Manual for the Assessment of Health and Humanitarian Emergencies

January 2002

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January 2002, first edition

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Acknowledgement
This manual replaces the former MSF "Manual Exploratory Missions and Rapid Assessments", written by Marcel van Soest, 1994. Important parts of that manual were revised and used in the present Manual for Assessment of Health and Humanitarian Emergencies.

We would like to express our special thanks to Dr Jennifer Leaning for the careful reading and providing suggestions on the content of this document.

We would like to thank the numerous MSF members both in Amsterdam office and in our field missions that provided input during the writing of this manual.

We welcome any comments or critical remarks from those using this manual, that may contribute to its further improvement and perfection.
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FOREWORD

This manual has been developed as a practical tool for conducting assessments in health and humanitarian emergencies, which includes the **initial (rapid) assessment phase** and subsequently more **in-depth assessment(s) phase**.[1] The assessment manual forms part of a series of practical guidelines used by MSF in different phases of the project cycle. The other documents are the project planning, monitoring, and evaluation manuals.

The manual outlines the essential information required to identify and prioritise the health **needs** of an affected population that occur within a specific **context**. Information on the health and humanitarian needs within a context combined with information on the local and international **response capacity** are required in order to determine the need for an MSF response. Health is defined in its broadest sense as 'a state of physical, mental and social well-being and not merely the absence of disease and infirmity' (World Health Organisation). Human rights concepts are based on international norms and documents. The core concept is the essential dignity of all human beings. Health and rights of the affected population are integrally linked. Violations of human rights and humanitarian law have health consequences. This should be considered during all aspects of the assessment. Assessing health needs is not only measuring quantifiable indicators. The larger context of the underlying determinants of health needs, human rights concerns, and the cause of the crisis needs to be explored in order to be able to design appropriate projects that addresses the health needs more fully.

The **methodological tools** for data collection are discussed, including using a participatory approach in problem identification and relating the needs to the culture and context of the beneficiaries/rights holders. A full participatory approach with the community requires time and expertise, which is usually not the case in emergencies. However, there are various levels of participation and there should be an attempt to maximise the amount of participation within each level of urgency of the situation.

The analysis involves interpreting the information collected and forecasting the needs and the response capacity. Reporting needs to be standardised and give clear recommendations on whether a project should be started and if so, the type of project that will be relevant, appropriate, coherent and connected to the needs, context and capacity of the affected population[2]. The assessment should reflect the MSF mission statement[3], guiding principles and core humanitarian values[4].

This manual should supply an overall framework of the essential elements in an assessment. It should be used in a flexible manner and adapted to a particular situation.

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[1] Rapid assessment is the first phase of an assessment. A more in-depth assessment will be necessary for those areas identified during the rapid assessment phase. This manual is intended to address the content and methodology of both kinds of assessment – initial (rapid) and in-depth.

[2] For more details please refer to the Monitoring & Evaluation Manual, MSF-Holland.

[3] The current MSF mission statement is outlined in the MSF international Chantilly document.

[4] The MSF guiding principles and core values are outlined in the Medium term policy MSF Holland 2000 - 2002

1. INTRODUCTION

Assessing the situation and needs of an affected population is an *iterative cyclic process*. Information that you collect, whether through observation or other forms of data collection, will continuously present more questions. The complete process has been divided into *7 steps* that include planning and preparing for an assessment, data collection, surveillance, analysis and reporting the findings, conclusions and giving recommendations towards MSF (non) intervention. Details of the steps are discussed in section 2.

The manual divides the assessment itself into *two major phases* (each consisting of data collection and analysis)

1 Initial (rapid) assessment phase
- identify urgent health and protection needs of the affected population → short-term project planning/activities
- identify areas of focus for in-depth assessment(s)

2 In-depth assessment phase(s)
- detailed identification of specific (sectional) health needs of the population taking into account the connectedness with the context and local response capacities → medium-term project planning

In all situations, both phases of the assessment should be conducted. However, the amount of time spent on collecting information before designing and implementing a programme will be determined by the magnitude, dynamics and likely evolution of the humanitarian crisis and the current and potential public health impact on the affected population. If the situation is one of rapid deterioration in the health status of the population, an immediate/urgent response from MSF may be warranted. Programmes or activities that can be implemented immediately should not be delayed by a complete assessment. In such situations, a short-term plan is made to address immediate needs. Follow up project planning will require more detailed assessment(s). This information is used in the medium-term project planning, which includes forecasting possible future scenarios. With this additional information, initial short-term project plans may require adjustment.

In situations where there has been a slower evolution of humanitarian needs (relatively more gradual deterioration in the health status as a consequence of a prolonged conflict or collapse of state), more time may be available to the assessment team. However, even in these situations where there may already be a focus of attention identified, essential general information as outlined in the initial (rapid) assessment should be collected. This should ensure that other potential areas of needs and vulnerable groups are not forgotten. In both situations, the initial (rapid) assessment should identify those areas that require more detailed in-depth assessment.

During the assessment, the groups and areas most at risk should be identified whether ethnic or religious minorities, unaccompanied children, households headed by women or those groups differentially affected by the emergency/disaster. This includes those at risk from health threats as well as those at risk of human rights violations or stigmatisation which might lead to health risks. The existing response capacity - both local and international - needs to be considered. This includes the availability of human and material resources.

The next chapter of the manual gives a general overview of the 7 steps in the assessment process. This is followed by a more detailed description of each step. For the relevant steps, specifically the data collection, there are checklists to be found in the annex outlining the information that should be collected by the different methodologies. The methodologies are described in chapter 3 with sufficient detail to facilitate their use in the field.

In assessments, there is a risk that the information collected is dependent on the background of persons on the assessment team. Often the team members will collect information, which they are familiar with and feel comfortable collecting. As a result, the information/report - the output - of such a mission may be incomplete. The body of the manual should be read before initiating an assessment. Be familiar with the different methodologies of data collection as well as their advantages and disadvantages in certain situations. The relevant checklists should be photocopied or printed to facilitate data collection in the field. It is hoped that the standardised approach outlined in this manual will be a sufficient framework to ensure that all areas are considered during any assessment.

When conducting an assessment, be aware of how you are being perceived by the affected population and authorities. Always be sensitive of the cultural and social context of the affected area in order to avoid doing harm during the assessment mission. Try not to raise unrealistic expectations.

2. ASSESSMENT STEPS

The assessment process is divided into a 7-step procedure. The steps are considered the overall direction to be taken during an assessment. However, the speed of progression through the assessment process should be flexible and adaptive to the situation. Be aware that there is overlap between the steps. As you collect information, there is ongoing interpretation and plans in how to collect more information to validate the information already collected as well as new areas identified for investigation.

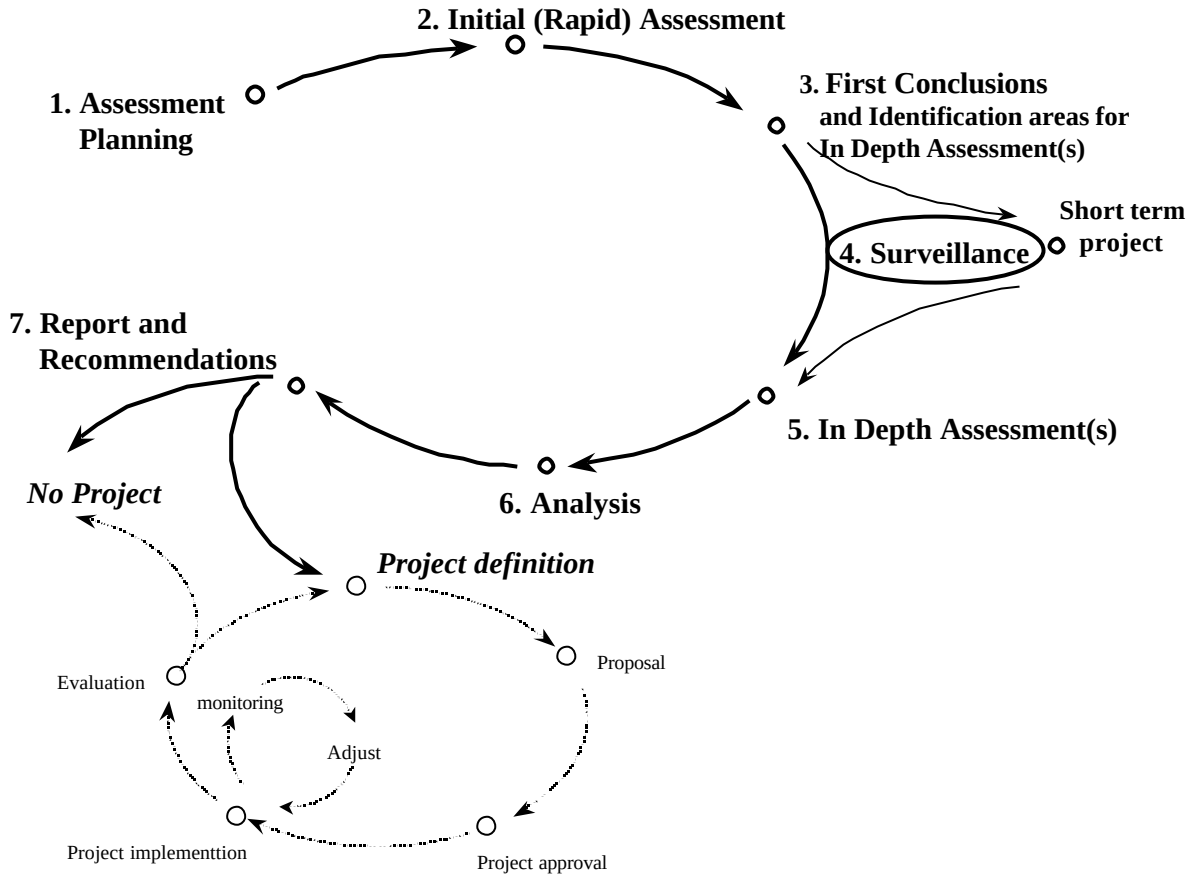

Figure 1. Assessment steps

OVERVIEW of STEPS

Step 1: Planning the Assessment

After the decision is made to conduct an assessment mission, planning of the mission is the essential first step. Good planning can avoid problems during an assessment. Ensure that there is clear understanding of the reasons for and expected results of the assessment by all parties.

Step 2: Initial (Rapid) Assessment Phase – Data Collection
There is essential information that should be collected in all assessments that cover the (potential) urgent needs of an affected population and their underlying public health causes. The speed at which this information is collected depends on the type of emergency. The various methodological techniques for collecting data are discussed in the methodology chapter. These techniques are used for both the initial rapid assessment and for the in-depth assessment(s). Specific checklists and forms are in the annex.

Step 3: First Conclusions and Identification of Areas for In-depth assessment(s)
After collecting data on potential urgent needs of the affected population, areas that require an immediate response should be identified. If there are emergency needs, short term programme planning and activities may need to be initiated at this step. If no such emergency needs are identified, then the rapid assessment information will be utilised to identify those areas where more in-depth data is required for deciding on an intervention.

Step 4: Surveillance
Ensuring or establishing an ongoing public health surveillance system is essential to monitor trends over time, assess changing needs of the affected population, evaluate the effectiveness of relief interventions and to plan or redirect future public health programmes. The initial (rapid) assessment provides baseline data, which can be used as a reference for further monitoring.

Step 5: In-depth Assessment(s) Phase– Data Collection
Much of the information collected here, overlaps with the Initial (Rapid) Assessment. The major difference is the depth in which certain areas are covered. Information gathered is more detailed and one attempts to gain a better understanding of the underlying causes of the conflict and public health issues. The methodological techniques are similar but time allows more rigorous methods of surveys, more extensive individual interviews as well as utilising a more participatory approach in data collection. The results of the in-depth assessment(s) should allow proper project planning.

Step 6: Analysis
Analysis involves interpreting the results of the information gathered in terms of the public health and human rights consequences of a humanitarian crisis and using this information in forecasting possible scenarios. This analysis should include information to answer two of the questions used in MSF decision taking on new projects: whether there is a necessity for outside intervention and whether it is necessary for MSF to intervene. In other words, is there a humanitarian crisis that has consequences on the health of a population where there is insufficient local and international coping capacity? The analysis should also look at the linkages between health and human rights as well as the possibility to work in accordance with humanitarian principles. In addition, the analysis should look at the most effective and appropriate responses as well as identify possible harmful effects of an intervention.

Step 7: Report and Recommendations
Results and conclusions need to be presented in a clear and concise manner. The most relevant information should be presented resulting in an overview of the total situation. The report includes

clear indication of the highest priorities and recommendations as to whether and how to address them. The report should be in a recognised and standardised format (annex 30) and be the basis for programme planning.

Annexes

The practical tools within each step - checklists and forms - to be used in the field are put together in the annexes. Topics are repeated in different checklists as a way to ensure that information collected is obtained by different methodologies and sources, thus allowing cross checking (triangulation). It is difficult to have a clear division of what should be included in the initial (rapid) assessment and what is deemed part of the in-depth assessment(s). The data collection annexes for step 2 and 5 has been arbitrarily presented as per methodology for Step 2 and information content for Step 5. However, of course methodology and content are needed for both steps. Remember that the information collected during the initial (rapid) assessment should ensure a broad overview of the emergency and identify the needs (immediate, medium term and potential).

The checklists in the in-depth section (annexes 17 to 28) attempt to cover the different sectors in more depth. However, in doing so, it encompasses the essential information required in the initial (rapid) assessment phase. So do not be alarmed at the repetition. The decision to include certain sector checklists will depend on the urgency of the situation, and how fast certain areas of focus are identified. All the checklists should be used in a flexible manner. One may not always follow the steps in order, but the steps and checklists should ensure that key information is not missed. In the text reference is made to other (MSF) guidelines for more details on certain assessment methods.

STEP 1: PLANNING THE ASSESSMENT

Decision on Initiating an Assessment

The initiative of an Assessment Mission can arise from the country co-ordinator or HQ (operational directors/emergency desk). An assessment mission is initiated because of *expected present or anticipated future humanitarian and health crisis* in an area. This decision can be triggered by different sources of information: continuous scanning/context analysis and forecasting, rumours, news by media or other agencies, request by authorities, etc.

The reasons for an assessment should be consistent with the MSF mid-term policy and specific country policies (if in place). If the undertaking of an assessment is the result of a perceived need for strategic presence [5] in a country, this needs to be clearly stated in the Terms of Reference (ToR) and understood.

After the decision has been made to do an assessment of a situation, some initial procedures need to be followed:

i) Definition of Terms of Reference clearly stating aims of the assessment
ii) Assessment Team Composition
iii) Briefings at head quarters (HQ) with the Operational Director (OD), Emergency Support Dep (ESD), Public Health Department (PHD), Humanitarian affairs Dep (HAD), Technical support group (TSG), Logistics and other relevant support groups
iv) Assessment Mission Announcement
v) Co-ordination with other Organisations
vi) Administrative Arrangements (including trip planning checklist: annex 1)

Terms of Reference (ToR)

Terms of Reference are essential. The ToR needs to include the known background to the situation, the justification of going, and the *overall purpose and objectives of the assessment*. The purpose of an assessment should be summarised in one sentence. The reasons for going should be clear to the assessment team, the country management team and the support departments. In addition, the expectations of OD(s) should be explicitly and transparently included in the ToR, but these should not bind or predetermine the recommendations made by the assessment team. A ToR will facilitate/determine what kind of information to gather and the methods in this manual can be adjusted to the ToR very precisely, which should be time and energy saving. Based on the ToR, the characteristics and composition of the assessment team members can be determined.

Assessment Team Composition

A mission team should be multidisciplinary and ideally consist of three persons. The composition will depend on the ToR. In general, at least one medical and one logistical person are needed. Based on expectations of what will be found a third person might be medical, nutritional, water and sanitation, mental health, technical, human rights, context, anthropological or other specialist. A *team leader* is selected and brief *job descriptions* should be made ensuring clear division of tasks. During the initial

[5] The term strategic presence is used in situations where there is no current humanitarian and health crisis but there are indications that an imminent crisis may occur. In these situations, MSF may want to be present to monitor and ideally respond timely to any emergencies.

rapid assessment, an area for in-depth assessment may be identified that requires a team member with specific technical expertise. This should be communicated with HQ and arrangements made to complement the team. In certain regions, nationalities of the team members may be sensitive. This should be reviewed with the humanitarian affairs department.

Briefings

Briefings should include a review and adjustment of this manual for the particular situation. This includes reviewing which measures and methods will provide valid and useful data for the purpose of deciding on an intervention. This can be done directly on the diskette of this manual so each team will take along the specific adjusted manual and report format for their unique mission. The sensitivity of information needs to be considered when taking written documents into the field. Briefings should be with the ODs, Emergency desk, Public Health Department, Humanitarian affairs Department, Logistics and all other relevant support departments. Other organisations present in the area should be contacted for background information. Information on reliable human rights organisations in the country of assessment can be obtained from the humanitarian affairs advisor. They can also advise on the risks of approaching a human rights organisation in the country. Often human rights organisations that can provide good information are based outside the assessment country.

