



The Sphere Project



Humanitarian Charter and Minimum Standards in Disaster Response

Chapter 1



The Sphere Project

The Sphere Project is a programme of the Steering Committee for Humanitarian Response (SCHR) and InterAction with Voice, ICRC and ICVA.

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Humanitarian Charter and Minimum Standards in Disaster Response

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*Code of Conduct for the International Red Cross and Red Crescent
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Humanitarian Charter and Minimum Standards in Disaster Response

1 Introduction

Meeting essential human needs and restoring life with dignity are core principles that should inform all humanitarian action. Through the Humanitarian Charter and Minimum Standards in Disaster Response, defined levels of service in water supply, sanitation, nutrition, food aid, shelter, site planning and health care are linked explicitly to fundamental human rights and humanitarian principles.

Accountability and effectiveness

The Humanitarian Charter and Minimum Standards reflect the determination of agencies to improve both the effectiveness of their assistance and accountability to their stakeholders. The standards are designed with this in mind and each standard is accompanied by a series of indicators. These are important not only to design and implement programmes, but also to provide a way for disaster affected people, agency staff, donors, the wider public and others to review the provision of assistance. The Humanitarian Charter and Minimum Standards thus contribute to a practical framework for accountability.

Cooperation

Cooperation between all humanitarian actors features strongly in the minimum standards. It has also been central to the philosophy of the Sphere Project and to its approach in producing this document. The Sphere Project was initiated by the agency networks Steering Committee for Humanitarian Response (SCHR) and InterAction¹ in 1997 to develop a humanitarian charter and an associated set of minimum standards. The project did not set out to invent new

standards; it sought to consolidate and reach agreement on existing ideas, and in doing this has consistently emphasised the collaborative nature of its work. This document therefore reflects experience, knowledge and practice from many countries, organisations and individuals.

The process of learning never stands still, nor has it ceased with publication of this document. The Sphere Project will continue to seek views and experience so that future editions continue to reflect current knowledge.

Applying the Minimum Standards

The Minimum Standards apply to any situation where people's normal means of support for life with dignity have failed, whether as a result of a natural or human-made disaster, in any country, on any continent. The standards provide a description of what people have a right to expect from humanitarian assistance and specify the minimum acceptable levels to be attained in water supply, sanitation, nutrition, food aid, shelter, site planning and health services. They have been made as specific as possible, but are intended to be adaptable to different emergency situations.

The burden of responsibility for providing humanitarian assistance falls on many shoulders. The people directly affected by a disaster and their neighbours are always the first to respond in any crisis. Yet it is the duty of governments and international bodies to exercise their political will to prevent, mitigate and alleviate disasters wherever possible. When people and their normal support systems are no longer able to meet basic human needs, assistance from humanitarian agencies is required.

As well as providing immediate assistance, humanitarian agencies are also concerned with finding ways of reducing the numbers affected and the intensity of calamities. These issues are not the focus of this document, which is concerned with the response to a disaster. However, there is a recognition throughout the standards that humanitarian assistance may help reduce future vulnerability and establish conditions that promote durable recovery.

Who this document is for

This document is designed primarily for humanitarian agency staff and will be useful for those involved in resource allocation; in the implementation and management of humanitarian assistance programmes; in recruitment, training and staff support; and in monitoring and evaluation.

It will also be useful for disaster affected populations and other stakeholders including coordinating bodies, local authorities, institutional donors, individual donors, scholars and journalists.

Assumptions

The achievement of minimum standards depends on a range of factors. Some factors are within the control and the remit of humanitarian agencies while others, particularly those relating to the wider political situation, security and protection, lie outside their control. (See the Humanitarian Charter.)

For agencies to achieve the minimum standards it is therefore assumed that:

- All those involved in humanitarian assistance share a common goal: to alleviate human suffering brought about by calamity and conflict through protecting life with dignity in ways that support durable recovery wherever possible.
- There is a shared commitment among all those involved in humanitarian assistance to achieve the minimum standards, and to coordinate their response.
- The agency has acquired sufficient financial, human and material resources to meet the standards.
- There is access to the affected population.

Making a difference

The Humanitarian Charter and Minimum Standards will not of course stop disasters from happening, nor can they prevent human suffering. What they offer, however, is the opportunity for humanitarian agencies

to enhance the effectiveness of their assistance and thus to make a significant difference to the lives of people affected by disaster.

They also offer the means by which agencies can define the extent and limit of their assistance, and firmly allocate the primary responsibility for prevention and mitigation of conflict and calamity to political actors.

The Humanitarian Charter and Minimum Standards were produced as a result of extensive and sustained cooperation between individuals and agencies, underpinned by a shared determination to meet fundamental human needs of people affected by disaster in ways that respect their dignity and rights. The minimum standards will be adopted by many agencies, both large and small, in many different parts of the world. Continued cooperation and commitment to sharing the lessons of experience will be critical as agencies begin the challenging task of putting the standards into practice.

