www.alertnet.org/db/an_art/20316/2009/00/5-174834-1.htm)

<sup>2</sup> Health Unlimited, *Delivering health services in fragile states and difficult environments: 13 key principles*, November 2007

<sup>3</sup> WHO, *The right to health*, Fact sheet no 31, 2008, <http://www.who.int/hhr/activities/factsheets/en/index.html>, p 10

<sup>4</sup> *Ibid.*

<sup>5</sup> The Sphere Project is undertaking another revision of the standards and these will be extended to include new innovations in disaster response. The new revision should be completed by 2010.

<sup>6</sup> WV's work includes the standards of control of communicable diseases and non-communicable diseases, general nutritional support and correction of malnutrition. It also supports the interrelated sectors of WASH, food security and shelter. WV does not usually engage in the support of health systems and health infrastructure.