Data Collection at Head quarters

Data collection is covered in Step 2 but is mentioned here to highlight the fact that much of the background information as well as information on the current situation can be obtained in Europe (sometimes more easily). The headquarters staff should assist in gathering and sifting information in a systematic and seasoned way. Individual team members are not expected to gather and analyse all the material by themselves. They should contact the relevant support departments who can assist in bibliographical searches and political analysis of documents and information in the public record.

Mission Announcement

Let other MSF sections (if already working there) and/or the Dutch Embassy (if not present, another friendly embassy) know that you are on your way. Be aware of any international MSF agreements relevant to the area. If the request is initiated from HQ, ensure that MSF H (if present) is fully aware of all plans. Inform the authorities at national and local level of purpose and timetable of the assessment mission.

Co-ordination with other Organisations and Government (if feasible)

Other organisations (other MSF sections, INGOs, UN agencies) as well as national and local government should be contacted to discuss their plans and intentions. If possible, assessments and subsequent interventions should be co-ordinated to avoid duplication of efforts. Pooling of resources can allow for more rapid and efficient assessments.

Administrative Arrangements

Include:

- travel and visas
- security clearances (understanding security risks, landmine awareness, existing security guidelines)
- organising transportation and other logistics, communication systems
- organise equipment required for the assessment (see annex 1 planning checklist)

STEP 2: INITIAL (RAPID) ASSESSMENT PHASE
DATA COLLECTION

Presented here is the overview of the general information required and the methods used to obtain such information. This information is used to identify urgent health and protection needs of an affected population, which may necessitate immediate action such as the provision of shelter, water, sanitation areas, food and life saving health care. It is also used to identify areas/sectors that are potential areas of need that are not covered by either local or international response capacities. It should be understood that this process may take only 1 or 2 days. The initial (rapid) part of the assessment is not a complete assessment, but only the first phase.

A lot of background (contextual) information can be gathered before departing to the assessment site and should help in already identifying potential sources of information. The safety of the assessment team should be acceptable. The level of security needs to be investigated before travelling to the affected area. Once at the affected area, the initial observation is important for an overall impression of the urgency of a situation and will assist in directing areas/sources for further investigation. The methodology used to collect data should be varied, concurrent, and allow for cross-checking of information. Consider the sensitivity of information collected and how it is recorded and kept. More detailed explanation of methodology is found in chapter 3.

In the annexes, the data collection annexes are split into two general sections: data collected according to methodology (annexes 2 to 14) and data collected according to sector (annexes 17 to 28). There is a lot of overlap in the information obtained in the two sections as the sections complement each other.

5 Context

The detail and amount of contextual information should balance with the urgency of a situation and the immediate needs of the population. Keep in mind that information collected should always be relevant to the overall assessment. One should get an idea of pre-emergency conditions as well as general contributors to the emergency/conflict. Much of this information can and should be collected before departure to the country. For useful Internet sites, see annex 2.

1.1 Pre-emergency Situation

a) Background information

General country characteristics; including geographical, climatic (temperature, rain fall), agricultural (crops, expected harvests), and economy.
Demography; including general population figures and relevant ethnic / tribal / religious groups.
Political situation; including state of national/regional authorities, political negotiations, and policies, opposition groups. Previous conflicts; including previous displacement / refugee population. Changing dynamics of the political situation. Events that occurred in the previous months that may have contributed to the emergency.
Human Rights Concerns ; concerns of target population, evidence of human rights violations, refugee protection, treatment or discrimination of minorities, women, and indigenous people.

b) Pre-emergency health care system

Structure of health services, level of functioning, limitation and constraints, financing of health care and stage of health reforms.

c) Pre-emergency health situation

Country health data; host country health data specific to the emergency zone and health data from where the affected population originated (if displaced or refugees). Mortality and morbidity rates and major morbidities contributing to burden of disease. What are the major endemic and epidemic disease patterns?

Nutritional status and food security, water and sanitation statistics

1.2 Current Situation

a) Type of emergency: first: confirming the existence and level of an emergency / disaster, then define type: chronic complex, armed conflict, sudden population movements, natural disaster, etc

b) General contributors to the emergency: control over natural resources, including land / water; ethnicity and religion, climatic influences, socio-economic contributors, etc

c) Onset and magnitude: describe evolution of emergency in a timeframe, extent of overall damage. What is expected in the near future?

d) Level of continuing or emerging threats: include security issues and potential/patterns of violence (armed conflicts, landmines)

Methodology:

- ***Review existing documents***: country files at HQ, MSF libraries, other sections and other NGOs or UN agencies, which are working in the country. Universities (in Holland KIT: Royal Institute of the Tropics) and donors may also have information in the form of country reports, studies, etc sitreps, country documents, reports from other organisations including human right reports, news media. ***Internet sites*** on political, geographical, health statistics, etc. (see annex 2)
- ***Observation*** : see observation checklist (annex 3)
- ***Key informant interviews***: government officials (Ministries of Defence, Interior, Health), UN agency officials (UNHCR, UNICEF, WFP, WHO etc), donors, embassies, EU, ICRC. INGOs (MSF sections, Oxfam, CARE, CRS, etc) Human rights organisations (Human Rights Watch, Amnesty International); who can be contacted in Europe through telephone, fax, e mail; perception of events (cause and dynamics) also with representatives of the affected and host populations, local NGOs (see annexes 4 to 12)

e) Affected area (sketch map)

Gather information on the geographical and environmental characteristics of affected area as well as the administrative and political divisions. One should mark the extent of the area as well as possible expansions. Rough Mapping of the affected area should include roads, villages/camps/public buildings (with displaced), distribution of population, and location of health facilities, water sources, markets. Distances (scale) should be specified as well as two or three levels of population density. Are there accessible or inaccessible areas, what are the reasons?

Methodology:
- ***Existing documents***: maps
- ***Observation***: if travel is by air, a preliminary observation of the affected areas can be made and photographed. This can include a gross estimate of extent of affected area(s), mass population movements, condition of infrastructure and geography. Large widespread areas may require more than one assessment team.
- ***Key informant interviews***: from the community, local NGOs, INGOs and UN agency staff.

f) Affected population (demography)

Estimate the size of the affected/unaffected population, breakdown by age, sex and vulnerable/risk groups. Estimate the average household size. Describe the socio-economic, cultural, ethnic and political characteristics of the population including prior health and nutritional condition. Is the population displaced (internally displaced / refugees)? What is the level of social coherence and coping capacity of the families/communities? Are there accessible or inaccessible populations/groups, what are the reasons? Are certain subsets of the population affected exclusively or more than other groups: if so what are the reasons, are there underlying inequities, discriminations, etc.

Methodology:
- ***Existing documents***: vital statistics, baseline level of health from national/regional levels of government, international and non-governmental sources and any MSF section already present, Internet sites (see above).
- ***Observations***: were all areas accessible, which areas visited (those more hit by the disaster)
- ***Key informant interviews***: as above
- ***Rapid survey***: sex and age distribution, average family size, number of population in vulnerable groups (annexes 13 and 14)

1.3 Security

a) Existing policies; What are the existing security policies and what are the restrictions for any intervention

b) Security risks; What are the security risks, history of incidents and targeting of aid workers, which areas are insecure/off limit, to what extent are members of the affected population and surrounding population armed and with what kinds of weapons? What is the range of non-state and state actors (guerrilla forces, army, NATO peace enforcement unit, UN peacekeeping force) and what are their rules of engagement (clarity, targeting civilians, adherence to Geneva Conventions, etc)? What are the requirements for any intervention with regards to security?

c) Resources; What kind of resources are required to ensure minimum security measures to start any intervention

2. Needs

2.1 Immediate health needs

Includes shelter, water, food, sanitation, curative health services, preventative services including vaccinations and psycho-social needs. Collect information on daily crude and under-5 mortality

rates/causes, major cause-specific morbidity, nutritional indicators/acute malnutrition rates, measles vaccination coverage, quantity and quality of water and sanitation available, food security , stress levels of affected population. What is the potential of epidemics (cholera, dysentry, measles, meningitis) and/or potential nutritional emergency/famine. What is the extent of known or suspected HIV and TB prevalence?

Look at the underlying public health causes of these needs as well as how human rights violations contribute to the identified health needs. See annex 28.

2.2 Immediate protection needs

Is the affected population (displaced/refugees) in a secure location where their safety and human rights are assured? While this is the responsibility of the state (if functioning) and/or the UN agencies and it is not the direct responsibility of MSF, MSF gathers information and advocates that the appropriate actors take their responsibility. Is there respect for and adherence to Human Rights Law (HRL) and Humanitarian Law (HL), including respect for the integrity of the person, access to humanitarian assistance, the security of refugees and displaced persons, and others?

Methodology:

- ***Existing documents***: hospital and clinic records (if existing)
- ***Observation***: walking through the affected area can give an impression of the adequacy of shelter, food availability, the general status of the population and potential hazards. Observed level of fear and willingness to be seen talking with you.
- ***Key informant interviews***: health staff, authorities, women, UNHCR and human rights groups
- ***Rapid survey***: recent death rates, recent rates of cause specific morbidity (diarrhoea, measles, traumatic injuries), nutritional status (MUAC or weight for height), vaccination coverage, state of housing, access to health care, food, water and shelter. Human rights abuses such as wounds (bullet, machete, landmines), torture, sexual assault, history of being targeted.

3. Response Capacity

3.1 Local response capacity / infrastructure

What is the local, regional and national capacity to respond to a crisis? Which actors / groups are present and in what sector are they active; including governmental bodies, local NGOs / grassroots organisations, private business, etc? What are the emergency or contingency preparedness plans? Have the authorities made an official request for assistance?

*Management / planning / co-ordination capacity***:** which governmental bodies are involved in responding to the emergency, which is the lead body and how does it relate to other governmental departments as well as to the relief community

*Financial capacity***:** of government, local NGOs

*Human resources capacity***:** medical personnel, non-medical personnel, and managers

*Infrastructure / logistics***:** including roads, transport, fuel, communication, and storage. What infrastructure is functioning, what is the extent of damage, how likely is it to be repaired?

*Health related infrastructure***:** existing medical services and equipment, drug supplies, technology available (laboratory, X-ray), surveillance capacity

*Community coping mechanisms***:** e.g. host families, local donations. And what is the anticipated

duration.

Methodology:
- ***Existing documents***: Administrative maps, annual reports of public sector services and personnel, health facility records (personnel, inventory, pharmacy, logistic) Emergency preparedness plans.
- ***Observation***: level of functioning of infrastructure and critical facilities, note damage to homes and markets, damage to roads. Amount of reserves: visits to stores and warehouses.
- ***Key informant interviews***: discuss plans, resources with authorities, local NGOs. Impressions of overall management and logistics

3.2 International response capacity

Is *MSF* present? If yes, what is its involvement and capacity (human resources, logistic, management and financial) in the country and neighbouring countries?

Which *international agencies* (UN agencies, OSCE, ICRC, INGOs) are present in the country / region, which are responding or planning to respond to the emergency? Include sector involvement, activities and capacity to expand. If there are protection issues, is there a UN agency taking responsibility? If UNHCR is present: what is their mandate, do they have protection officers, what are they doing and how effective are they in providing protection?

What *resources* have already been allocated / procured / requested for the relief operation?

What is the *co-ordination mechanism*: overall authority, distribution of tasks and responsibilities. Relation with the government bodies.

Which *donors* are present? What is the contribution of the donor community: define per sector, amount, receiving organisation, location and beneficiaries.

Custom Procedures: what are the procedures for importation: is NGO registration required, import duties, tax exemption, which drugs can be imported?

Communication: any restrictions to use radios, mini-m, etc, availability of power supply and equipment

Methodology:
- ***Existing documents***: Country activity reports, project proposals, sitreps, OCHA / UN / ICRC / OSCE updates and appeals, press releases, donor reports, internet (INGO websites)
- ***Observation***: Presence of INGOs / donor / UN / OSCE staff, vehicles, offices, on the ground activities.
- ***Key informant interviews***: discuss activities, plans, and resources with INGO staff, UN, OSCE, ICRC/IFRC, donors. Impressions of overall capacity.

STEP 3: FIRST CONCLUSIONS AND IDENTIFICATION OF AREAS FOR IN-DEPTH ASSESSMENT(S)

AT this stage in the assessment *urgent health and protection needs are identified* that require an immediate response. Short-term planning/activities may need to be implemented as a first response to save lives, forestall further decline in mortality and morbidity and ensure safety for the affected population. For areas to be considered see annex 15.

At the same time *areas are identified that require further and more detailed assessments*: Decisions are made on what information is needed for proper programme planning, how to evaluate and investigate any discrepancies in the data gathered so far, and whether a more intensive survey is needed to confirm the findings and validate the data.

STEP 4: SURVEILLANCE

Assessing the quality and needs of a health information and surveillance system is included as part of the initial (rapid) assessment:

- If there is no existing surveillance system, then as soon as it is clear that immediate input of MSF is required, a surveillance system needs to be set up.
- If there is an existing surveillance system, then the reliability of data should be assessed and if required improvements and training should be done.

A surveillance system consists of ongoing collection of data, the analysis of that data, the dissemination / feedback of the data analysed , and the implementation of a response based on the conclusions of the analysis. Surveillance systems need to collect information on mortality (crude, age-, sex-, and cause-specific), nutritional status, morbidity of significant public health concerns and diseases of epidemic potential. Samples of disease surveillance forms are found in annex 16. For more detail regarding the set up of a surveillance system, refer to the MSF Surveillance in Emergency Situations Guideline.

The system should also monitor access to food and clean water and should include sufficient information regarding human rights abuses. Blocked access, differential access to health care (based on what you know about the ethnic, gender, socio-economic distribution of the population), differential exposure to violence/trauma, population movement or flight (whether forced or voluntary) and obstruction to aid should be recorded systematically. It can be very basic but should produce reliable data that can be a very powerful tool to alert and persuade other organisations and donors of the need to act. Some of this information may be very sensitive so attention should be paid to how the information is requested and recorded. According to the context, this data may require a separate more confidential format and should be discussed with the Humanitarian Affairs department.

STEP 5: IN-DEPTH ASSESSMENT(S) PHASE
DATA COLLECTION

1. Context

Context and dynamics of humanitarian crisis: more detailed background information (see annex 17), including information on underlying causes and ongoing tensions.
Political environment and policies: Organisation of government. National, regional and local policies about health sector, existing and planned health policies. Attitudes of authorities to minorities and other groups. Government policies on key human rights issues.
Socio-economic factors: structure of the economy, income levels and distribution, educational level and literacy, employment patterns, type and distribution.
Cultural values and beliefs: Data on social aspects focus on traditional beliefs and values that facilitate or impede behavioural changes (health seeking behaviour). Do ethnic and/or religious differences cause tensions?
Security (see annex 18)

2. Needs

Specific areas of information about needs under:

- Curative and Preventative Health Services (including mental health)
  - General health checklist (annex 21)
  - District health assessment form (annex 22)
  - Health facility assessment form (annex 23)
  - Epidemic checklist (annex 24)
  - Psycho social checklist (annex 25)
- Nutrition (food and agriculture) and Food Security
  - Nutrition and food security checklist (annex 20)
- Water, Sanitation and Hygiene
  - Water checklist (annex 19)
  - Sanitation and hygiene checklist (annex 26)
- Shelter and non food items
  - Shelter checklist (annex 27)
- Humanitarian/Human rights situations including violence and security
  - Human rights concerns (annex 28)

Detailed checklists are located in the annex section. The checklists are presented according to sector and attempt to be fairly broad and therefore a lot of the information overlaps with the step 2 annexes (data collection per methodology). Essential information for the initial (rapid) assessment is highlighted but depending on the situation, one can select the information that is useful. The checklists are by no means complete but are meant to give some sense of the types of information that may be useful in deciding whether a project is required and assist in project planning. Additional references are given on specific subjects that can be useful when there is a known focus of interest.

Methodologies are discussed in Chapter 3. All methodologies should be used but should be more rigorous and participatory than during the initial (rapid) assessment phase.

3. Response Capacity

3.1 Local Response Capacity

Infrastructure: transport modes, communications and utilities (electricity)
Organisational characteristics of public and private sectors: what is the level of functioning of services provided by both sectors. What are the emergency preparedness plans (if any) and what is the capacity to respond to emergencies (existing and/or future)?
Organisational characteristics about the affected community: more detailed information about community composition, organisation and capabilities to act. What are the strengths and weaknesses of community leadership, organisations and structures?
Health services: service facilities (types and number, capacity, location), service utilisation, service gaps, organisational arrangements.
Resources: financial, personnel, buildings, equipment, vehicles, and drugs.

3.2 International Response Capacity

MSF Logistics: housing/office possibilities, possibility of hiring local staff, transport
(see Logistic checklist, annex 29)
Other international organisations: medium-term plans for projects, bringing in resources

Methodology:

- ***Review documents***: more detailed review. Understand the underlying causes of situation and the determinants of ill health.
- ***Observation***: a detailed look at and a visual inspection of the area focused in the rapid assessment. Also look at what is going on in the affected area (i.e. do people have livestock, do they have crops in their gardens, latrines, water), study the road conditions and transport problems within the area. Observe the functioning of the social and commercial services like health facilities, markets, food distributions, registration systems, military/police services. Also make notes on what people do; is this contradictory to the information obtained during interviews?
- ***Interviews***: verify with ***key informants***, information collected by other methods. ***Individual*** interviews with range of persons within and around the affected population. Ensure that the most vulnerable are included as well as a range of view points; range of persons of different gender, age, socio-economic class.
- ***Focus groups interviews***: community perceived needs, their priorities, their views on acceptable services.
- ***Surveys***: more detailed, specific surveys can be done targeting specific area identified during the initial (rapid) assessment
- ***Rapid Participatory Appraisal (RPA)***[6]: in a situation where time allows, use a participatory approach in collecting and analysing data.