Note

1. The Steering Committee for Humanitarian Response (SCHR) is an alliance of organisations for voluntary action, created to improve coordination and cooperation among humanitarian agencies. Members are: CARE International, Caritas Internationalis, International Federation of Red Cross and Red Crescent Societies, International Save the Children Alliance, Lutheran World Federation, Médecins Sans Frontières, Oxfam International and the World Council of Churches. SCHR, with the Red Cross Movement, is author of the Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief.

InterAction is a coalition of over 150 US-based non-governmental organisations working to promote human dignity and development in 165 countries around the world. Member agencies are active in programmes to ease human suffering and to strengthen people's abilities to help themselves. InterAction coordinates and promotes these activities and helps to ensure that goals are met in an ethical and cost-efficient manner.

Other agencies participating in the Sphere Project include: VOICE, a European Consortium of agencies working in emergencies; the International Committee of the Red Cross (ICRC); and the International Council of Voluntary Agencies (ICVA), a consortium of non-governmental organisations from the North and South holding observer status on the project management committee. UN agencies (including UNHCR, OCHA, UNICEF, WFP, WHO, UNDP) have stated their support and are contributing to the project. Donor agencies from many OECD countries (Australia, Belgium, Canada, Denmark, the Netherlands, Sweden, Switzerland, UK and USA) have contributed support for this collaborative effort.

2 *The Humanitarian Charter*

Humanitarian agencies committed to this Charter and to the Minimum Standards will aim to achieve defined levels of service for people affected by calamity or armed conflict, and to promote the observance of fundamental humanitarian principles.

The Humanitarian Charter expresses agencies' commitment to these principles and to achieving the Minimum Standards. This commitment is based on agencies' appreciation of their own ethical obligations, and reflects the rights and duties enshrined in international law in respect of which states and other parties have established obligations.

The Charter is concerned with the most basic requirements for sustaining the lives and dignity of those affected by calamity or conflict. The Minimum Standards which follow aim to quantify these requirements with regard to people's need for water, sanitation, nutrition, food, shelter and health care. Taken together, the Humanitarian Charter and the Minimum Standards contribute to an operational framework for accountability in humanitarian assistance efforts.

1 Principles

We reaffirm our belief in the humanitarian imperative and its primacy. By this we mean the belief that all possible steps should be taken to prevent or alleviate human suffering arising out of conflict or calamity, and that civilians so affected have a right to protection and assistance.

It is on the basis of this belief, reflected in international humanitarian law and based on the principle of humanity, that we offer our services as humanitarian agencies. We will act in accordance with the principles

of humanity and impartiality, and with the other principles set out in the *Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief* (1994).

The Humanitarian Charter affirms the fundamental importance of the following principles:

● **The right to life with dignity**

This right is reflected in the legal measures concerning the right to life and freedom from cruel, inhuman or degrading treatment or punishment. We understand an individual's right to life to entail the right to have steps taken to preserve life where it is threatened, and a corresponding duty on others to take such steps. Implicit in this is the duty not to withhold or frustrate the provision of life-saving assistance. In addition, international humanitarian law makes specific provision for assistance to civilian populations during conflict, obliging states and other parties to agree to the provision of humanitarian and impartial assistance when the civilian population lacks essential supplies.¹

● **The distinction between combatants and non-combatants**

This is the distinction which underpins the 1949 Geneva Conventions and their Additional Protocols of 1977. This fundamental principle has been increasingly eroded, as reflected in the enormously increased proportion of civilian casualties during the second half of the twentieth century. That internal conflict is often referred to as 'civil war' must not blind us to the need to distinguish between those actively engaged in hostilities, and civilians and others (including the sick, wounded and prisoners) who play no direct part. Non-combatants are protected under international humanitarian law and are entitled to immunity from attack.²

● **The principle of non-refoulement**

This is the principle that no refugee shall be sent (back) to a country in which his or her life or freedom would be threatened on account of race, religion, nationality, membership of a particular social group or political opinion; or where there are substantial grounds for believing that s/he would be in danger of being subjected to torture.³

2 Context

We recognise that it is firstly through their own efforts that the basic needs of people affected by calamity or armed conflict are met, and we acknowledge the primary role and responsibility of the state to provide assistance when people's capacity to cope has been exceeded.

International law recognises that those affected are entitled to protection and assistance. It defines legal obligations on states or warring parties to provide such assistance or to allow it to be provided, as well as to prevent and refrain from behaviour that violates fundamental human rights. These rights and obligations are contained in the body of international human rights law, international humanitarian law and refugee law. (See sources listed below.)

As humanitarian agencies, we define our role in relation to these primary roles and responsibilities. Our role in providing humanitarian assistance reflects the reality that those with primary responsibility are not always able or willing to perform this role themselves. This is sometimes a matter of capacity. Sometimes it constitutes a wilful disregard of fundamental legal and ethical obligations, the result of which is much avoidable human suffering.