[6] Rapid Participatory Appraisal is explained further in chapter 3, Data Collection Methodology

STEP 6: ANALYSIS

Much of the information collected in interviews, by observation and from documents is in the form of statements, opinions and descriptions. *Qualitative data* is analysed by identifying categories, sorting answers and then interpreting the findings. Data in each category should be summarised to produce a concise statement of the main findings. *Quantitative data* can be used to calculate specific health indicators (rates) according to definitions and compared with standard benchmarks (for calculations and benchmarks, see annex 30). If results differ from the standard, the cause of this differentiation needs to be examined and clearly explained in the report. Further discussion of data types and methodologies are found in chapter 3.

An important first part of data analysis is getting a sense of the data quality and scope. Data belonging to both categories needs to be evaluated in terms of its reliability, accuracy, completeness, consistency, plausibility and cross-correlation with data from other sources. Sources of data must also be evaluated in terms of credibility, comprehensiveness, representativeness, and specificity. Comment on how the results are validated by the different methods. (Potential) bias and errors – whether in data collection, survey design, analysis and interpretation – should be evaluated for their influence. Analysis should take into consideration the possible interaction of the various indicators, for example, a possible relationship between malnutrition rates and mortality rates.

Interpretation of the analysed data:

- Evaluate the data analysed within the contextual situation of the affected area and the dynamics of an emergency.
- Identify those at risk or vulnerable – define the affected population
- Determine the priority health and protection needs and human rights concerns of the affected population (backed up by data)
- Assess the local and international response capacity—present and anticipated
- Determine the unmet health and protection needs and human rights concerns of the affected population
- Determine potential emerging health and human rights concerns
- Assess the risks of intervention -- security, negative consequences / harmful effects of aid to a conflict. Identify factors[7] (and their relative importance) that are: potential tension/dividers/capacities for war and potential connectors/local capacities for peace. Consider how bringing in aid/resources will interact with these different factors? For more detail see annex 30
- Assess the consequences of no intervention
- Ascertain the main (anticipated) problems as a result of the crisis (ethnic balance disturbed, burden of the existing infrastructure, sharing few / limited resources, environmental consequences)
- Assess whether assistance can be provided to the affected (target) population according to humanitarian and MSF principles of neutrality, impartiality and independence

[7] Anderson MB. *Do no harm: how aid can support peace – or war.* Lynne Rienner Publishers, Inc. London 1999.

The analysis should answer the following two questions used in MSF decision making on new projects:

1. Is there a necessity for outside intervention? (based on the needs assessment within a given context)
2. Is there a necessity for MSF to intervene? (based on the assessment of the response capacity within a given context).

Analysis should always be done **DURING** the field trip, while the team is still in the field, as additional questions usually arise during and after the analysis. One may want to further cross-check or confirm initial conclusions. It is important to make time available in a safe and comfortable setting for the analysis.

STEP 7: REPORT AND RECOMMENDATIONS

The Report has to contain:

- an ***introduction and contextual overview*** of the affected area and the population
- presentation of the ***results of the data collection***, which should include indicators that show the impact of the humanitarian crisis on the health needs, as well as a brief description of the methodology and its limitations in the setting.
- ***data on the response capacity,*** both local (state of the existing infrastructure, existing local resources) and international response capacity (co-ordination efforts, resources)
- ***forecasting of different possible scenarios*** depending on evolution of crisis (ongoing conflict, worsening, resolution, etc).
- ***recommendations***:

- identify immediate and medium-term *health and human right needs* and *prioritise* actions that address them.
- recommend the *best strategy* to approach these actions considering the context and current response capacities. This should take into account the same criteria as used in evaluations: impact, effect on vulnerable groups, coverage, connectedness, appropriateness, and coherence [8].

  A SWOT analysis should be done for the proposed intervention.

A general outline for a report is presented in annex 30 in the form of a table of contents. It should be kept in mind that apart from a summary of all the information gathered, the report should provide an analysis of the data, should explain the urgency of the health and humanitarian situation as well as expected developments in the near future.

After the report and recommendations are made to HQ, two remaining questions need to be answered by the Management Team (MT) in HQ:

1 Is MSF willing to intervene?
2 Is it a possibility for MSF to intervene?

The assessment report and recommendations are taken into consideration as well as the overall organisational capacity and planning of MSF.

[8] See MSF Holland Monitoring and evaluation Guidelines

3. DATA COLLECTION METHODOLOGY

Assessments are often done in chaotic emergency situations. There may be constraints to collecting data: difficult or lack of access, time limitations, security incidences. Therefore data collection may not proceed in a logical step-by-step fashion. However the planning of data collection and the analysis should be systematic.

When collecting any data, always consider:
-is it ***useful*** in making decisions (do not collect too much or irrelevant data)
-how ***feasible*** is it to collect (considering the available resources and personnel)
-how ***reliable*** is it (accuracy, completeness, biases, representative of the affected population)
-is it worth the ***cost*** (includes security issues)

In general, there are two types of data: qualitative and quantitative. One is not better than the other. Both have their specific value:

- **Qualitative data** consist of phrases spoken by persons or observations. It is collected during unstructured or semi-structured interviews and/or by observation. Qualitative methods give depth and understanding on political, cultural and social and technical issues. It aids to contextualise the data.
- **Quantitative data** consist of numbers or numerical measurements. It is usually collected in a standardised and structured way. Structured questionnaires and/or measurements are collected using a specific design (surveys) so that prevalence, risks, rates etc can be calculated which are representative of the affected population in a way that minimises bias.

The way qualitative and quantitative data are collected is important for its validity and reliability. **Triangulation**, meaning the use of two or more different methods in combination, allows cross-checking of information obtained from different sources.

There are ***four main methods*** of collecting data :

3.1 Reviewing Existing Information / Documents

This includes reports, surveillance records and other documents (published and unpublished).

<u>Potential Sources of written information</u>
-HQ level (international reports, journals, media reports)
-MSF country reports, sitreps
-Census/vital statistics
-National and regional ministry records related to policies on health, housing, water, sanitation, environmental, social service and disaster plans etc
-International agencies, NGOs, institutions (in Europe and in country) reports of programmes, consultancies, studies, surveys
-Hospital and clinic records
-Historical records
-Internet sites (sites of health statistics, context reports, historical overviews, etc). See annex 2.

Question the reliability of the sources. Even official data are subject to limitations. Do the data represent the affected population? Are their groups within the population who are not included or are the statistics too general to recognise statistics on particular groups? How complete is the morbidity surveillance, in terms of (under-)reporting, use of proper case definitions etc?

3.2 Observation

Observation is a continuous process through out the assessment. It is an ongoing eye witnessing – active as well as passive - of all that is encountered during the assessment and includes:

a) Visual Inspection of the Affected Area

Examination of the physical environment, including visits to medical facilities, markets, food distribution sites, etc. These observations should be recorded. A map of key elements should be made.

b) Observation as validating data gathered from other sources

While interviewing can give information about what people think and say, observation will give information about what people *actually do*. It also provides information on the context surrounding events and actions.

Observation can be **overt** (people know you are watching) or **covert** (people are not aware). This information can be gathered independently of peoples wishes to co-operate but the ethics of this needs careful consideration. Private activities cannot (ethically) be observed.

The advantage of this method is that there is no intermediary when collecting the data. You record what you see. However a disadvantage is observer bias -- data collected is likely to vary according to observer and their interpretation can be culturally conditioned. Also the presence of an observer can have an effect on people's behaviour, they may show you what they want you to see.

3.3 Interviews

There are different types of interviews depending on the structure. An interview can be highly **structured**, usually with 'closed' questions and coded responses (traditional questionnaire). Interviews can also be **semi-structured**, with open-ended questions and an interview guideline or **in-depth**, where one or two issues are covered in great detail and questions are more based on what the interviewee says.

Interviews can be with ***individuals***, special interviewees (***key informants***) or with groups (***Focus Group Discussions***, which are discussed in the next session). Sampling for interviewing is usually selected in order to get a range of people's views. It is important that information obtained is representative of the affected population and does not just reflect one section of that society.

Key informants are people who you suspect to possess a lot of knowledge about the topic you are interested in. They are individuals who are looked upon as representatives of the opinion and experiences of a whole or sub-group. A key informant can be government officials, health personnel

(including traditional birth attendants), teachers, social workers, village elders, and leaders/members of local and international non-governmental organisation, leaders/members of informal groups (women or the poor). Key informant interviews are a major tool for Initial (rapid) Assessments. They can provide information about a community in a fairly short period of time and without a large number of people needing to be interviewed. It is important that persons identified as key informants represent the views of the community or sections within it and not their own views. Often persons chosen as key informants are the more vocal, better off, better-educated and more powerful members of the community, which can introduce a bias. They may not represent the views of the more vulnerable in the society. Time and effort should be spent locating key informants who represent the more vulnerable groups in the population (women and children, certain ethnic or religious group, etc.) Cross-checking is necessary and should include a few interviews with members of vulnerable groups. When time allows, more individual interviews should be conducted in order to get a range of opinions.

Informant security is vital. Be aware that by approaching someone for an interview, even randomly, may make that person more vulnerable in his own local setting. Always introduce yourself, explain the reasons for the interview and ask if they are willing to be interviewed. Informed consent should be clear and respectful. Assure the respondents that the information will be kept confidential. If information is sensitive, record only initials, age, sex and position as well as date and place of interview.

Interviews should be interactive and sensitive to the language and concepts used by the interviewee. Choice of translator is important, especially in settings where human rights abuses are known to occur and where there are distinctions between groups (religious, ethnic and gender). Be aware that having a certain translator may limit the type of information that can be collected (e.g. male translator for issues regarding abuse of women). Check that you have understood the respondents' meaning instead of relying on your own assumptions. Be aware of how you are perceived by the interviewee and how that affects the responses (responder bias).

Focus Group Discussions [9](FGD)

A focus-group interview is a type of group interview in which a small group (usually 8-12 people) discusses a topic freely and spontaneously, guided by a facilitator. The facilitator's role is to guide the discussion but not take part. If the assessment team member is an active participant in the discussion, then this should be called a group discussion rather than a FGD. FGD can be a quick and convenient way to collect data from several people simultaneously. They are helpful for gaining insight into people's perceptions, attitudes, opinions, behaviour and experiences. FGD can be used to examine not only what people think but how they think and why they think that way.

The idea behind focus group discussions is that people feel less inhibited in a group than in a one-to-one situation and that interaction in the group stimulates people to express their views. Although the opposite may occur, especially for sensitive topics. Informants can add information to each other's statements thus enabling the collection of more information than may be possible with individual interviews. They also use group interaction as part of the method. This can highlight (sub)

[9] Also referred to as focal group discussions

cultural values or group norms and generate new ideas. Sensitive/taboo subjects can sometimes be explored in depth but this depends on the group composition and how comfortable they perceive the environment. But it should be kept in mind that confidentiality can not be guaranteed in a group setting. This limitation should be explained to the participants.

Participants are selected according to their suspected knowledge on the topic. The group should be homogenous enough to capitalise on the shared experiences (sex, age, socio-economic class) but diverse enough to have fruitful discussions from different perspectives. Be aware that the hierarchy or differences (gender, ethnicity, etc) within a group may inhibit some from talking. It can be difficult to organise, facilitate a discussion and analyse the resultant data.

For more information on interviews, techniques, questionnaire design and focus group discussions, consult the recommended reading list in section 3.6.

3.4 Surveys

Surveys are episodic methods of gathering data from a selected representative subgroup of the affected population. They are useful for obtaining information that is not routinely collected (because of costs or feasibility). The major difficulty in surveys is ensuring that the sample group is sufficiently representative of the affected population.

Good sampling depends on the method (selection of people should be done as randomly as possible) and the size of the sample (the larger the sample, the more representative of the population from which it is selected).

There are different types of surveys: Health surveys, KAP (knowledge, attitude and practice) surveys, household surveys.
The household survey provides the "hard" data to confirm or reject initial impressions gathered from interviews and visual inspections. Surveys can include questions related to the human rights situation (if possible due to sensitivity), which can contribute to a more systematic understanding of the situation.

A major concern in survey work is how to reduce interviewer bias. Bias can result from a tendency to provide socially acceptable responses, or even the opposite, of making a situation seem worse than it is in reality. It is important that there is good translation of questions, that the meaning is understood. Survey questionnaires should be re-translated back to the original language by a different translator to check the accuracy of the local translation. Inter-rater reliability check (degree to which the results obtained by one interviewer can be replicated) should be done in rigorous epidemiological sound surveys. This can be time consuming.

For more information on surveys, consult the recommended reading list in section 3.6.

3.5 Rapid Participatory Appraisals (RPAs)

Rapid Participatory Appraisal is a way of collecting information needed for programme planning; it is not a method. All the different methodologies are used during a RPA. RPAs use open ended

research guides in small samples , involve a participatory assessment of health needs as perceived and defined by the affected population, and are considered short term research. However RPAs are not useful in the initial rapid assessment phase because of the length of time required.

The basis of this approach is to involve the community, especially the most vulnerable groups, in choices about their own health improvements. The community assists in information collection and analysis: describing the major threats to health, the priorities as well as assisting in developing the plan of action. There is an emphasis on gaining information about views and beliefs about health, the use of both traditional and modern health care.

Conducting a RPA: involves a multidisciplinary team consisting of those responsible for resources, authorities and members of the community (including women). Usually a ten-day workshop on the methods of collecting and analysing data is required.

For more information on the Rapid Participatory Appraisals, consult the recommended reading list in section 3.6.

3.6 Recommended Reading

Health assessments:

Epicentre and MSF. *Rapid health assessment of refugee or displaced populations.* MSF; Paris 1999

Methodology:

General: Smith PG and Morrow RH. *Methods for field trials of interventions against tropical diseases*. UNDP/World Bank/WHO; 1991.

World Health Organisation. *Qualitative research for health programmes*. WHO, Mental health division; Geneva 1994.

Observation:
Mays N and Pope C. Observational methods in health care settings. *BMJ* 1995; **311**; 182-84.

Interviews:
Britten N. Qualitative interviews in medical research. *BMJ* 1995; **311**: 251-3

Kitzinger J. Introducing focal groups. *BMJ* 1995; **311**: 299-302

Krueger RA. *Focus-group – A practical guide for research*. Newbury Park; London 1990.

Bowling A. 'Questionnaire design'. In: *Research methods in health*. Open University Press; 1997.

Rapid Participatory Appraisal:
Annett H and Rifkin S. *Guidelines for rapid participatory appraisal to assess community health needs.* World Health Organisation; Geneva 1995.

Scrimshaw SCM and Hurtado E. *Rapid assessment procedures for nutrition and primary health care.* United Nations University; Tokyo 1997.

SECTION II

ANNEXES

STEP 1

PLANNING

ANNEX 1

ANNEX 1

PLANNING CHECKLIST

Items can help simplify or amplify data collection in the field.

- Portable Computer (extra diskettes)
- Communication Equipment (Mini-M, mobile telephone, CC mail program)
- Maps of country / region
- MSF address and telephone list (list and telephone of contacts in country)
- Compass [optional: Global Positioning System (GPS)]
- Camera (with flash), film and extra batteries
- Tape recorder (check sensitivity)
- Cash

- This assessment manual, also on diskette (to allow revision of forms and questionnaires to specific situations)
- Additional copies of all checklists/forms (if more than one site will be visited)
- MSF security guidelines on the country (if exists)
- MSF Surveillance in Emergency Situations
- Specific MSF guidelines where appropriate (Epidemic guidelines, Nutritional guidelines, Refugee Health book, etc) Also available on diskette.