The frequent failure of warring parties to respect the humanitarian purpose of interventions has shown that the attempt to provide assistance in situations of conflict may potentially render civilians more vulnerable to attack, or may on occasion bring unintended advantage to one or more of the warring parties. We are committed to minimising any such adverse effects of our interventions in so far as this is consistent with the obligations outlined above. It is the obligation of warring parties to respect the humanitarian nature of such interventions.

In relation to the principles set out above and more generally, we recognise and support the protection and assistance mandates of the International Committee of the Red Cross and of the United Nations High Commissioner for Refugees under international law.

3 Minimum Standards

The Minimum Standards which follow are based on aid agencies' experience of providing humanitarian assistance. Though the achievement of the standards depends on a range of factors, many of which may be beyond our control, we commit ourselves to attempt consistently to achieve them and we expect to be held to account accordingly. We invite other humanitarian actors, including states themselves, to adopt these standards as accepted norms.

By adhering to the standards set out in chapters 2-6 we commit ourselves to make every effort to ensure that people affected by disasters have access to at least the minimum requirements (water, sanitation, food, nutrition, shelter and health care) to satisfy their basic right to life with dignity. To this end we will continue to advocate that governments and other parties meet their obligations under international human rights law, international humanitarian law and refugee law.

We expect to be held accountable to this commitment and undertake to develop systems for accountability within our respective agencies, consortia and federations. We acknowledge that our fundamental accountability is to those we seek to assist.

Notes

1. Articles 3 and 5 of the Universal Declaration of Human Rights 1948; Articles 6 and 7 of the *International Covenant on Civil and Political Rights* 1966; common Article 3 of the four *Geneva Conventions* of 1949; Articles 23, 55 and 59 of the *Fourth Geneva Convention*; Articles 69 to 71 of *Additional Protocol I* of 1977; Article 18 of *Additional Protocol II* of 1977 as well as other relevant rules of international humanitarian law; *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* 1984; Articles 10, 11 and 12 of the *International Covenant on Economic, Social, and Cultural Rights* 1966; Articles 6, 37 and 24 of the *Convention on the Rights of the Child* 1989; and elsewhere in international law.

2. The distinction between combatants and non-combatants is the basic principle underlying international humanitarian law. See in particular common Article 3 of the four *Geneva Conventions* of 1949 and Article 48 of *Additional Protocol I* of 1977. See also Article 38 of the *Convention on the Rights of the Child*.
3. Article 33 of the *Convention on the Status of Refugees* 1951; Article 3 of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* 1984; Article 22 of the *Convention on the Rights of the Child* 1989.

Sources

The following instruments inform this Charter:

Universal Declaration of Human Rights 1948.

International Covenant on Civil and Political Rights 1966.

International Covenant on Economic, Social and Cultural Rights 1966.

The four *Geneva Conventions* of 1949 and their two *Additional Protocols* of 1977.

Convention on the Status of Refugees 1951 and the *Protocol relating to the Status of Refugees* 1966.

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984.

Convention on the Prevention and Punishment of the Crime of Genocide 1948.

Convention on the Rights of the Child 1989.

Convention on the Elimination of All Forms of Discrimination Against Women 1979.

Guiding Principles on Internal Displacement 1998.

3 Summary of the Minimum Standards

This section provides an overview of the minimum standards for each of the five sectors described in chapters 2–6: water supply and sanitation, nutrition, food aid, shelter and site planning, and health services. Each chapter provides indicators, guidance notes and contextual information, all of which are essential to the interpretation and application of the standards.

Minimum Standards in Water Supply and Sanitation

1 Analysis

Analysis standard 1: assessment

Programme decisions are based on a demonstrated understanding of the emergency situation and on a clear analysis of the health risks and needs relating to water supply and sanitation.

Analysis standard 2: monitoring and evaluation

The performance of the water supply and sanitation programme, its effectiveness in responding to health problems related to water and sanitation, and changes in the context are monitored and evaluated.

2 Excreta Disposal

Excreta disposal standard 1: access to, and numbers of toilets

People have sufficient numbers of toilets, sufficiently close to their

dwelling to allow them rapid, safe and comfortable access at all times of the day and night.

Excreta disposal standard 2: design and construction

People have access to toilets which are designed, constructed and maintained in such a way as to be comfortable, hygienic and safe to use.

3 Water Supply

Water supply standard 1: access and water quantity

All people have access to a sufficient quantity of water for drinking, cooking and personal and domestic hygiene. Public water points are sufficiently close to shelters to allow use of the minimum water requirement.

Water supply standard 2: water quality

Water at the point of collection is palatable, and of sufficient quality to be drunk and used for personal and domestic hygiene without causing significant risk to health due to water-borne diseases, or to chemical or radiological contamination from short term use.

Water supply standard 3: water use facilities and goods

People have adequate facilities and supplies to collect, store and use sufficient quantities of water for drinking, cooking and personal hygiene, and to ensure that drinking water remains sufficiently safe until it is consumed.

4 Vector Control

Vector control standard 1: individual and family protection

People have the means to protect themselves from disease vectors and nuisance pests when they are estimated to be a significant risk to health or well-being.

Vector control standard 2: physical, environmental and chemical protection measures

The number of disease-bearing vectors and nuisance animals that pose a risk to people's health and well-being are kept to an acceptable level.

Vector control standard 3: good practice in the use of chemical vector control methods

Vector control measures that make use of pesticides are carried out in accordance with agreed international norms to ensure that staff, the people affected by the disaster and the local environment are adequately protected, and to avoid creating resistance to pesticides.

5 Solid Waste Disposal

Solid waste disposal standard 1: solid waste collection and disposal

People have an environment that is acceptably free of solid waste contamination, including medical wastes.

Solid waste disposal standard 2: solid waste containers/pits

People have the means to dispose of their domestic waste conveniently and effectively.

6 Drainage

Drainage standard 1: drainage works

People have an environment that is acceptably free from risk of water erosion and from standing water, including storm water, flood water, domestic wastewater and wastewater from medical facilities.

Drainage standard 2: installations and tools

People have the means (installations, tools etc) to dispose of domestic wastewater and water point wastewater conveniently and effectively, and to protect their shelters and other family or communal facilities from flooding and erosion.

7 Hygiene Promotion

Hygiene promotion standard 1: hygiene behaviour and use of facilities

All sections of the affected population are aware of priority hygiene practices that create the greatest risk to health and are able to change them. They have adequate information and resources for the use of water and sanitation facilities to protect their health and dignity.

Hygiene promotion standard 2: programme implementation

All facilities and resources provided reflect the vulnerabilities, needs and preferences of all sections of the affected population. Users are involved in the management and maintenance of hygiene facilities where appropriate.

8 Human Resource Capacity and Training

Capacity standard 1: competence

Water supply and sanitation programmes are implemented by staff who have appropriate qualifications and experience for the duties involved, and who are adequately managed and supported.

Minimum Standards in Nutrition

1 Analysis

Analysis standard 1: assessment

Before any programme decisions are made, there is a demonstrated understanding of the basic nutritional situation and conditions which may create risk of malnutrition.

Analysis standard 2: response

If a nutrition intervention is required, there is a clear description of the problem(s) and a documented strategy for the response.

Analysis standard 3: monitoring and evaluation

The performance and effectiveness of the nutrition programme and changes in the context are monitored and evaluated.

2 General Nutritional Support to the Population

General nutritional support standard 1: nutrient supply

People's nutrient needs are met.

General nutritional support standard 2: food quality and safety

Food that is distributed is of sufficient quality and is safely handled so as to be fit for human consumption.

General nutritional support standard 3: food acceptability

Foods that are provided are appropriate and acceptable to the population.

General nutritional support standard 4: food handling and safety

Food is stored, prepared and consumed in a safe and appropriate manner, both at household and community level.

3 Nutritional Support to Those Suffering From Malnutrition

Targeted nutritional support standard 1: moderate malnutrition

The public health risks associated with moderate malnutrition are reduced.

Targeted nutritional support standard 2: severe malnutrition

Mortality, morbidity and suffering associated with severe malnutrition are reduced.

Targeted nutritional support standard 3: micronutrient deficiencies

Micronutrient deficiencies are corrected.

4 Human Resource Capacity and Training

Capacity standard 1: competence

Nutrition interventions are implemented by staff who have appropriate qualifications and experience for the duties involved, and who are adequately managed and supported.

Capacity standard 2: support

Members of the disaster affected population receive support to enable them to adjust to their new environment and to make optimal use of the assistance provided to them.

Capacity standard 3: local capacity

Local capacity and skills are used and enhanced by emergency nutrition programmes.

Minimum Standards in Food Aid

1 Analysis

Analysis standard 1: assessment

Before any programme decisions are made, there is a demonstrated understanding of the basic conditions that create risk of food insecurity and the need for food aid.

Analysis standard 2: monitoring and evaluation

The performance and effectiveness of the food aid programme and changes in the context are monitored and evaluated.

2 Participation

Participation standard

Recipients of food aid have the opportunity to participate where possible in the design, management and monitoring of the programme.

3 Coordination

Coordination standard

Agencies, local authorities, the affected population and donors coordinate their efforts in the design and implementation of the food aid programme.

4 Requirements

Requirements standard

The food basket and rations are designed to bridge the gap between the affected population's requirements and their own food sources.

5 Targeting

Targeting standard

Recipients of food aid are selected on the basis of food need and/or vulnerability to food insecurity.

6 Resource Management

Resource management standard

Food aid commodities and programme funds are managed, tracked, and accounted for using a transparent and auditable system.

7 Logistics

Logistics standard

Agencies have the necessary organisational and technical capacity

to manage the procurement, receipt, transport, storage and distribution of food commodities efficiently and effectively.

8 Distribution

Distribution standard

The method of food distribution is fair, equitable and appropriate to local conditions. Recipients are informed of their ration entitlement and of the rationale for the levels provided.