- Arm Circumference Tape (MUAC)
- First aid kit, anti malarials, mosquito net and repellent, PEP kit
- Clipboards, pens and paper (including MSF paper)
- MSF stamp and business cards
- MSF charter and general information of MSF (in local language if possible)
- Notebooks
- Squared paper
- Calculator
- Flashlight (candles)
- Water bottle

Depending on expected situation other items can be added such as:
- population counter
- pool tester, turbidity tube
- measuring board and weighing scales
- other

Annex 1 (step 1)

STEP 2

INITIAL RAPID ASSESSMENT

Annexes 2 – 16

ANNEX 2

USEFUL WEBSITES

General information on emergencies

- http://www.reliefweb.int/w/rwb.nsf (relief web) with links to UNOCHA
- http://www.paho.org (Pan-American Health Organization)
- http://www.icrc.org (International Committee of Red Cross)
- http://www.unhcr.org (UNHCR)

General country data

- http://www.odci.gov/cia/publications/factbook/index.html (U.S. Central Intelligence Agency 1998 World Fact book)
- http://www.atlapedia.com/online/countries (Key Facts and Statistics on the Country)
- http://lcweb2.loc.gov/frd/cs/cshome.html (Library of Congress)
- http://www.un.org/Pubs/CyberSchoolBus/menureso.html (UN dept of economic and Social affairs – statistic division)
- http://www.census.gov/ftp/pub/ipc/www/idbprint.html (US Census Bureau)
- http://www.un.org/Depts/unsd/refs3.htm (UN statistics Division)
- http://www.worldbank.org/data (World Bank)

Medical country data

- http://www.ippf.org/index.htm (International Planned Parenthood Federation)
- http://www.undp.org/hdro/statistics.html (UNDP Human Development Report)
- http://www.who.org/ (World Health Organisation)
- http://www.unicef.org/statis/ (UNICEF)

Nutritional data

- http://www.fews.net/ (USAID famine early warning system)
- http://www.fao.org/WAICENT/faoinfo/economic/giews/english/giewse.htm (Global Information and Early Warning System on Food and Agriculture (GIEWS)

Human rights country data

- http://www.state.gov/www/global/human_rights/hrp_reports_mainhp.html (US State Department)
- http://www.hrw.org (Human Right Watch)
- http://www.phrusa.org (Physicians for Human Rights)
- http://www.amnesty.org (Amnesty International)

annex 2 (step 2)

ANNEX 3

OBSERVATION CHECKLIST

Approaching the emergency zone, one can observe (and detect) many important aspects of the situation. It can give you an overall impression of the urgency of the situation. This checklist helps to pick up visual "clues". Review the checklist with the driver or pilot before you leave so that he can help spot the things one needs to see. Make notes and rough drawings to start mapping the area. Also make notes of the observations which might be useful during the interviews. A respectful entry to the affected area will aid in securing access and co-operation.

Observation is a continuous process. However, certain points should be recorded systematically (record place, date and time observations made). These observations should be used to validate information obtained from other sources, remembering that what people say may be different from what they do. Observation can also provide new areas of investigation and sources of information (e.g. help identify key informants and how they interact with the community)

1. General area observations:

- Terrain (dessert, mountain, etc.)
- Ground cover (grassy, sandy, barren, etc.)
- Presence of surface water (lakes, rivers)
- Status of local crops and vegetation
- Road types and conditions, road blocks, amount of traffic
- Signs of flooding, environmental degradation, etc.
- Signs of fighting, landmines

2. Affected area observations:

- Layout and organisation (esp. living areas)
- Size and possibility for expansion
- Density (crowding)
- Population movements
- Geographic location (on hill, in valley, etc.)
- Markets
- Location of health facilities, water sources, sanitation sources
- Condition of roads both now and in rain/snow seasons.
- Overall cleanliness
- Signs of gardens (crops) and animals (in field or roaming loose), micro economy
- Peoples' freedom to enter/leave affected area (note watchtowers, barbed wire, locked gate, road blocks, etc.)
- Presence of soldiers, rebels etc
- Level of relief agency activity (e.g., people actively working, presence of relief supplies, trucks, etc.)

annex 3 (step 2)

3. Location observations:

Proximity to: Border and/or front line
Towns/villages
Roads/railways
Surface water (lakes, rivers)
Host country (or friendly) forces or hostile forces
Refugee crossing points and other refugee/displaced settlements
Alternative sites

Visualise the information by a rough drawing of a map!

4. Affected population observations:

- Overall condition (healthy, active, obviously malnourished, etc.)
- State of dress, including shoes
- Friendliness/hostility/fear/depression
- Social activities (amount of alcohol / drugs available)
- Presence of men (as percentage of total population) and elderly
- Presence and appearance of children less than 5 yrs (skinny, oedema, normal, fat)
- Presence of unaccompanied minors, street kids
- Presence and appearance of pregnant and lactating women
- Activity levels in women, children
- Appearance of wounded / traumatized
- Presence of weapons

5. Detailed observations per sector:

- ***Shelter***: type, materials, number of shelter and number of homeless (for detailed checklist, see annex..)
- ***Water***: source, distance, quality and quantity, queuing, storage, spillage (for detailed checklist, see annex..)
- ***Sanitation and hygiene***: number, type and usage of defecation facilities, cleanliness, drainage and stagnant water, refuse disposal, washing facilities, soap availability and usage, vectors (flies, mosquitoes and rodents) (for detailed checklist, see annex..)
- ***Food and food security***: presence of food stock at household level, malnourishment, markets, food distributions (for detailed checklist see annex..)
- ***Health services and feeding centres***: number and types of facilities and level of functioning, number of patients waiting, staff presence, drug stocks (for detailed checklist see annex...)
- ***Logistics and security***: condition of roads, transport, communication means, power supply, number, size and condition of warehouses, conditions of storage (pallets, temperature, etc), supplies on hand, evidence of pests, security (guards, fences, lightening) and record keeping (for detailed checklist, see annex..)

annex 3 (step 2)

ANNEX 4

KEY INFORMATION INTERVIEWS CHECKLIST

General Points

This section contains some issues that can be highlighted by some of the major key informants. The topics listed are not complete but should serve as an interview guide only. Much of the information is repetitive. This is intentional as it allows for cross checking. Additional information about the context and background of the affected area can be obtained. Also topics that have been more detailed in certain key informant checklists can be used for other key informants.

Information should be systematically recorded. Note down the reliability of the source and the biases they may have.

The key informants that are listed below do not compile a complete list but attempts to cover the major people that are often identified as key informants. Remember that key informants should understand or represent the views of the community rather than themselves as individuals. Try and get a range of people from different backgrounds. Make an effort to get representatives from the vulnerable groups in the community.

These topics can also be used when conducting individual interviews but this should be marked clearly when recording the information.

List of Key Informants Checklists

- Government Officials / Authorities
- Embassies / Donors
- UN Agency like UNHCR, UNICEF
- Director of Health, Representative of MoH, Health Workers
- WFP and/or Food Distributor / Relief Agency
- Administrator / Senior Relief Officer
- Representative Humanitarian Agency (INGO, LNGO, ICRC, local Red Cross)
- Representatives of Community (formal and informal leaders/members)

ANNEX 5

KEY INFORMANT: GOVERNMENT OFFIAL (S) / AUTHORITIES

A. Registration information

1. Name; Position; From which ministry / government department.
2. Interview date; Address; Telephone Number
3. Previous posting, length of time in current post

B. Government View of Emergency / Policies

1. How do they describe the emergency and how do they think that it will evolve? What is the government's official position on the emergency? Are there any sensitivities?

2. What is their assessment of the damage? Who are the groups mostly affected?

3. What do they feel are the priority needs of the affected population?

4. What has been their response up to now and what are their short term and longer term plans for the future? Has there been an appeal for international assistance made by the government?

5. Which government departments are involved and what are their roles?

6. What is the government's capacity to deal with the situation: emergency preparedness or contingency plans.

7. What is the government's contribution? Have commitments already been made (food, staff, other resources)?

8. When the government/authority is involved in co-ordination, what is required from an INGO/MSF (permission letter, registration, etc). What has been the relationship before. Is there any Memorandum of Understanding between the authorities and MSF. What do they expect from MSF?

9. If there are refugees: has the government officially granted refugee status Y/N Have they or will they provide protection to the affected population?

10. Where does the Ministry of Health fit in the government's hierarchy? What are their general policies regarding health?

11. Has a similar emergency occurred before (health crisis like epidemic, natural disaster, etc)? What happened then; what was the government's response; what was the outcome?

annex 5 (step 2)

C. Population Specifics

1. Original population size (before conflict). Total number of affected population (local/refugees/displaced) and unaffected population in affected area. Breakdown by age, sex, ethnic group and socio-economic status.

2. What services were available for the inhabitants prior to the humanitarian crisis?

3. If refugee or displaced populations: place of origin; distance travelled (in km and in time), means of transport and date of arrival. Anticipated future arrivals.

4.Current location; general condition of environment and population; security situation population; problems currently occurring in/around area.

D. On site activities

1.Official in charge

2.Involved government departments, NGO's and UN agencies including their tasks

3.Lead agency for co-ordination of emergency relief.

E. Security

1.Brief profile of the warring/conflicting parties; impact on daily risks and risks of having contact with these warring parties

2.Security situation on-site for relief agencies and expats; when/where did security incidents happen; who are the primary targets; why are these groups targets (military/ strategic, property (theft & lootings), violence and/or revenge)

3.Necessity for military escorts; areas, districts, travel routes with (high) risks; mines and roads

4.Travel permit and/or camera permit needed.

annex 5 (step 2)

ANNEX 6

KEY INFORMANT: EMBASSIES / DONORS

A. Registration information

1. Name; Position; Organisation interviewed.
2. Interview date; Address; Telephone Number.
3. Length of time at current post, previous posting

B. Current Situation

1.What do they generally know about the existing emergency including: history of crisis, magnitude, population affected, and any groups discriminated against, certain vulnerable groups.

2. What is their overall assessment of the situation? And what is their view on the near future of the crisis?

3. What existing programmes do they fund or are involved in. Where are they located?
What international or local organisations do they work with?

4. What are their concerns about security? Have they had difficulties with delivery of relief supplies?

C. Policies

1. What are their donor policies, generally and regarding the existing emergency? Is money available? What are their plans / commitments generally and towards the emergency?

2. What are their official and unofficial positions towards the problem?

3. What are their impressions with how the government (including MoH) functions(coping capacities, respect of humanitarian principles and human rights law); how the UN systems functions, and the shortcomings and strengths of NGO's?

4. Interest in repatriation/plans for repatriation

ANNEX 7

KEY INFORMANT: UN AGENCIES

A. Registration information

1. Name; Position; Agency interviewed; How long in affected area
2. Interview date; Address; Telephone Number
3. Length of time in current post and region, previous experience

B. Population Specifics

1.Current location; Size of site/area; general condition of environment and population; security situation population; problems currently occurring in/around camp/area

2. Number of residents (local population); number of total pop (displaced+refugees+locals); total pop. before crisis (original population size); total number of people in need + source

3. In settings of population displacement (internally or refugees): a) Total number of refugees/displaced + source; date of arrival b) Place of origin; distance travelled (in km and in time) and means of transport. c) Number of arrivals per time unit; anticipated future arrivals

C. Policy / Protection / Security Issues

1. What are the current policies of the UN, government, and others towards protection? Has host country signed Geneva refugee protocol and what is their record on human Rights? UN representative at site; UN objectives towards the (potential) emergency/crisis (short and long term)

2. What is the official status of refugees; is (forced) repatriation already happening or in the planning process? Location of crossing points and/or front line; possibilities for border crossing and/or front line crossing and its procedures to do so if possible for refugees/displaced as well as aid workers/expats; situation on other side in general and specifically towards (potential) returnees

3. Access to the affected population/protection issues (e.g., actual or threatened combat in area, risk to refugees/displaced from local population or from host country military)

4. Profile of the warring parties; impact on daily risks and risks of having contact with these warring parties; is there any impact on security

5. Incidents where local and expat people are involved; areas, districts, travel routes with (high) risks; in case of incidents: who are the primary targets; why are these groups targets (military/ strategic, property (theft & lootings), violence and/or revenge)

6. Background of counterparts, authorities, church; do these contacts contribute to more risks or more safety

7. How does the UN system work with the authorities, with other INGOs, local NGOs?

D. Assistance

1. Committed UN support (funds, staff)/release of emergency funds/arrival time of UNHCR emergency unit; negotiations donors for relief

2. Coordination of NGO activities, who is responsible / in charge and level of functioning

3. Principal operating partners and programmes and (adequate) staff; experienced in relief operations; other agencies on site and their programmes (supplementary & therapeutic feeding, food distributions, medical programmes, water & sanitation programmes)

4. UNHCR/UNICEF involvement in general distribution/supplementary feeding; quantities pp/pd; intermediate agencies (transport, store-site); order procedures and their possible problems/shortcomings; the state of condition of emergency preparedness

5. Agencies working on the other side of the border/front line and their programmes; in the case of refugees, if any relief policy has been set up or has been planned by Gov't of departure country and/or UN to prevent more refugees or to support the returnees in case of repatriation

6. Views regarding data availability and quality. Helpful documents or surveys, other sources of information.

7. Needs which haven't been met yet; possible need for assessment on specific topics

E. Security

1. Security situation on-site for relief agencies and expats; necessity for military escorts; weapons; road blocks / check points; latest incidents on roads and on-site (like fights, robberies, etc.)

2. Landmines and roads (blocks, high jacking, other incidents)

annex 7 (step 2)

ANNEX 8

KEY INFORMANT : DIRECTOR OF HEALTH / REPRESENTATIVE of MOH / HEALTH WORKERS

A. Registration information

1. Name; Organisation; Position;
2. Interview Date; Address; Telephone Number;
3. Length of time in current position, previous post

B. Population and Area Specifics

1. What is the total population of the region/districts/ main towns, villages (serviced per health facility) pre-emergency. What is the size of the affected population; are they local inhabitants, returnees or displaced/refugee (illegal) populations, if so where do they originate and when did they arrive?

2. What is the population profile of affected and unaffected populations (men/women rate/<5yrs%/<15yrs%). Which ethnic groups among the population (plus percentages).

3. If displaced populations, where are they located; open or closed sites? If camp setting: name of site; date site established; size of site (estimated sq. metres). What are the numbers of homeless or evacuated accommodated in public shelters or evacuation centres?

4. How many new arrivals have there been since certain time unit; what is the expected pattern of migration for the future.

5. In their view, what are the major problems - Water (quantity, quality), epidemics, shelter, security, food supply, psychological stress; What is the total number of people in need; survival threatened by lack of adequate shelter and/or lack of blankets, clothing.

6. How many deaths have there been within the last month/week/24 hours (if possible for the total population and for the under 5 population). What is the data source (count, estimate, rumour, etc.).

7. Description of site - road access, sanitation, storage, shelter, cooking fuel, water sources

C. Health Facilities

1. Number and type of facilities in the area (divided by non- and functioning); quantity and quality health staff; is/was out-reach work/mobile medical team functioning; accessibility and utilisation of Primary Health Care; statistics/annual report incl. OPD+IPD visits and mortality; existence and usage of traditional health system; usage of diagnosis and treatment protocols

in the health facilities. Views on the level of functioning of the health care system, their constraints

2. Accessibility hospital for referrals - locals/displaced/refugees (travel time/distance/admission policy).

3. Feeding centres; quality and quantity of staff; usage of guidelines; is out-reach work functioning?

4. EPI: cold chain; type of immunisations; number of immunisations done previous month; mass programmes; vaccination supplies and regularity of supplies (expiry date); vaccine supplier; vaccination schedule used for children; vaccination coverage figures esp. measles if available. Views on level of functioning.

5. Drugs supplies, regularity of supplies and expiry date; standard drug list; fee system; supplier. Stock system, records. Standardised treatment protocols.

6. Is there health screening for new arrivals?

D. Morbidity / Mortality

1. Top 5 morbidity and mortality incl. rates; total # of deaths in last month, last week, and last 24 hours; trends; comparison with situation before conflict/ disaster; prevalence of communicable infectious diseases; seasonal influences on morbidity/mortality; levels of psycho-social stress. Their views on the reliability and quality of the data.

2. If epidemic, number of cases, currently increase or decrease (epidemic curve), number of deaths (case fatality rate), actions undertaken

E. Nutrition

1. Malnutrition rate and its source; trends; measuring method; marasmus - kwashiorkor ratio; diagnosis quality; moderate - severe ratio; mortality caused by malnutrition

2. Feeding programmes (supplemental and therapeutic); # of enrolled/admitted; # of attending, level of functioning

annex 8 (step2)

ANNEX 9

KEY INFORMANT: WFP and/or FOOD DISTRIBUTOR / RELIEF AGENCY

A. Registration information

1. Name; Position; Organisation interviewed; How long in area.
2. Interview date; Address; Telephone Number.
3. Length of time in post / region, previous experience

B. Population Specifics

1.Total affected and unaffected population; classification (local / refugees / illegal immigrants / displaced / returnees / etc.); Population profile (men/women ratio/<5yrs%)

2. Is number of affected population changing, how many new arrivals have there been since certain time unit; what is the expected pattern for the future.

3. What are the major problems - Water (quantity, quality), epidemics, shelter, security, food supply.

4. Description of area - road access, sanitation, storage, shelter, cooking fuel, water sources

C. Food Security

1. Food distribution; contents and quantities of food basket, official and reality (food basket monitoring); distribution points (is food distributed with dignity and respect); accessibility to distribution points (especially for vulnerable or stigmatised groups) and max distance to distribution points; warehouses; transport; road condition; corruption and other problems.

2. Diversion of food: for arms or black market, proportion, persons involved

3. Registration system; % registered of population in need; reasons for not covering total population in need; anticipating inaccessibility due to rainy season/insecurity?

4. Food acceptability to local population? Is cooking fuel/wood and equipment available? Is food aid sold - what do they buy with the money?

5. Organisation of supplementary and therapeutic feeding programmes; who provides the food; contents of meals; frequency of meals; problems and needs.

6. Food reserves of the population; comparison of displaced/refugees - local pop; when was the last harvest - when is the next harvest; Was the last harvest any good - what is the prospect for the next harvest? What are the main crops; are seeds and tools available to everyone; is there sufficient land for everyone; is land being prepared;

7. Is there a functioning market; what is the availability of the main staple crops; price comparison with situation before conflict; can the poor afford to buy food? Is there an opportunity to earn money - how? What are the wild foods available.