9 Human Resource Capacity and Training

Capacity standard 1: competence

Food aid programmes are implemented by staff who have appropriate qualifications and experience for the duties involved, and who are adequately managed and supported.

Capacity standard 2: local capacity

Local capacity and skills are used and enhanced by food aid programmes.

Minimum Standards in Shelter and Site Planning

1 Analysis

Analysis standard 1: assessment

Programme decisions are based on a demonstrated understanding of the emergency situation and on a clear analysis of people's needs for shelter, clothing and household items.

Analysis standard 2: monitoring and evaluation

The performance and effectiveness of the shelter and site planning programme and changes in the context are monitored and evaluated.

2 Housing (family shelter)

Housing standard 1: family living quarters

At the onset of the emergency, people have sufficient covered space to provide protection from adverse effects of the climate. They have sufficient warmth, fresh air, security and privacy to ensure their dignity, health and well-being.

Housing standard 2: environmental impact

Sheltering of disaster affected people has minimal negative impact on the local environment. Appropriate corrective measures are taken if a negative impact is identified.

3 Clothing

Clothing standard

The people affected by the disaster, including host families, have sufficient blankets, clothing and footwear to provide protection from the climate and to ensure their dignity and well-being.

4 Household Items

Household items standard 1: items for households and livelihood support

Families have access to household utensils, soap for personal hygiene and tools.

Household items standard 2: environmental concerns

Degradation of the local environment is minimised by promoting the use of, and making available, fuel-economic cooking implements and stoves.

5 Site Selection

Site standard 1: site selection

The site is suitable to host the number of people involved.

Site standard 2: site planning

Site planning ensures sufficient space for household areas and supports people's security and well-being. It provides for effective, efficient provision of services and internal access.

Site standard 3: environmental concerns

Environmental protection measures minimise damage that may be caused by the displaced population and assistance interventions.

Site standard 4: security and planning

Site selection and planning enables the personal liberty and security of all people, particularly groups at risk.

6 Human Resource Capacity and Training

Capacity standard 1: competence

Shelter and site interventions are implemented by staff who have appropriate qualifications and experience for the duties involved, and who are adequately managed and supported.

Capacity standard 2: local capacity

Local skills and capacity are used and enhanced by shelter and site programmes.

Minimum Standards in Health Services

1 Analysis

Analysis standard 1: initial assessment

The initial assessment determines as accurately as possibly the health effects of a disaster, identifies the health needs and establishes priorities for health programming.

Analysis standard 2: health information system – data collection

The health information system regularly collects relevant data on population, injuries, diseases, environmental conditions and health services in a standardised format in order to detect major health problems.

Analysis standard 3: health information system – data review

Health information system data and changes in the disaster affected population are regularly reviewed and analysed for decision making and appropriate response.

Analysis standard 4: health information system – monitoring and evaluation

Data collected is used to evaluate the effectiveness of interventions in controlling disease and in preserving health.

2 Measles Control

Measles control standard 1: vaccination

In disaster affected populations, all children 6 months to 12 years old receive a dose of measles vaccine and an appropriate dose of vitamin A as soon as possible.

Measles control standard 2: vaccination of newcomers

Newcomers (if this is a refugee situation) are systematically vaccinated. All children 6 months to 12 years old receive a dose of measles vaccine and an appropriate dose of vitamin A.

Measles control standard 3: outbreak control

A systematic response is mounted for each outbreak of measles within the disaster affected population and the host community population.

Measles control standard 4: case management

All children who contract measles receive adequate care in order to avoid serious sequelae or death.

3 Control of Communicable Diseases

Control of communicable diseases standard 1: monitoring

The occurrence of communicable diseases is monitored.

Control of communicable diseases standard 2: investigation and control

Outbreaks of diseases of epidemic potential, such as measles, acute respiratory infections, diarrhoeal diseases including dysentery and cholera, and malaria are investigated and controlled according to internationally accepted norms and standards.

4 Health Care Services

Health care services standard 1: appropriate medical care

Emergency health care for disaster affected populations is based on an initial assessment and data from an ongoing health information system, and serves to reduce excess mortality and morbidity through appropriate medical care.

Health care services standard 2: mortality reduction

Health care in emergencies follows primary health care (PHC) guidelines and targets health problems that cause excess mortality.

5 Human Resource Capacity and Training

Capacity standard 1: competence

Health interventions are implemented by staff who have appropriate qualifications and experience for the duties involved, and who are adequately managed and supported.

Capacity standard 2: support

Members of the disaster affected population receive support to enable them to adjust to their new environment and to make optimal use of the assistance provided to them.

Capacity standard 3: local capacity

Local capacity and skills are used and enhanced by emergency health interventions.

Appendix 1

Glossary of Key Terms

The glossary defines key terms in the context of the Humanitarian Charter and Minimum Standards in Disaster Response.

Disaster

A situation where people's normal means of support for life with dignity have failed as a result of natural or human-made catastrophe.

Disaster affected people/population

All people whose life or health are threatened by disaster, whether displaced or in their home area.