D. Bulk Rations (Food Basket)

1. Total number of affected population receiving food assistance; why have some not been receiving assistance?

2. How are the numbers in need estimated; is there a registration system; is there double registration; is food distributed per person or per family or per house;

3. Start date of feeding operations; what food and what quantities distributed; target quantities; reasons why targets not met; what food rations (KCal/pers) are distributed; if less than minimum what is the reason?

4. Other food sources available; what quantities; to everyone or selected groups; when is the next harvest; is food, fresh food and/or salt for sale on the market and can people afford it.

5. What are the local staple foods; Are the foods distributed acceptable to the population? Is distributed food for sale at the market

6.How many organisations are involved in general food distribution; What are the target populations and what are the numbers served by each organisation.

E. Malnutrition / Supplemental and Therapeutic Feeding

1. Malnutrition rate; data source; trends; measuring method; cut-off points used (for severe and moderate); % marasmus, % kwashiorkor;

2. Nutritional situation adult population, pregnant and lactating women; micro-nutritient deficiency; comparison displaced/refugees - local population.

3. Are there any selective feeding programmes; which groups receive selective feeding; how many participants are there in supplementary feeding and therapeutic feeding.

4. Feeding programmes (supplementary (wet and dry) and therapeutic); # of admitted last

week (new cases therap. feeding); # attending; coverage rate (admitted/total in need); # of deaths last week (suppl.+therap.); # of discharged last week (suppl.+therap); further needs?

annex 9 (step 2)
5. Increase or decrease in admissions feeding centres; is there a need for more selective feeding programmes; supplementary (wet or dry), therapeutic; where; for which groups; which agencies are doing selective feeding - can they expand their programmes.

6. How reliable is the selective food supply? How can MSF order it and how can it be delivered?

F. Storage and Transport

1. Is the food pipeline adequate - are there any bottlenecks? Have donors pledged sufficient foods and deliver them on time; will foods be purchased locally or imported.

2. Can stocks cover new needs (i.e., anticipated new arrivals, displaced, newly accessible areas); If stocks are not adequate what are the prospects for getting it.

3. Are there any major transport or storage problems; Storage system: central warehouse or regional or direct to extended delivery points

annex 9 (step2)

ANNEX 10

KEY INFORMANT: CAMP MANAGER / ADMINISTRATOR / SENIOR RELIEF OFFICER

A. Registration information

1. Name; Organisation; Position; How long on site
2. Interview Date; Address; Telephone;

B. Population Specifics

1. Name site and/or location; date site established; size of site (estimated sq. kilometres).

2. Total population; total # of displaced/refugees; classification (refugees/illegal immigrants/displaced/returnees/etc.); population profile (men/women ratio/<5yrs%); which ethnic groups among the population (plus percentages); # of homeless or evacuated accommodated in public shelters or evacuation centres.

3. How many new arrivals have there been since certain time unit; what is the expected pattern of migration for the future.

4.To what extent are people staying in the camp (day and night)? Reasons for leaving the camp? How do they interact with the local population?

5. What are the major problems - Water (quantity, quality), epidemics, shelter, security, food supply; What is the total number of people in need; services urgently required but not provided; survival threatened by lack of adequate shelter and/or lack of blankets, clothing; which essential household utensils are in critical shortage.

6. How many deaths have there been within the last month/week/24 hours (if possible for the total population and for the under 5 population). What is the data source (count, estimate, rumour, etc.).

7. Description of campsite - road access, sanitation, storage, shelter, cooking fuel, water sources

C. Water

1. Source; distance to source; quantity available (estimated litres per day) and duration estimated to be sufficient (reliability); # of sources and types of sources

2. Degree of protection; purification/treatment at source and/or at campsite; quality of water storage in the shelters

3. Water supplies systems available; type of problems/damages (chlorination, contamination, broken water pipes, damaged pumping stations)

4. Does everyone have equal access? If not, Why?

D. Food

1. General rations (per beneficiary); total quantities of each distribution product distributed per time unit; distribution frequency; agency with overall responsibility

2. Suppl. + therap. feeding programmes, if yes within existing health structure or separate with the responsibility of relief organisations; feeding centres (existing and/or planned); responsible agencies for centres

3. How equitable is the distribution mechanism? Are any groups getting less? Why?

E. Sanitation

1. Defecation facilities; distance from shelters; if latrine: latrine/pop ratio; maintenance; rainy season problems with sanitation; drainage problems during rainy season

2. Garbage disposal - where, how, organised Y/N, and its impact on environment; collection Y/N; if yes whose responsibility

3. Disposal of the dead: procedures, supplies required

F. Security / Management

1. Presence of armed group in the camp. To what extent does the camp management has control of the camp interior?

2. How are disputes in the camp resolved? Who are the leaders (formal and informal) and how well (in terms of fairness and effectiveness) do they function?

3. Protection/perceived risk from:
a) cross-border military action
b) local military action
c) violence among refugees
d) violence among local/host population
Is violence targeted at certain groups/subgroups? Why?

4. Profile warring/conflicting parties; impact on daily risks and risks of having contact with these parties

5. Who can contribute to MSF's security; who increase insecurity; incidents where local and expat people are involved; who are primary targets; why are these groups targets (military/ strategic, property (theft & lootings), violence and/or revenge)
annex 10 (step 2)

ANNEX 11

KEY INFORMANT: REPRESENTATIVE HUMANITARIAN AGENCY (INGO, LNGO, ICRC, local Red Cross)

A. Registration information

1. Name; Organisation; Position; How long in area
2. Interview Date; Address; Telephone Number.
3. Length of time in current post / region. Previous experience.

B. Population Specifics

1. Total affected and unaffected population; classification (local / refugees / illegal immigrants / displaced / returnees / etc.); Population profile (men/women ratio/<5yrs%)

2. Is the number of affected in the population increasing, how many new arrivals have there been; what is the expected pattern for the future.

3. Description of area - road access, sanitation, storage, shelter, cooking fuel, water sources

C. Needs

1. What are the major problems - Water (quantity, quality), epidemics, shelter, security, food supply.

2. How many deaths have there been within the last month/week/24 hours (if possible for the total population and for the under 5 population). What is the data source (count, estimate, rumour, etc.)

3. Overall assessment of situation, including:
- affected population local/refugees/displaced (conditions - morbidity & mortality; malnutrition; water; sanitation - , needs, priorities)
- relief programmes staffing (adequate or additional number/type needed)

4. What is security situation for the population? Are their rights respected? How is population's access to relief programmes?

5. Needs which haven't been met yet; need for assessment on any specific topics

D. Relief Programmes

1. Current programmes (feeding, health, water & sanitation, agricultural, etc.)

annex 11 (step 2)
2. Planned programmes (immediate, future)

3. On-site staff (number, types, experience)

4. Funding duration at current activity/funding level

5. Problems with access to site/security problems for staff/other obstacles to programme. Problems with independence in assessment, implementation and monitoring.

6. Has agency a programme on the other side or in other locations in the region

E. Health

1. Top 5 morbidity and mortality incl. rates; total number of deaths in last month, last week, and last 24 hours; trends; comparison with situation before conflict; prevalence of communicable infectious diseases; seasonal influences on morbidity

2. Health problems area/camp: comparison affected (local/refugees/displaced) with unaffected population; health & psycho-social needs; expected health problems in near future (epidemics, famine, drugs/staff/health care availability-accessibility)

3. Medical programme of agency and input (budget, donor, staff, drugs); population coverage; problems; needs; relationship government; information system

4. If epidemic, number of cases, currently increase or decrease (epidemic curve), number of deaths (case fatality rate), actions undertaken.

Additional Questions for ICRC

F. International Humanitarian Law (IHL)

1. Their assessment on the overall situation, specifically political, military and economic.

2. Violations of IHL: violations of medical neutrality, access to care, treatment of prisoners, abuses against minorities, assaults on / targeting of civilians

3. War crimes: problems in obtaining / documenting evidence. How dangerous to be seen interested in human rights?

4. Types of conflict according to Geneva protocols.

5. Communications with warring parties / government. Extent of impact. How do these actors uphold the tenets of IHL and human rights.

annex 11 (step 2)

ANNEX 12

KEY INFORMANT: REPRESENTATIVES of COMMUNITY (Formal and informal leaders/members)

A. Registration information

1.Name (or initials); Position; Group represented
2. Interview date; Address; contact number.

B. Population Specifics

1. Total population, number of affected and unaffected persons

2. Number of people they represent and the percentage of the total population (women, ethnic group, poor)

3. Average family / household size, how many are female headed households?

4. What is the social structure of the community (social and political organisations)?
5. Health seeking behaviours: before crisis. Important health beliefs and traditions. What were main health problems ?

6. Cultural/traditional beliefs concerning shelter, food preparation, water collection, hygiene and sanitation practices. What was daily life like before the crisis?

7. What emergency-related skills are present in the population (health workers, engineers, construction, etc)? What percentage of male and female are literate, possible translators?

C. View of the Emergency

1. Effect of the emergency on their group; how it affects their daily lives and how they cope.

2. Their groups needs and priorities. In their opinion, what are the (5) most important disease problems (in children/adults)?

3. Their groups planned response to the emergency: what have they done so far and what are their short term and longer term plans.

4. Security: do they feel safe / protected? Perceptions on the current security situation and future developments.

annex 12 (steps 2)

ANNEX 13

RAPID SURVEY

In the initial (rapid) assessment phase, 'quick and dirty' surveys should give an estimate of the immediate health needs (crude mortality rates, nutritional status, prevalence of disease specific morbidities and vaccination coverage). The results should be interpreted in the light of the less rigorous methods used and therefore should be used for emergency short term activities and not necessarily for medium term project planning. Well designed surveys with larger sample sizes and therefore more statistically valid can be done later during the in-depth assessment(s) phase. In emergencies one needs to balance accuracy with timeliness, in addition to accounting for resources and logistical constraints.

Preparatory Survey Steps:

1. Define the **area under study**: location of population centres, densities and access routes: Map of the affected area, including defined road access / streets, population centres, business districts, areas of no housing, etc. The more detailed, the easier to choose a sample.
2. Estimate **size of affected population** (the denominator): In some situations, the size of the affected population may be known with some degree of certainty either through administrative records (census) or counting at transit points / registration centres. However often this is not the case and one must extrapolate by counting (or estimating) the number of dwellings and the average family size. If the area/camp is large and it is difficult to count the shelters, then calculate for sections of the camp and extrapolate based on the size of the camp. The size of the camp can be obtained by measuring the average length and width either with pacing or with a vehicle (odometer). GPS and assist in defining the geographical co-ordinates of the camp perimeter in order to calculate the surface area. Aerial photography can also be used.
3. Determine **sample size and methodology for selecting sample**: The survey sample should attempt to be representative of the total affected population. Avoid sampling those who are the most easily accessible (near roads, market places, etc) and ensure that sampling is done in a wide enough area to include members from all groups. There are different ways of sampling and the method chosen will depend on the urgency of the situation, the expertise available and the logistic constraints. Simplest and quickest way is to choose a sample of 50 households at random. *Cluster sampling*: divide the affected area into clusters of approximately equal size (may be villages, urban districts, rural sections). Then select randomly 30 clusters. Within each cluster, select random starting points and then chose the households to be interviewed systematically (e.g. interview every fifth or tenth house until required number). The number of households per cluster will depend on what you want to assess. For vaccinations and post disaster modified cluster sampling, 7 households are chosen per cluster. For more detailed and statistically valid surveys, an epidemiologist should be employed.
4. **Questionnaire design**: Depending on the topic(s) of interest one can compile a questionnaire with a certain amount of questions per topic. All questions should be very basic and kept simple, bearing in mind the time constraint.

ANNEX 14

Household Questionnaire for rapid assessment

General information

Date:_____ Name interviewer_____

Village/City/Camp:_____ HH # / block:_____

Number of households living in the dwelling:_____(if more than 1, fill in questionnaire) per family

Location of origin:_____ Time living in this place:_____ months

Household composition and health

Household composition (in years)	Current Number in dwelling	Code ❶	No. of deaths in last (1) month	No. of diarrhoeal diseases during last 7 days	No. of fever during last 7 days	Vaccinated against measles (Y / N)	Confirmed with card (Y / N)	MUAC code (δ)
Males > 15								
Female > 15								
Males 5-15								
Females 5-15								
Males < 5								
Females < 5								
Total								

❶ **Code:** Head of household; **H**
Income provider; **I**
Pregnant; **P**
Lactating; **L**

(δ) **code:** > 125 mm: **A**
between 110 – 125 mm: **B**
between 110 - 125 mm or oedema: **C**
110 mm: **D**
< 110 mm and oedema: **E**

Access to Health care

Location/source of health care if required:_____

Distance to nearest clinic:_____ km / _____min/hrs walk

Biggest problem if requiring health care:_____

Shelter

Persons sleeping per room/tent

? 1-2 ? 3-4 ? 5-6 ? >7

Estimated surface per room/tent_____m2

annex 14, Household Questionnaire for rapid assessment (page 1)

Water

Source of drinking water

? Surface water

? Well water

? Piped water

? River water

? Rainwater

? Tanker truck

? Other_____

Water

Time to water source;_____ min / hrs walk

Estimated quantity of water per day:_____ ltrs

Likelihood of water contamination

? Yes ? No ? Unsure

Way of storing water_____

Capacity of water storage_____ ltrs.

Sanitation

Type of defecating facility

? Flush toilet

? Pit latrine

? Defecating area

? No facility

? Other_____

Number of people per facility:_____

Food

Do you have sufficient food for your household

? For today only

? For 2 – 4 days

? For 5 –10 days

? For longer

remarks:_____

_____

Fuel

What type of fuel are you using

? Electricity

? Firewood

? Coals

? Kerosene/diesel

? Dung

? Other_____

Fuel stock for how many days?

? <1 ? 1-2 ? 3-7 ? >7

Security / protection

Do you feel secure here? ? Yes ? No

If not, why?_____

_____

___

_____

___

annex 14, Household Questionnaire for rapid assessment (page 1)

STEP 3

FIRST CONCLUSION AND IDENTIFICATION OF AREAS FOR IN DEPTH ASSESSMENTS

ANNEX 15

ANNEX 15

FIRST CONCLUSIONS and IDENTIFICATION of AREAS FOR IN DEPTH ASSESSMENT(S)

Considerations:

Water:

Is there sufficient amount of water per person, is the quality sufficient?

Ensure that existing water sources are protected from pollution.

Establish maximum storage capacity and consider transporting water.

----- for more in-depth assessment: annex 19

Nutrition and Food Security:

Is there sufficient amount of food per person? Is there any evidence of malnutrition?

Ensure that at least the minimum need for energy is met, especially for vulnerable groups. If obvious malnutrition, consider setting up feeding centres but a nutritional survey should be done as soon as possible.

-----for more in depth assessment: annex 20

Health Care:

Is there evidence of high mortality and morbidity rates and what are the main causes? What is the risk of a measles outbreak? What is the risk of other epidemics occurring on the short term?

Ensure that there is basic curative care available (personnel, drugs and medical supplies) for the main causes of morbidity and mortality. Consider measles immunisation.

------for more in depth assessment: annex 21 to 24

Sanitation:

Is there sufficient sanitation present?

Ensure that human excreta are isolated from sources of water and shelter.

-----for more in depth assessment: annex 26

Shelter:

Is there sufficient shelter available for all of the affected population?

Ensure that there is enough shelter, temporary housing, plastic sheeting, blankets and/or tents.

-----for more in depth assessment: annex 27

Psycho-social*:*

Are there signs of important psycho-social needs, high level of traumatic stress?

-----for more in depth assessment: annex 25

annex 15 (step 3)

Protection / Human rights concerns:

Is there sufficient protection of the affected population?

Is there evidence of ongoing human rights abuses (such as discrimination or harassment of subgroups, vulnerable people, or violations of medical neutrality)?Ensure that the actor responsible to provide security is taking up the responsibility

----- for more in depth assessment: annex 28

Security:

Is it safe enough for relief workers to operate?

STEP 4

SURVEILLANCE

ANNEX 16

ANNEX 16
DISEASE SURVEILLANCE

Sample of morbidity and mortality weekly surveillance form

(should be adapted to specific situations)

Week _____

(ideally week starts on Monday through Sunday) and classified according to calendar week 1 up to week 52.

From: ____ / ____ /____ to: ____ / ____ / ____

Source of data: name, location of health facility: _____

Collected by: _____

Estimated total and under-five population at beginning of week:_____

At end of week:_____

(Take into account: births, arrivals, deaths, departures).