Groups at risk

People considered to be exceptionally vulnerable.

Local authorities

Government or leaders recognised to be in control in the country or region in which the disaster affected population is located.

Host government

Government of the country in which humanitarian assistance takes place.

The humanitarian principle

Prevention and alleviation of suffering, protection of life and health and respect for human dignity.

Humanitarian assistance

The provision of basic requirements which meet people's needs for adequate water, sanitation, nutrition, food, shelter and health care.

Impartial assistance

Assistance is that given on the basis of need alone and makes no distinction as to race, creed, nationality, sex, age, physical or mental disability.

Humanitarian actor

An organisation that supports the provision of humanitarian assistance.

Humanitarian agency

A local or international non-governmental organisation, UN body or donor institution whose activities support the provision of humanitarian assistance.

Staff

Employees of humanitarian agencies.

Stakeholder

Anybody affected by, or who can affect, humanitarian assistance.

Accountability

The responsibility to demonstrate to stakeholders, foremost of whom are disaster affected people, that humanitarian assistance complies with agreed standards.

Transparency

Openness and accessibility of humanitarian agencies, their systems and information.

Minimum standard

The minimum acceptable level (of service) to be attained in humanitarian assistance.

Indicator

'Signals' that show whether a standard has been attained. They provide a way of measuring and communicating both the impact, or result, of programmes as well as the process, or methods, used. The indicators may be qualitative or quantitative.

Appendix 2

Acronyms in chapters 1-6

ACC/SCN:

United Nations Administrative Committee on Coordination/
Subcommittee on Nutrition

ACT:

Action by Churches Together

ALNAP:

Active Learning Network for Accountability in Practice

CDC:

Centers for Disease Control and Prevention

DAC:

Development Assistance Committee (OECD)

FAO:

Food and Agriculture Organisation

IAPSO:

Inter-Agency Procurement Services Office (UNDP)

ICRC:

International Committee of the Red Cross

LWF:

The Lutheran World Federation

MSF:

Médecins Sans Frontières

NCHS:

National Centre for Health Statistics

NGO:

Non-governmental organisation

INFCD:

International Nutrition Foundation for Developing Countries

OCHA:

UN Office for Coordination of Humanitarian Affairs

OFDA:

Office of Foreign Disaster Assistance (USAID)

OECD:

Organisation for Economic Cooperation and Development

PTSS:

Programme and Technical Support Section (UNHCR)

SCHR:

Steering Committee for Humanitarian Response

UNDP:

United Nations Development Programme

UNDRO:

United Nations Disaster Relief Organisation

UNEP:

United Nations Environment Programme

UNHCR:

United Nations High Commissioner for Refugees

UNICEF:

United Nations Children's Fund

USAID:

United States Agency for International Development

WHO:

World Health Organisation

WFP:

World Food Programme

WMO:

World Meteorological Organisation

Appendix 3

The NGO Field Cooperation Protocol

The NGO Field Cooperation Protocol was signed in September 1996 by 25 agencies. Further information is available from InterAction.

Recognising the importance of cooperation among NGOs in enhancing performance and accountability in disaster assistance efforts, the signatories to this NGO Field Cooperation Protocol will instruct their representatives engaged in disaster response to consult with other NGO representatives similarly engaged to try to reach consensus in dealing with the following issues:

- A. Establishment of a forum for NGO internal consultation and interface with other disaster response participants
 - 1. Jointly supported office
 - 2. Regular meetings
- B. Relations with local authorities
 - 1. Registration
 - 2. Taxation
 - 3. Payment of extraordinary fees
 - 4. Policy advice to host authorities
 - 5. Conforming to host authority protocols
 - 6. Training host authority officials
- C. Local employment practices
 - 1. Wage and benefit levels and economic consequences
 - 2. Political involvement of local staff
 - 3. Conditions of employment
 - 4. Hiring diversity

5. Training of local staff and beneficiaries

D. Local leasing/contracting/procurement practices

1. Price levels
2. Payment of extraordinary fees
3. Local procurement commitment

E. Media relations

1. Criticism of other agency projects
2. Clustering at media focal points
3. Relations with local media

F. Security arrangements

1. Hostage policy
2. Payment of extraordinary fees
3. Location of housing
4. Communications channels and procedures
5. Evacuation planning
6. Convoy organisation and scheduling
7. Protection of sensitive information

G. Relations with indigenous NGOs

1. Incorporation in project design/implementation
2. Training
3. Pass-through funding

H. NGO-military relations

1. Security
2. Logistics
3. Infrastructure maintenance/repair

I. NGO-UN relations

J. Division of labour

1. Sectoral and/or geographic

K. Information sharing on project selection

L. Adoption of socio-economic programme approaches





The Sphere Project

Humanitarian Charter
and Minimum Standards
in Disaster Response



Minimum Standards in Water Supply and Sanitation

Chapter 2



The Sphere Project

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Minimum Standards in Water Supply and Sanitation

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The Sphere Project

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Minimum Standards in Water Supply and Sanitation

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Minimum Standards in Water Supply and Sanitation

Introduction

1 The importance of water supply and sanitation in emergencies

People affected by disasters are more likely to become ill and to die from diseases related to inadequate sanitation and water supplies than from any other single cause. The most important of these are diarrhoeal diseases and others transmitted by the faeco-oral route. Their transmission is encouraged by inadequate sanitation, poor hygiene and contaminated water supplies. Other water and sanitation-related diseases include those carried by vectors associated with solid waste and water.

The main purposes of emergency water supply and sanitation programmes are to provide a minimum quantity of clean drinking water, and to reduce the transmission of faeco-oral diseases and exposure to disease-bearing vectors. A further important objective is to help establish the conditions that allow people to live and to perform daily tasks, such as going to the toilet, and washing with dignity, comfort and security.

2 The Humanitarian Charter and Minimum Standards in water supply and sanitation programmes

The aims of water supply and sanitation programmes, as well as those of the other sectors, flow from a wider goal which is the cornerstone of humanitarian practices. This goal is to alleviate human suffering brought about by calamity or conflict through protecting life with dignity in ways that support durable recovery.

Translating this goal into practice requires a clear commitment by agencies to humanitarian principles and to the implementation of minimum standards. The Humanitarian Charter and Minimum Standards together provide the policy and organisational framework to enable this to happen and to ensure systems of accountability.

The Humanitarian Charter reaffirms the importance of fundamental humanitarian principles and the rights of disaster affected communities to humanitarian assistance. Through the Charter, signatory agencies commit themselves to defined minimum standards for the provision of humanitarian services. The standards for water supply and sanitation (this chapter), nutrition (chapter 3), food aid (chapter 4), shelter and site planning (chapter 5), and health services (chapter 6) build on the principles laid out in the Humanitarian Charter and demonstrate how the rights of people affected by disasters should be realised in practice.

The standards set out in this chapter describe what people should have as a minimum for their health and dignity. Agencies should strive to do better wherever possible.

3 Using the standards

The standards apply to any situation where people's normal means for support of life with dignity have failed whether as a result of a natural or human-made disaster in any country, on any continent. They provide a description of what people have a right to expect from humanitarian assistance. The standards do not focus on disaster preparedness, mitigation or rehabilitation, though these are considered where relevant.

The intention is to provide a tool to help create the conditions for effective interventions and for the achievement of the minimum standards. The standards have been made as specific as possible, but they remain widely applicable to different emergency situations within current operational and policy frameworks.

4 Assumptions

To achieve the minimum standards in a wide variety of emergency contexts, it is assumed that:

- Agencies are driven by humanitarian principles and are committed to best organisational practices as a means to achieving their wider goal.
- There is a shared commitment among all those involved in humanitarian assistance to achieve the minimum standards, and to coordinate their response.
- The agency has acquired sufficient financial, human and material resources to meet the standards.
- There is access to the affected population.
- All other sectors are meeting their standards (as described in other chapters).

5 Structure of this chapter

After this introduction the chapter is divided into the following sections:

1. Analysis
2. Excreta Disposal
3. Water Supply
4. Vector Control
5. Solid Waste Disposal
6. Drainage
7. Hygiene Promotion
8. Human Resource Capacity and Training

Each of the sections includes the following components:

- **The standards:** these specify the minimum acceptable levels to be attained in each area.
- **Key indicators:** these are 'signals' that show whether the standard

has been attained. They provide a way of measuring and communicating both the impact, or result, of programmes as well as the process, or methods, used. The indicators may be qualitative or quantitative.

- **Guidance notes and critical issues:** these explain why each standard is important and may include: specific points to consider when applying the standard in different situations; guidance on tackling practical difficulties; advice on priority issues.

Critical issues might relate to the standard or indicators, and describe dilemmas, controversies or gaps in current knowledge. Filling these gaps will help improve the minimum standards for water supply and sanitation in the future.

Further relevant information, including a bibliography, is supplied in the Appendices. The particular good practice features for the water and sanitation sector are described in Appendix 3.

The organisation of the chapter reflects the division of activities and responsibilities that commonly occurs in emergency situations. Action in each of these areas contributes to the overall aims of the water and sanitation programme as defined above, and is closely linked both epidemiologically and operationally to the objectives and activities of the other sectors. The analysis standards proposed for assessment, monitoring and evaluation relate to all areas within the water supply and sanitation sector.

Progress in achieving standards in one area determines the importance of progress in other areas. For instance, in situations where excreta disposal and hygiene facilities are inadequate, it is more urgent to reach the minimum water quantity standard than in situations where the environment is relatively free of pathogens due to adequate sanitation and hygiene conditions. Priorities should be decided on the basis of sound information shared between sectors as the situation evolves.