Mortality:

Reported main cause of death	**Female / age** (years)				**Male / age** (years)				**Total**
	< 1	1 – 4	5– 14	> 15	< 1	1 - 4	5 - 14	> 15	
Diarrhoeal disease									
Respiratory disease									
Malaria									
Measles									
Malnutrition									
Trauma									
Other / unknown									
Total									

Average daily Crude Mortality Rate (CMR) (deaths/10,000 tot. pop/day) _____

Average daily Under-five Mortality Rate (deaths/10,000 under-five pop/day) _____

annex 16 (step 4)

Morbidity:

Primary symptom Or diagnosis	**Female / age** (years)				**Male / age** (years)				**Total**
	< 1	**1 – 4**	**5– 14**	**> 15**	**< 1**	**1 - 4**	**5 - 14**	**> 15**	
Watery Diarrhoea									
Bloody diarrhoea									
Fever with cough (LRTI / URTI)									
Malaria (fever and chills)									
Measles									
Malnutrition									
Trauma									
Other specified: ……..									
Other / unknown									
Total									

Ensure standard case definitions for each category.

annex 16 (step 4)

STEP 5

IN DEPTH ASSESSMENT

ANNEXES 17 - 28

ANNEX 17

CONTEXT: BACKGROUND INFORMATION CHECKLIST

A. General Country Characteristics :

1. Geographical features of affected area (lakes, rivers, mountains) including ground water table.
2. Weather and climate, including temperature extremes, rainy seasons, amount of rainfall
3. Agriculture and crop patterns (usual crops, seasons, expected harvest)
4. Macro economy: main trade agreements and the existence of natural resources.

A. Demography:

1. General population figures (census and growth rates) and distribution within country (urban vs rural)
2. Relevant ethnic / tribal / religious groups and distribution

C. Socio-economic Factors

1. *Structure of economy*, income levels and distribution, (un)employment, level of corruption.
2. *Educational level*, literacy rates.
3. *Describe community and family structures*. The powerful, decision makers, the vulnerable groups, etc
4. *Describe clan structure*: their influence on government/authorities, the tensions between different clans, family feudalism, etc
5. *Status of women*: access to health care and education, can women inherit property, hold land title, what is the percentage of women working, what type of work and relative salaries/income. At what age do women usually marry, is female circumcision practised, etc.

D. Cultural values and Beliefs

1. *How does the population's belief system influence their decisions and attitudes regards to health* (traditional health care, influence on health seeking behaviour, etc)
2. *How does the population's belief system influence their decisions and attitudes regards to Human rights* (gender issues in Islam, stigmatisation of specific diseases such as aids, TB, etc)

E. Political environmental

1. *Organisational structure of the government* and most important actors.
2. *Describe opposition groups/parties*. Their status in government, legitimacy. Relationship with different ethnic/religious groups in the country and abroad. Relevance to affected population/area.
3. *Democratic status*. What are the policies of the government concerning minorities, gender, other ethnic groups, religions and movements, is there freedom of speech and press and who controls it, etc

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4. *Destabilising factors*: natural resources, control over territory, trade and smuggling, illicit drugs,

land and water scarcity, land disputes, ethnicity and religion, fundamentalists, corruption and organised crime, unemployment, urbanisation, dictatorship and suppression, etc.

5. Previous conflicts, including displacements
6. *Stabilising factors*: factors which stabilise the (potential) conflict such as a common enemy, economic interest, natural resources.
7. *International stakeholders* (multinationals, other governments, UN agencies), and their interests and influence. What are the economical and defence pacts.

F. Policies of the government

1. *Health policy*; Organisational structure of the MoH, level of decentralisation, national vs local health policies. Does any written health policy exist already? What are the main policies regarding health or related programmes (how much financial support from the government, relationships with NGOs, private practitioners/pharmacies and decentralisation policies)? What is the donor (IMF, World bank) influence on health policy. Is there is a drug/importation policy.
2. *Legal policies*; How does the legal system deal with discriminated groups and specific human rights violations.
3. *International policies*; Which international treaties did the government sign (Geneva convention, universal document of human rights, rights of the child (child soldiers) UN covenants and protocols, WTO, NATO, etc. What is the country's human rights record? Has it allowed humanitarian assistance and adhered to humanitarian principles when dealing with international relief organisations in the past?

ANNEX 18

SECURITY CHECKLIST

A. Existing policies

1. *Guidelines;* Is there already a security guideline from other MSF sections, UN, other organisations available for this area/country and does it cover the current emergency. Does a MSF-Holland security guideline exist already.
2. *Restrictions;* Are there any restrictions (specific nationalities to work in the area, driving of expats, MSF curfew, location of residence/office, staying overnight in the target area, etc)
3. *Official policies;* Are there any government/rebel policies (restricted access, curfews, etc) Does the intervention require specific back up in HQ (Crisis team)

B. Security risks

1. *Threats;* What are the main threats to humanitarian workers (kidnapping, landmines, shelling, cross fire war, aerial bombardments, etc)
2. *History;* What is the history of each security risk over the last few years. Quantify the incidents, location and organisation and who was responsible. What are the predictions based on the history
3. *Insecure areas;* Map the areas of concern and verify with other organisations.
4. *Areas inaccessible / off limit;* Which areas are accessible and which are inaccessible/off limit. Are any specific permits required from central/local authorities, army commanders, rebel leaders
5. *Relation with the community;* How does the MSF security depends on relationships with the local community

C. Resources

1. *Communication;* What means of communication is available/required/possible. How do other organisations communicate and does the UN co-ordinate/facilitate in this. Does any radio frequency/tel/contact list exist.
2. *Transport;* What transport is available/required/possible. Does one need to drive in convoys, use or avoid MSF logo's, restrictions on the drivers/other local staff's ethnicity driving through specific areas, are armed guards required, does hiring transport provides better security than using MSF vehicles, etc.
3. *Protection;* What kind of protection is required for local and international staff (armed guards/police near the MSF office/residence) and are they paid. How do other organisations deal with this and how much do they pay. What is the role of the local authorities in this.
4. *Ethnicity;* Is a balance between ethnicity/tribe of importance when recruiting local staff. Can this become a security risk in a later stage of the programme.
5. *Co-ordination;* Is there any UN/INGO/ICRC/local authority security officer present.
6. *Further in depth assessment;* If an in depth security assessment is needed, are people with specific skills required (language, experience in insecure environment, knowledge of the political contexts, etc)

Further Recommended Reading:

- MSF. Security Guidelines

- MSF. Protocol for Handling Abduction Cases

ANNEX 19

WATER CHECKLIST

A. Water quantity:

1. **Amount** of water available per person per day. Is this amount available every day or is the supply irregular?

2. Determine **source(s)** of water, quantity of available water per source and reliability of each source:

Hand pumps and Wells

- Calculation of quantity of available water: hand pump can generally supply 1 m^3 water per hour. Determine the hours of use of pump and time to fill the water containers/volume. Well volume calculation: height x diameter x 3,14. A plumb line can be used to measure the depth of well; repeating this at different times during the day to check the changing water level.
- Does the water source give water all day or does it dry up during certain hours: if drying up, for how long?
- How many hours a day do people use water from this source?
- Is queuing observed at the water source (empty jerry cans left behind)

Water tanks

- Capacity of water tanks: number, location, number of re-fills (check that one re-fill gives the full amount)
- How many hours / day is the tank filled with water
- Is queuing observed at water tank

Piped Water supply

- How many hours / day is the water system providing water (intermittent water supply has a high risk of contamination)

Spring

- Estimate discharge (measuring time to fill up one bucket with a known volume capacity)
- Is discharge stable through out the year

Water storage of households

- number of water containers and their capacities and the average number of refills to estimate

Other sources

- includes surface water, rain catchments, etc. how safe are these sources
- What is the static ground water level in the area?

B. Water Quality

1. Look at colour, smell, turbidity (test using the turbidity tube), pH (test using the pool tester)

2. Possible **contamination** of water sources?

- Ground water / spring water: what is distance to latrines and waste disposal; description of protection
- Surface water: risk of contamination: clothes washing, animals, chemical pollution, etc.
- Water- related diseases including guinea worm, bilharzia, etc (cross check with morbidity statistics)

3. What **water treatment** is being done and how often checked?
    - Chlorination of water tanks, piped systems: Measure Free Residual Chlorine (pool tester). What is the protocol/procedure of chlorination process, how often? Is there locally available chlorine?
    - Filtration systems: types, cleanliness, maintenance and operation.

C. Access to water

1. Location of water distribution points: are they accessible to the population, if not: reasons.
2. Length of time users wait for water: observed crowding / fighting at water points.
3. Is there safe access to water for all groups especially the vulnerable groups.
4. What is the price of water, is it affordable for all?
5. Does everyone have the means to transport water (jerry cans, other containers)? What kinds of transport and storage containers do people have?
6. Are certain groups blocked from access? If so, why?

D. Functioning of water system

1. Who is in charge of the local water system and responsible for maintenance and repairs?
2. Is there local expertise for repair or rehabilitation?
3. Organisations involved (or with capacity) in water and sanitation programs (Oxfam/ICRC/UN/Ministry of Works)
4. Is there a need for a water and sanitation specialist?

When evaluating water quantity, quality, sources, etc: use different methodology

- observation
- individual and key informant interviews
- rapid surveys (sanitary surveys)

Further Recommended Reading:

- MSF. *Public health engineering in emergency situations*. MSF 1994.
- House and Reed. *Emergency water sources – guidelines for selection and treatment*. WEDC Loughborough, 1997
- Almedom, A O. *Hygiene Evaluation Procedures – approaches and methods for assessing water and sanitation related hygiene practices*. London School of Hygiene and Tropical Medicine. London, 1997 : gives a very good overview of all different methodologies including health walk, community mapping, focus group discussions, interviews, etc.
- Davis J and Lambert R. *Engineering in emergencies: a practical guide for relief workers*. Intermediate Technology Publications Ltd, London, 1995.

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ANNEX 20

NUTRITION / FOOD SECURITY CHECKLIST

A. General / background information

1. Normal consumption patterns of affected population: staples, any taboos, acceptable substitutes. How is food prepared?
2. Breast feeding and weaning practices: possible contribution to malnutrition

B. National / Regional Food Security: Pre-crisis and Crisis

1. National agricultural production: types of crops, planting season, harvest times, cash or subsistence, amount produced, exportation and any deficiencies
2. National livestock including fishing industry: production and consumption, type of livestock, exportation
3. Market system: government regulations, imports, local production
4. National / regional food reserves: type and quantity available
5. UN / WFP national / regional food stocks
6. Previous history of food deficiencies: extent, causes, location, duration, response and effects

A. Household Food Security: Pre-crisis and Crisis

1. Income / purchasing power
2. Local markets: size, number, distance, products for sale (staple foods, meat fish, vegetables, non-food items, drugs), quantities, prices (affordable), level of market activity. Availability of key items for cooking (fuel, wood)
3. Household level of agriculture: type (gardens, crops, livestock), proportion for household consumption, proportion for income generation.
4. Household food availability: types and quantity of food available within the household

D. Effect of Crisis on Food Security

1. Damage / destruction of crops, food stocks, animals. Current and predicted availability of crops.
2. How has it affected access to food / land: are certain groups more affected?
3. Market indicators of food shortages: absence/shortage of staple food on the market, rising prices, changes of supplies (increase meat may mean people are selling animals), increased crowds at warehouses/distribution points.
4. Nutritional indicators of food shortages: acute moderate and severe malnutrition rates, mortality and morbidity rates especially in under fives.
5. Social indicators: increased fighting over food supplies, begging, migration/displacement, increase sales of animals, household items.
6. What is the probable evolution over time: will there be a food shortage in the future

E. Nutritional Status

1. Nutritional surveillance / surveys: methods including sampling and coverage, results, capacity to conduct surveys

2. Prevalence of acute moderate and severe malnutrition pre crisis and crisis: difference between seasonal norm; difference between locations, if so, why?
3. Any reported change in numbers of new cases of malnutrition at health facilities (clarify case definition, method of diagnosis)
4. Specific vitamin / mineral deficiencies: prevalence, anticipated

F. Food Aid

1. Which agencies are involved in food aid (government, UN/WFP/INGOs/LNGOs), which type (general food distributions, blanket or targeted supplementary feeding, therapeutic feeding)
2. Describe each food distribution programme: what is provided, how often, quantity and quality of food, targeted population, registration, distribution mechanisms (food lines, management of distribution points), role of women, is there differential provision of food aid to the population, why?
3. Describe supplementary and therapeutic feeding programmes: entry and exit criteria, monitoring, supervision, food provided (quantity / calories per day)
4. Amount of food available, on ground, in pipeline and potential to expand (donor willingness), is it sufficient to meet needs? What is the capacity to expand response?
5. What are the negative aspects to food aid, are there feasible alternatives?
6. Food basket monitoring of quantity, quality and equity of food distribution: what methodology, which agency is doing

Further Recommended Reading

- MSF Nutrition Guidelines

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ANNEX 21

HEALTH CHECKLIST

Refer to district health and health facility assessment forms.

Additional information:

A. Health Indicators

1. Main causes of morbidity and mortality in region (pre-emergency and emergency), seasonal variation.
2. Previous reports of communicable diseases / outbreaks in region
3. Climatic, seasonal and environmental factors that may influence change in disease pattern (e.g. overcrowding, squalid conditions)
4. War related injuries, traumatic casualties

B. General Characteristics of Health Care

1. Describe the varied health facilities available: number of each (hospitals, clinic, dispensary), locations, conditions.
2. Health care utilisation: what is the proportion of the population who uses the different service, for specific illnesses? Is there overcrowding? What factors contribute to health seeking behaviours?
3. Referral services: system, level of functioning
4. How are other traditional services integrated into the formal health sector?
5. Private sector: how big, influences, regulated, case management practises.

C. Health Programs

1. Describe the varied health services / programs available: biomedical (western), traditional, folk medicine
2. Maternal Child Health (MCH) programs: Antenatal care? Deliveries: what proportion of women deliver at home, with a trained midwife, nurse, trained or untrained TBA or relative. Do TBAs refer patients to the formal health service, are they associated with health facilities?
3. Expanded Program of Immunisation (EPI): functioning cold chain, management, supervision, supplies, coverage
4. Specific disease control programs: strategy, coverage, facilities

D. Health Planning / Management

1. National health plan: is it available. What are the targets set by this plan. Are they achievable? Are there district health plans?
2. Management systems: Co-ordination of health managers: communication, relationships,
3. How are inter-sectoral concerns dealt with: is there a committee, how effective/efficient does it work.
4. Health information: how is it recorded, transferred from health centre to district level and how is feedback given? What information is sent, how often?

6. Training opportunities for health staff: what is offered, who runs training programmes, cost, number and type of training facilities in the region. Health worker knowledge and skills can be tested by survey/questionnaire.
7. Community involvement / participation in health issues: does the community take part in identifying needs, priorities and possible actions? How is this done? What are the perceived community health problems?

E. Medical Supplies

1. Drug supply system: central / decentralised; government / private controlled; effect of crisis on drug supply, estimated continuity of supplies and future shortages, stockpiles.
2. Essential drug list, usage. Rational drug use: standard treatment protocols
3. Local drug production: level of quality, disruption by crisis

F. Health Care Financing

1. What is the national/district/local budget for health (public programmes). Budgeting and resource allocation: who is responsible?
2. Of recurrent budget, how much is allocated for salaries, drugs and supplies, transport, travel allowances, maintenance, recurrent costs.
3. What form of financial payment scheme is present: cost recovery, insurance, other. How do consumers pay for services, which services, is there a fee schedule, what about those unable to pay, what is the percentage of recurrent costs covered by the fees.
4. Salaries of staff: are they paid regularly and on time, do they cover basic living costs, are there standard allowances (lunch, travel), what about housing?

Recommended Further Reading:

- Kielmann AA, Janovsky K and Annett H. *Assessing district health needs, services and systems: protocols for rapid data collection and analysis*. AMREF/GTZ; Macmillan, London 1992.
- Maier B, Gorgen R, Kielmann AA, Diesfeld HJ and Korte R *Assessment of the district health system: using qualitative methods*. GTZ/ITHOG; Macmillian, London 1994.
- MSF. Refugee Health
- Epicentre and MSF. *Rapid health assessment of refugee or displaced populations*. MSF; Paris 1999
- World Health Organization. *Rapid health assessment protocols for emergencies*. WHO; Geneva 1999.

ANNEX 22

DISTRICT HEALTH ASSESSMENT FORM

Methodology: Review MoH reports (monthly, annual), Health Facility Records, Observation, Key informant interviews with director of health, health personnel.
Note: this form is a suggested outline and will need revision based on context.

Name of District:
Date of visit:
Source(s) of information:
Person(s) / Agency doing assessment:

A. General information

Total population of district:
Resident pop: Displaced/refugee pop:
Area of district (square km):
Pop/Sq.Km.:
Subdistricts (name / population):

B. District Health Staff

Number and type:
District medical officer (DMO) (name):
District nursing officer (DNO) (name):
Health inspectors: public health officers: community health officers:
Health administrators (accountants, planners):

C. Health Facilities

Type of facility	*Location*	*Catchment pop*	*Level of function*	*Support*
District hospital				
Other hospitals				
Health centres				
Dispensaries				
Health posts				

* Specify number and ideally locations. Check if mapping of facilities is available.
* Note size of population served (both resident and displaced/refugee)
* Note if functioning or destroyed (duration). For detailed assessment of each health facility, use the health facility assessment form.
* Note who financially supports the clinic or provides supplies: government, NGOs, church, cost recovery, etc
* Note: other health care providers: private practitioners (regulated/registered or not), private clinics, private pharmacies.

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A. Mortality and Morbidity Statistics

For the whole district. Note how mortality and morbidity figures are collated. How complete is the information from the health facilities. Check case definitions and consistency in use.

Mortality Top 5 causes:*		*Morbidity Top 5 OPD*:*		*Top 5 IPD*:*	
< 5 yrs	≥ 5 yrs	< 5yrs	≥ 5yrs	< 5yrs	≥ 5yrs
1.					
2.					
3.					
4.					
5.					

* Under and over age 5.
Check for potential epidemic diseases: diarrhoeas (cholera, dysentry), measles, meningitis, etc
Check for number of major injuries and type of injuries.
Look at past, seasonal trends.

Vaccination coverage (in under 5yrs population) for district:
- BCG (%)
- Polio (%)
- DPT (%)
- **Measles** (%)
- Tetanus Toxoid (%)

Have there been any mass campaigns (past, planned for future)?

A. Supplies and Logistics

1. Drugs and medical supplies
- Is there essential / standard drug list used? Per type of facility?

- How are drugs supplied to the health facilities, how often, are they in kits?

- Where does the district get their drugs, how regular is it supplied, are there periods of shortages?

- What drugs are available in the district store at time of visit?

- What is the condition of the Cold Chain? Are vaccines regularly delivered? How many in district stock?

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2. Transport

Type of vehicles	*Number*	*Level of functioning*
Ambulances		
Automobiles		
Motorcycles		
Bicycles		

Who provides fuel, or money for fuel and maintenance?

What is the accessibility (by road or other means)?

3. Communication / Supervision

What means of communication from district to health facilities?

No. of supervisory visits per month:

Supervisory checklist (take copy if exists):

ANNEX 23

HEALTH FACILITY ASSESSMENT FORM

Methodology: Review MoH reports, Health Facility Records, Observation, Key informant interviews with health personnel. For additional information: record on back of the page (this is to be encouraged!)

Name of health facility:
Date of visit:
Source(s) of information:
Person(s)/Agency doing assessment:

A. General information

Type [hospital, polyclinic, ambulatory post, etc]:
Supported by [gov, NGO, UN, etc]:
Location (village/city, rayon,):
Catchment Area:

Catchment Population	**Ethnic Group(s)**
Resident population:	
Displaced population:	
Geographical origins:	

B. Staff

Type of staff	*No. stationed*	*No. present*	*Average Salary*	*Freq of payment*
Doctors – Total				
Surgeons				
Paediatrician				
Anaesthesiologists				
Obstetricians				
Medical assistants				
Nurses				
Midwives				
TBAs / CHWs				
Pharmacist				
Laboratory				
Other				

Note: Level of training and qualifications

C. Services

Does the facility offer the following services:

Outpatient services*:*	*yes/no/non-functioning*	*average weekly visits*
Curative services		
Antenatal care program		
Delivery program		
Family planning		
EPI		

Well baby clinics Feeding program

Note:
Seasonal variation, increase/decrease in numbers of visits and reasons

Vaccination services*: No. weekly vaccinations Target pop No. vaccines stock*
BCG
Polio
DPT
Measles
TT

- Record coverage rates (previous years and now):
- Comment on registration system:
- List cold chain equipment present, type and number, if functioning, any constraints: (visually inspect and review temperature charts)

Inpatient Services *No. Beds No of patients (during the visit) Average No. monthly admissions*
Total
General medical
General paediatric
Surgery
Obstetric/gynaecology
Trauma/orthopaedic
Other

- If surgery: type of operations performed

Diagnostic Services *yes/no/non-functioning Number weekly tests performed*
Laboratory
X-ray
Other

List:
- Types of tests offered:
- Number and type of equipment (e.g. microscopes):

Referral Services
Is this a referral facility?
If not, where are patients referred:
-distance
-means of transport available

D. Surveillance / Mortality and Morbidity Statistics
Surveillance system
- Comment on system of collecting data, frequency, analysis and feedback:
- Comment on accuracy (of case definition) and completeness:

- Take a copy of the surveillance form used

Mortality and Morbidity Data

See annex 1 for example of recording cause specific mortality and morbidity on a daily, weekly or monthly basis. If possible: record cause specific mortality and morbidity for last week (or month).

List top 5 causes of mortality and morbidity and note source of information

Mortality Top 5 causes:	
General pop (Crude) / no. per month	*< 5 years old / no. per month*
1.	
2.	
3.	
4.	
5.	

Morbidity Top 5 causes	
General pop (Crude) / aver. no. per month	*< 5 years old / aver. no. per month*
1.	
2.	
3.	
4.	
5.	

- Check for occurrence of potential epidemic diseases and other communicable diseases
- Check if there are any groups or subgroups who have different utilization and mortality/morbidity patterns that may suggest differential access, vulnerable groups or discriminated groups.
- Check number of war-wounded, mine injuries, other violence related trauma

E. Drugs and Supplies

1. Drug and medical material Supply

- Is there essential / standard drug list used (if so, pick up copy)?
- How regular are drugs supplied, are they in kits, who supplies them?

- How long does the drug supply last, are there periods of shortages?

- What drugs are available at time of visit?

- Are drugs free of charge?
- Are emergency drugs free of charge?
- Do patients procure drugs and medical materials? Where?

- Are vaccines regularly delivered? How many in stock?

- Check pharmacy records (accuracy, completeness)

annex 23 (step 5)

2. Medical Equipment
List numbers and type of:
stethoscopes_____, otoscopes_____, sphygmomanometer_____, other_____
dressing instruments_____

Surgical equipment_____
_____
Surgical suites_____
Anaesthetic equipment (inc. ventilators)_____
Obstetric equipment_____

F. Building and Transport
1. Buildings
Number of buildings_____ number of wards_____ number of rooms_____
Comment on cleanliness, condition and rehabilitation needs:

Water source (quantity and quantity):

Heating source (type, fuel supply):

Defecation Facilities (type, number, and condition):

Hygiene management: (soap, washing and hand washing and shower facilities):

Waste collection system (comment on cleanliness):
Refuse pit_____, incinerator_____
Light source_____, generator_____.

Warehouse(s), storage rooms.

Physical inventory of what is available at the health facilities.

2. Transport

Type of vehicles	*Number*	*Level of functioning*
Ambulances		
Automobiles		
Motorcycles		
Bicycles		

Who provides fuel, or money for fuel and maintenance?

Accessibility (road/air) seasonal?

3. Communication
Radio/telephone/Fax/other

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ANNEX 24

EPIDEMIC CHECKLIST

A. Confirmation of an Epidemic

1. Review reported cases: clinical case histories and laboratory tests
2. Define working case definition (major signs and symptoms) and diagnostic criteria for suspect, probable and confirmed cases
3. Check health information system (if any) for cases/deaths and classify according to suspect, probable and confirmed cases
4. Search for missed cases (deaths)
5. Establish criteria for an epidemic threshold (disease dependent): review previous levels of endemicity, season variations in incidence of disease
6. Confirmation of epidemic by clinical examination consistent with case definition, laboratory testing (includes sending to a reference laboratory) in numbers greater than epidemic threshold

B. Description of an Epidemic

1. Who is affected? Characteristics of cases / deaths: age, sex, residence, etc (identify high risk groups)
2. Who is at risk? Estimate population at risk (denominator)
3. Where have cases occurred? Mapping of cases / deaths
4. When did cases occur? Epidemic incidence curve
5. Calculate incidence rate, attack rate (cumulative incidence rate) and case fatality rate
6. Health impact of epidemic (actual and potential) on the population: seriousness of disease, case fatality rate, risk of spreading, number of susceptible, population at risk

C. Cause of an Epidemic

1. Causative agent: if feasible confirm by laboratory tests
2. Source and transmission: may require a case control study and environmental assessment
3. Level of exposure to susceptible and high risk groups

D. Response Capacity

1. Ability of local / national health services to respond
2. Ability and willingness of international community to respond

Further Recommended Reading

MSF, Guidelines for Epidemics: General Procedures, Cholera, Malaria, Measles, Meningococcal Meningitis

Benenson A (ed). *Control of Communicable Diseases in Man*

ANNEX 25

PSYCHO – SOCIAL CHECKLIST

A. Mental Health Policy

1. Is there a national mental health policy? When was it introduced? What does it include (prevention, curative, emergency responses)? Who is included (refugees, displaced, host communities)? Is there a written document? Does the policy address the current emergency / conflict? How effectively is it being implemented?
2. Who is responsible for the implementation of mental health activities, what is the position within the MoH?
3. What is the level of policy implementation? Is it only psychiatric?
4. What is the allotted budget for mental health programs?
5. If there is not a mental health policy, what happens to those who suffer mental disorders?

B. Cultural / Socio-economic Issues relating to Mental Health

1. What is the perception of mental health by the population? Are people stigmatised or marginalized if classified as mentally ill?
2. How do people understand and deal with trauma? What are their coping mechanisms? How do they deal with loss, grieving? How do they deal with issues of crime, homicides, drugs, and AIDS?
3. How is traumatic stress experienced and coped with in the culture?

C. Mental Health Needs

1. Health statistics on psychological, psychiatric medical diseases. Suicides.
2. What has been the exposure of the population to specific traumatic events (number and location): armed attack, bombings/shelling, killings, executions, torture, sexual assault, physical assault, landmines, abduction, imprisonment, destruction of home and properties.
3. What is the amount of disruption of family / community structures: separation of family, deaths within the family, change in traditional family roles
4. Has there been sudden displacement? How does this impact on the population (loss of family members, loss of possessions, lack of privacy, shortages of essential needs)?
5. What kinds of psychological (recollections, dissociations, avoidance reactions, hyper-arousal) and psycho-somatic symptoms (physical problems without medical cause like headache, etc) are seen: proportion of consultations. Are these symptoms recognized as psychological and psycho-somatic?
6. What are the chronic mental health needs, psychiatric illness?

D. Mental Health Resources

1. Mental health services: number available, services provided, accessibility, capacity (to expand)
2. Social welfare services, social support and self help groups (youth, women, cultural, religious, etc), traditional services.

annex 24 (step 5)

3. Number of mental health personnel (psychologists, psychiatrists, nurses, social workers). What is level of training and knowledge of Post Traumatic Stress Disorder?

4. Psychotropic drugs: prescribing protocols, availability, cost for patient, usage.
5. International NGOs activities regarding mental health (current and planned): content of program, location, target population.
6. Local NGOs and community activities regarding mental health (current and planned).
7. Are there training programs for training in mental health services – psychiatric, community psychiatric nurses, psychologists, social workers: content of course, capacity, cost, location.

E. Community Response Capacity to Psycho-social Stress

1. Activities / groups in the community that reduce stress.
2. Safety nets in the community.

Further Recommended Reading:

- De Jong K, Post and traumatic stress in communities: introduction and policy paper MSF Holland. MSF H; July 1998
- MSF H: General Explo / Assessment Form Mental Health and Psycho-social assessment questionnaire
- WHO. *Tool for the rapid assessment of mental health needs of refugees and displaced populations: a community-oriented assessment*. World Health Organisation: Geneva; Sept 1999.

ANNEX 26

SANITATION / HYGIENE CHECKLIST

Defecation Facilities

1. Types of defecation facilities: defecation areas / trench latrines / pit latrines / sewage system / other
2. Number, placement and location of defecation facilities in the affected area
3. Average number of persons per defecation facility. What are the capacity / plans if the number of affected people increase?
4. Are defecation facilities provided per individual family (or group of families) or are they communal facilities
5. Cultural preferences for design and placement of facilities (gender segregated, family, etc). Are people washers or wipers / squatters or sitters?
6. Materials used for anal cleaning
7. Utilisation of defecation facilities, if not why not?
8. Safe access to facilities for women and girls, as well as vulnerable groups? Is lighting provided for use at night?
9. Cleanliness of facilities, is there any visible open defecation (look behind old buildings and outskirts). Is there a significant presence of flies?
10. Organisation of cleaning, who is responsible?
11. Proximity of defecation facilities to water sources, storage areas, distribution points and shelters. What is the static ground water level in the area?
12. Local material used / available for the construction of latrines?

B. Hygiene and Hygiene Facilities

1. Hand washing facilities: number, utilisation, are they located near the defecation facilities?
2. Soap: available and used for hand washing and body washing
3. Showers: number, location and utilisation
4. Washing facilities: number, location, and utilisation
5. Cleanliness of showers and washing places, who is responsible
6. General level of hygiene practised by affected population: if poor, why? Is it due to lack of soap or water or other reasons?
7. Health education on hygiene: ongoing or planned (by which agencies)
8. Menstruation: what supplies are available, what are women doing?

C. Refuse Disposal

1. Type of solid waste generated (what garbage is observed, amount, location)
2. Waste collection and disposal system: describe type (garbage pits, containers, incinerators, etc), utilisation. How and where is the waste disposed, how often, what means are available and who is responsible?
3. Risk of contamination of water sources
4. Cleanliness of area

D. Vector Control

1. Any vector borne disease risks?
2. Mosquito breeding sites: presence of stagnant water or risk during rainy period
3. Drainage system: functioning, capacity, potential for flooding
4. Control measures for insects: type of control measures (chemicals, spraying, maintenance of drainage systems, excreta disposal, screening, scrub clearance, etc), programmes, regulations and resources. Who is responsible?
5. Rodent control: presence of rodents. Hazards and control measures. Who is responsible

E. Disposal of Dead

1. Cultural practices: funeral and burial procedures
2. Is there a health risk (e.g. cholera)

Further Recommended Reading:

- MSF**.** *Public health engineering in emergency situations*. MSF 1994. (revised version to appear in 2002)
- Almedom, A O. *Hygiene Evaluation Procedures – approaches and methods for assessing water and sanitation related hygiene practices*. London School of Hygiene and Tropical Medicine. London, 1997 : (gives a very good overview of all different methodologies including health walk, community mapping, focus group discussions, interviews, etc.)
- Davis J and Lambert R. *Engineering in emergencies: a practical guide for relief workers*. Intermediate Technology Publications Ltd, London, 1995.

ANNEX 27

SHELTER CHECKLIST

A. Pre emergency Shelter

1. Types of dwellings: types of construction commonly used for private dwellings and public buildings
2. Normal construction time for a dwelling, who normally does this, cost
3. Average number of people per dwelling

B. Present Shelter Situation

1. Number of private dwellings, public buildings damaged or destroyed. Which are habitable without repair or with minimal repairs?
2. Number of people living with host families or in public buildings: how long can this situation last, negative long term effects
3. Number and capacity of buildings (private and public) that can be used as temporary shelters (assess water and sanitation of these buildings)
4. Local materials used for shelter by the population

C. Shelter Needs

1. Number of people requiring shelter: is the need temporary (weeks) or likely a longer indeterminate time? Note: number of people sleeping / living outside shelter.
2. Need for temporary shelter (plastic sheeting / tents). Possibility of providing local building materials for immediate, temporary shelter
3. How does climate affect the needs: day / night temperatures, season, forecast, etc. Are there needs for: winterisation, heating, ground sheeting, etc
4. How does the type of shelter affect the privacy and security of the population, especially the vulnerable groups?
5. Other shelter needs: clinics, feeding centres, schools, warehouse
6. Anticipated needs (emergency preparedness for potential influx)

D. Shelter Logistics

1. Construction materials: what is needed and where found (natural resources, local products, brought from outside). Availability / costs.
2. Availability of plastic sheeting / tents / stoves: local availability, cost and time to import
3. Site planning: suitable sites and capacity for shelters, government policies, restrictions

E. Non food Household Needs

1. Bedding (blankets, mattresses, sleeping mats, mosquito nets): number of people without, availability

2. Clothing requirements
3. Ventilation and heating requirements: system in use
4. Location of cooking: in/out shelter, central kitchen: availability of cooking utensils, fuel

annex 27 (step 5)

ANNEX 28

HUMAN RIGHTS CONCERNS

It is not necessary for an assessment team to understand the full range of human rights issues present in a particular situation. There are, however, a number of issues that typically arise out of the health and human rights linkage that MSF addresses. An assessment that examines these issues -- and in doing so the causes of the health crisis -- will best ensure that any MSF project instituted will be well situated to raise the organisation's humanitarian concerns.

A. Violations of Human Rights

1. Look for serious violations (killings, rape, unlawful detention, etc.) that affect not just certain individuals, but which occur on a large scale or appear to be directed against a population group, perhaps because of ethnicity, gender, religion or some other status.

B. Violations of Humanitarian Law

1. Violations of humanitarian law (the laws of war) that affect the civilian population, such as indiscriminate or disproportionate attacks on civilians and civilian property.
2. Violations that would hinder the population's access to humanitarian assistance, such as blockades of convoys or attacks on hospitals.

C. Refugee & IDP Protection

1. In many situations involving refugees and internally displaced persons (IDPs), the governing authority (whether the state or a rebel group) is often unable or unwilling to ensure that the basic rights of the displaced population are protected. As a result, refugees and IDPs are often subject to human rights violations. While MSF itself is not able to protect displaced persons, we will advocate on their behalf to press the responsible authorities and the international community (normally the UNHCR) to ensure their security.

D. Humanitarian Principles

1. These are the fundamental principles that MSF and other NGOs have accepted to guide our work, and include humanity, neutrality, impartiality, independence and proximity. Find ways to ensure that MSF's involvement in the crisis is consistent with our principles.

Further Recommended Reading:

- MSF, *Advocacy Information Kit*, Humanitarian Affairs Department, Dec 2000

annex 28 (step5)

ANNEX 29

LOGISTICS CHECKLIST

A. Transport

1. **Airports**: functioning capacity, cargo handling, useable runways (altitude, length, surface), type of aircrafts, navigational aids, availability of aviation fuel, customs, landing clearance procedures, security arrangements, local air carriers (rates, availability), location
2. **Trucking**: road conditions as relates to possibility of delivering relief supplies by truck, any restrictions, permits, security, cost, availability (government, private/commercial, UN agency, NGO), fuel availability and cost, maintenance and spare parts.
3. **Vehicles** for programme: Possibility to rent, buy or import. Fuel costs, spare parts, maintenance options.
4. Other: railroads, boats, etc
5. **Roads**: condition of road network, amount of damage, accessibility during different seasons and insecurity, road blocks, alternative routes,

B. Communication

1. What is the system available (radio, (mobile) telephone, handsets, UN, etc). Level of functioning.
2. Is authorisation required, permits for radios, other equipment? From whom and how does it take?

C. Electricity

1. What is the power system: pre-emergency and currently?
2. What are the requirements for MSF (office, clinic, cold chain, etc)
3. What is available locally / cost: generators, fuel, ability to repair, etc.

D. Warehousing

1. Number of warehouses: availability, amount of damage, ownership (government, private)
2. Capacity and adequacy: ventilation, roofing, refrigeration, cleanliness, pest proof, need for pallets, is there a forklift available, places for trucks to turn/park.
3. Cost per square meter.
4. Security (lighting, fence, guards, location of warehouse)

E. MSF Housing / Office

1. Hotels, guesthouses for expats to stay
2. Possible buildings available to rent for office, housing

Further Recommended Reading:

- MSF. Log-admin Kit

annex 29 (step 5)

STEP 6

ANALYSIS

ANNEX 30

ANNEX 30

QUANTATIVE AND QUALITATIVE DATA DEFINITION AND BENCHMARKS

A. Quantitative Data Analysis

1. Population Profile

The heterogeneity of the population can be judged in:

***sex ratio*: <u>number of women of all ages</u>**
number of men of all ages

which is normally equal to +1.02. If it exceeds 1.10, then heterogeneity exists which need to be explained. Evaluate for over or under representation of women.

(Approximate) standard population data in developing countries:

17% of a population is younger than 5 years (if the population is homogeneous)

For every 100 children younger than 5 years:

. 22% are younger than 1 year
. 21% are 1 year
. 20% are 2 years
. 19% are 3 years
. 18% are 4 years

45% of the population is younger than 15 years.

To find out whether the population is homogeneous or not, a comparison can be made:

- **The number of children younger than 5 years in the camp compared with the expected number (= total population x 0.17)**
- **The number of children aged less than 15 years compared with the expected number (= total population x 0.45)**

The usual proportion of women in a normal population is 51%

50% of women are aged between 15 and 45 years (child bearing age).

The fertility rate is 20% (for every 1,000 women of child bearing age, 200 are pregnant. This figure takes abortions and unknown pregnancies into consideration).

- **Number of pregnant women= total population x 0.51 x 0.5 x 0.2.**
- **Number of babies younger than 1 year (number of lactating women) = total population x 0.17 x 0.22**

annex 30 (step 6)

2. Mortality Rates

Death rates are the most specific indicators of the health status of a population. In an emergency situation, the ***Crude Mortality Rate (CMR)*** is usually expressed as deaths per 10,000 population per day. A CMR of more than 1 per 10,000 per day is considered elevated and a rate of more than 2 per 10,000 per day indicates an emergency situation that is already out of control and immediate action should be taken. In most situations, children less than 5 years of age are at the greatest risk and ***<5 yr mortality rates (U5MR)*** are usually 4-5 times the death rates in older age groups. In a refugee population served by well-run relief efforts, overall mortality rates should not exceed 1.5 times those of the host population.

Because the number of deaths changes from day to day, it is important that rates are calculated over a period of days. The usual periods are one week or one month. For example, take the number of deaths occurring each day over a 7-day period and average the total; the resulting average daily number is used in analyses.

Analysis Procedure:

$$\textbf{Crude Mortality Rate (CMR)} = \frac{\text{Number of deaths} \times 10{,}000}{\text{No. of days} \times \text{Population}} = \textbf{Deaths per 10,000 per day}$$

$$\textbf{<5 Mortality Rate (U5MR)} = \frac{\text{Number of <5 deaths} \times 10{,}000}{\text{No. of days} \times \text{<5 Population}} = \textbf{Deaths per 10,000 per day}$$

Benchmarks for evaluation of daily mortality rates:

	crude mortality	**<5 mortality**
Normal rate in developing country	0.5/10,000/day	1.0/10,000/day
Relief program: under control	<1.0/10,000/day	<2.0/10,000/day
Relief program: very serious situation	>1.0/10,000/day	>2.0/10,000/day
Emergency: out of control	>2.0/10,000/day	>4.0/10,000/day
Major catastrophe	>5.0/10,000/day	>10.0/10,000/day

Source: Hakewill & Moren 1991.

If the top 5 causes of death is known and statistics have been collected the ***percentage of deaths caused by a specific disease*** can be calculated:

$$\textbf{Percentage (<5) Cause of Death} = \frac{\text{\# of each major cause of (<5) deaths} \times 100}{\text{\# of total (<5) deaths in that same period}}$$

Make this calculation for all top 5 diseases and make a pie graph; 6th piece of pie is "others".

The ***Case Fatality Rate (CFR)*** can be calculated after a surveillance system has been functioning. Usually this is based on in-patient records. Display with a line/bar graph to observe trends.

$$\frac{\text{\# of specific disease category deaths} \times 100}{}$$

Case Fatality Rate = # of specific disease category cases

annex 30 (step 6)

3. Morbidity Rates

Many deaths in emergency situations are caused by preventable conditions such as diarrhoeal disease, measles, malaria and acute respiratory infections, often exacerbated by malnutrition. With the help of weekly statistic forms compiled from the registration books of the OPD and/or IPD and/or feeding centres the following rates can be calculated, which gives an indication of the major causes of morbidity:

$$\textbf{Disease specific incidence rate} = \frac{\textbf{\# of specific disease category cases x 100,000}}{\textbf{total population at risk}} = \textbf{cases/100,000}$$
(OPD+IPD+FC statistics)

$$\textbf{\% <5 OPD patients with specific disease} = \frac{\textbf{\# of specific disease <5 cases x 100}}{\textbf{total <5 visits}}$$
(OPD statistics)

$$\textbf{<5 Morbidity pattern} = \frac{\textbf{\# of each major disease <5 cases x 100}}{\textbf{total \# of <5 visits}}$$ (make a pie graph)
(OPD+IPD+FC statistics)

4. Nutritional Status

$$\textbf{Global Acute Malnutrition Rate} = \frac{\textbf{\# of children < -2 Z score W/H (or < 80\% W/H) and/or oedema}}{\textbf{total \# children measured}}$$

$$\textbf{Severe Acute Malnutrition Rate} = \frac{\textbf{\# of children < -3 Z score W/H (or < 70\% W/H) and/or oedema}}{\textbf{total \# children measured}}$$

Benchmarks for evaluation of malnutrition rates:

	global acute malnutrition	**severe acute malnutrition**
Normal rate	<5%	<1%
Under control	<10%	<2%
Very serious situation	>10%	>2%
Major catastrophe	>20%	>5%

Estimation of Global Acute Malnutrition Rate:
(% children with MUAC < 125 mm and/or oedema)

$$= \frac{\textbf{\# of children with MUAC < 125 mm and/or oedema}}{\textbf{total \# children measured}}$$

Estimation of Severe Acute Malnutrition Rate:

(% children with MUAC < 110 mm and/or oedema)

$$1 = \frac{\text{\# of children with MUAC < 110 mm and/or oedema}}{\text{total \# children measured}}$$

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Benchmarks for evaluation of estimated malnutrition rates:

	Proportion MUAC < 125 mm
Under control	< 5%
Further investigation	5-15%
Serious	> 15%

Calculation procedures can be looked up in the Nutrition Guideline. Indicate methodology used (mass screening or cluster survey), determination of sample (how representative of children between 6 months and 5 years) and sample size. When possible, indicate confidence intervals.

5. Food Rations

Target Full Ration Food Basket

Energy	2100 kcal per person per day
Proteins	10% of total Kcal (1 gram protein = 4 kcal)
Fat	10% of total kcal (1 gram fat = 9 kcal)

Commodities to be included:

Cereal , Pulse, Oil/Fat, Fortified Cereal Blend, Sugar, Salt

6. Water

Quantity:

$$\frac{\text{Total volume of water available daily from all sources (litres)}}{\text{Total number of people}} = \text{Amount of water available per person/day.}$$

Amounts of needed water per day per person:

- Drinking: 5 litres as a minimum for survival
- Drinking and cooking: 5 litres as a minimum
- Drinking, cooking and hygiene: 15-20 litres as a minimum
- Feeding centres: 20-30 litres per beneficiary per day
- Health centres: 40-60 litres per patient per day

It should be noted that the need is dependent on the local climate and culture. E.g. in dry and hot areas people need more water for drinking. The amount of water used for cooking and washing is dependent on cultural habits. Additional water may be needed for livestock and/or sanitation systems.

Quality:

Faecal Coliforms per 100 ml risk (for non-disinfected water supplies at point of delivery)
0-10 reasonable quality

10-100 polluted
100-1000 very polluted
over 1000 grossly polluted

The presence of faecal coliform bacteria indicates that the water has been contaminated by faeces of human or other warm-blooded animals. Concentrations of faecal coliforms are usually expressed as the faecal coliform count per 100 ml of water.

For piped water supplies to populations over 10,000 people or for all water supplies at times of risk or presence of diarrhoeal epidemic, water is treated with a residual disinfectant (chlorination / filtration) to a standard of:

- Free residual chlorine at the tap is 0.2 – 0.5 mg per litre
- Turbidity is below 10 NTU

7. Evidence of Differential Access to Health Care and Violence
Utilising mortality, morbidity, and nutritional statistics, and comparing with population demographics, are there groups/subgroups within the population who appears to have less access to health care or more exposure to violence.
Number and type of violent injuries. Timing and location where occurred.

B. Qualitative Data Analysis

1. **Content Analysis**: frequency of issues mentioned per interview by different sources will assist in defining priorities (example childhood diarrhoea, cost of health care). What are the main points of the various interviews.
2. **Sorting and Coding**: information is categorised according to predefined or emergent themes. For example: responses about health seeking behaviour can be categorised as to socio-economic class of mother or belief system.

C. Impact of Aid on crisis/conflict

1. Identify the **tension / dividers / capacities for war** in the contextual situation of the crisis. What divides the population, how are the people divided and who gains from the war? What are the reasons sited for the war: are they historical or new. What are the long standing, underlying causes of the conflict and what are those factors that are currently manipulated by the gainers of the conflict? How much of the conflict is influenced by outside (external) factors? Assess the degree of importance of each factor.

2. Identify **connectors and local capacities for peace** in the contextual situation of the crisis. For this one must understand the social structure and group dynamics in the affected population in order to identify actual or potential areas that bring people together (women's groups, elders, etc). These factors may not be as obvious as the dividers and capacities for war. Assess the degree of importance of each factor.

3. Identify the characteristics of **MSF and the proposed programme/activity** options and how

they will effect the factors identified in 1 and 2. Much of the effect is through how resources are transferred and the implicit message imparted when dealing with authorities (e.g. supportive, acknowledgement).

For more information: refer to
Anderson, MB. Do no harm: How aid can support peace – or war.

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STEP 7

REPORT AND RECOMMENDED STANDARD FORMAT

ANNEX 31

ANNEX 31

REPORT and RECOMMENDATION STANDARD FORMAT

General remarks on writing the report

A general outline for a report is presented below in the form of a table of contents. Not all information gathered during the assessment is relevant and needs to be included in the report. It is also important to give an indication on source and reliability of the information presented. The report should end with clear conclusion of the situation and recommendations for an MSF intervention. Be concise and to the point, use tables and boxes if possible instead of long narratives. Bear in mind that long reports are less likely read!

Cover page
Content page
Glossary (organisations, ministries, etc)

1. Executive summary

2. Context pre emergency situation
2.1 Background information
General country characteristics
Demography
Economy
Political situation
Human rights situation
2.2 Pre emergency health situation
Existing Health Care system
Country health indicators/data
Pre emergency nutritional status and food security

3. Context current situation
3.1 Current situation; General description and the type of emergency / problems
3.2 Affected population and accessibility
3.3 Onset and magnitude3.4 Map of affected area
3.5 General contributors to the current situation
3.6 Level of continuing or emergency threats
3.7 Security

4. Needs assessment and sector response capacity
4.1 Methodology
4.2 Health
Current health situation
Psycho-social needs
Level of functioning of health care system

Surveillance system
Local health response capacity
International response capacity
Unmet health needs
Potential emerging health problems

4.3 Nutrition / Food security
Nutritional status indicators
House hold food security
Food distribution
Local nutritional response capacity
International response capacity
Unmet nutritional needs
Potential emerging nutritional problems

4.4 Water, sanitation and hygiene
(*Use similar format as above)*

4.5 Shelter

4.6 Logistics

4.7 Protection needs

5. General response capacity

5.1 Local response capacity / infrastructure
Other actors involved and their capacity
Management, planning and co-ordination
Financial resources available
Human resources available
Infra structure/ logistics
Community coping mechanism

5.1 International response capacity
MSF presence and capacity in country
Summary of humanitarian actors (per sector) and donors
Overall resources available and planned
Logistics and government procedures

6. Conclusion

7. Recommendation for MSF intervention

8. Appendices

Annex 1; Terms of Reference Assessment team (ToR)
Annex 2; Itinerary of the assessment
Annex 3: Map of the country
Annex 4; …….

Additional information on the report:

1. Executive summary

The executive summary is normally one to two pages long and describes the general situation. It should include an overview of the humanitarian situation, brief analysis of data collected, conclusions of unmet needs, recommended actions for MSF and consequences of actions/inactions of MSF.

2. Context pre emergency situation

It is not necessary to give lengthy 'economic development' reports on a particular country. Information should be relevant to the current situation and should assist you and the reader in understanding the reason why certain events are happening. The situation should be interpreted in the light of historical perspective. (For more information see: Step 2, page 16)

3. Context current situation

Again, information reported should be relevant. This chapter describes the type of emergency, people and areas affected, magnitude of the problems and future predictions. It also includes the assessment on security for humanitarian workers to provide immediate assistance (incl. access to the target group) and the possibility to do conduct further in depth assessments.

4. Needs assessment and sector response capacity

This chapter describes the current situation per sector, the response capacity per sector, any unmet needs and the potential emerging problems. For each sector the main problems and needs should be highlighted and how they relate to the emergency situation. Data presented should include indicators, which quantify the consequences of the emergency (e.g. mortality rates, increases in disease specific morbidity rates, malnutrition rates, epidemic attack rates, case fatality rates, vaccination coverage rates, percentage of lost facilities and personnel, etc). The level of disruption of services per sector should be described. For health this should be specified per service (preventative, outreach, MCH, EPI / cold chain, diagnostic, curative care / drug supply, health information systems / surveillance and referral services). Indicate the source and reliability of the presented data. Also describe the social and psychological effects of the current situation on the population and the community.

Specify potential emerging problems including an analysis on risks for epidemics and the likeliness of future deterioration in the situation per sector. Analyse the unmet needs in light of the sectoral local and international response capacity.

5. General response capacity

While summarising the most urgent needs it should be clarified how these are perceived by the population, the authorities and by the assessor. By describing current or planned action by the population itself, the host government, UN organisations and different humanitarian

organisations, it becomes clear where the gaps are in assistance provided and how a potential intervention by MSF can provide an added value. An example of a table that might assist in summarising data;

Organisation (donor)	Type of relief (per sector)	Target area	Estimated number of recipients	Amount/value

Current or proposed co-ordination mechanisms should be described with particular attention to whether these co-ordination bodies pay attention to the humanitarian principles and in how far taking part would compromise MSF's independence to an unacceptable level.

6. Conclusion

A brief summary of the current humanitarian and human rights situation and an overview of current most urgent humanitarian needs are given (per sector). Future developments are predicted by describing the most likely scenarios (best and worse case scenarios).

7. Recommendation for MSF intervention

Based on the gathered information and expected developments the assessment team should make recommendations on further action to be under taken by MSF. This might mean an intervention with certain focus, no intervention or further monitoring of the situation. While formulating the recommended action one should take into account the most urgent needs, options for effective response (including accessibility) and plans by other actors. It is important to also consider how needs are perceived and prioritised by the population itself. Although it should never delay an urgent effective action, the consequences of a proposed intervention for the population on the short and long term and its effects on existing structures should be taken into consideration. A SWOT analysis should summarise the strengths and weaknesses of the proposed action as well as outlining opportunities and threats

8. Appendices

Information which is interesting and relevant to the context but not essential to get a message across to the reader, use appendices.

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