The minimum standards describe the conditions necessary for stabilising the emergency situation and providing an acceptable level of health and protection of life with dignity in the short to medium term. They do not describe the absolute minimum necessary for short-term

survival, and are not expected to be achieved immediately. Survival standards of water supply and sanitation should be established as soon as possible in order to prevent avoidable disease and death in the early stages of an emergency. These should be seen as steps on the way to achieving minimum standards which are acceptable over the longer term. The minimum standards equally may not be appropriate for situations which last for a number of years, and so should not be seen as maximum standards. Water supply and sanitation interventions should be matched to the type and severity of the emergency, working towards minimum standards as quickly as possible, and responding to urgent needs with intermediate solutions. Minimum standards for water supply and sanitation should be reached within three to six months of the start of the programme.

6 Links with other sectors

Reference to other sectors' technical standards is made where relevant. The purpose of this is to highlight how work in one sector is closely linked to work in other sectors, and that progress in one is dependent on progress in other areas.

The Minimum Standards

1 Analysis

Programmes that meet the needs of disaster affected populations must be based on a clear understanding of the situation. The people affected by the disaster, agencies, donors and local authorities need to know that interventions are appropriate and effective. Analysis of the effects of the disaster and of the impact of the water supply and sanitation programme itself, is therefore critical. If the problem is not correctly identified and understood then it will be difficult, if not impossible, to make the right response.

Standardised methods of analysis that are used across the sectors have great potential to identify rapidly acute humanitarian needs and to ensure that resources are directed accordingly. This section sets out agreed standards and indicators for collecting and analysing information to identify needs, to design programmes and to monitor and evaluate their effectiveness.

The analysis standards apply before any programme takes place and throughout the programme cycle. Analysis starts with an immediate initial assessment that identifies the impact of the disaster and whether and how to respond. It continues with monitoring, which identifies how well the programme is meeting needs and determines whether changes are required; and with evaluation, which determines the overall effectiveness of the programme and identifies lessons for the future.

The sharing of information and knowledge among all those involved, including the affected populations, is fundamental to achieving a full understanding of the problem and coordinated assistance. Documenting and disseminating information from the analysis process contributes to a broad understanding of the adverse public health and other consequences of disasters and assists in the development of improved disaster prevention and mitigation strategies.

Analysis standard 1: assessment

Programme decisions are based on a demonstrated understanding of the emergency situation and on a clear analysis of the health risks and needs relating to water supply and sanitation.

Key indicators

- An immediate initial assessment that follows internationally accepted procedures is carried out by appropriately experienced personnel.
- The assessment is conducted in cooperation with a multi-sectoral team (water and sanitation, nutrition, food, shelter and health), local authorities, representatives of the affected population and humanitarian agencies intending to respond to the situation.
- The information is gathered and presented in a way that allows for transparent and consistent decision making.
- The information gathered identifies needs and health risks related to water supply and sanitation, and baseline data for monitoring and evaluation.
- All working and damaged water and sanitation systems are inspected.
- The assessment considers the national standards for water supply and sanitation in the country where the disaster has occurred, and in the country where humanitarian assistance is provided if different.
- Recommendations are made on whether or not external assistance is needed. If assistance is required, recommendations are made on priorities, a strategy for intervention and resources needed. There is consideration of:
 - The social and political structure of the population.
 - The estimated number of people affected and demographic characteristics.

- Local capacity and resources.
 - Special attention for groups at risk.
 - Access to the affected population.
 - Security.
 - The possible long-term implications and environmental impact of the interventions proposed.
- An assessment report is produced that covers key areas and appropriate recommendations.
 - Assessment findings are shared with other sectors, national and local authorities, representatives of the affected population and participating agencies.

Guidance notes and critical issues

1. Timeliness is of the essence for the initial assessment, which should be carried out as soon as possible after the disaster. If required there should be an immediate response to critical needs at the same time. As a general rule, a report should be generated within a week of arrival at the site of the disaster, though this depends on the particular event and the wider situation.
2. People who are able to collect information from all groups in the affected population in a culturally acceptable manner should be included, especially with regard to gender and language skills.
3. The procedure for conducting the assessment should be agreed upon by all participants before field work begins and specific tasks contributing to the assessment should be assigned accordingly.
4. There are several different techniques for information gathering and these should be chosen carefully to match the situation and the type of information required. As a general rule, information should be gathered more frequently when the situation is changing more rapidly, and when there are critical developments such as new population movements or an epidemic outbreak of diarrhoea. Initial assessments may be quick and unrefined but analysis

improves as more time and data are available. Checklists are a useful way of ensuring that all the key questions have been examined. See Appendix 1 for an example checklist.

5. Information for the assessment report can be compiled from existing literature, relevant historical material, pre-emergency data and from discussions with appropriate, knowledgeable people including donors, agency staff, government personnel, community leaders, women, elders, participating health staff, teachers, traders and so on. National or regional level preparedness plans may also be an important source of information.
6. The assessment and subsequent analysis should demonstrate an awareness of underlying structural, political, economic and environmental issues operating in the area. It is imperative that prior experience and the views of the people affected by the disaster are taken into consideration when analysing the dynamics and impact of the new emergency. This requires inclusion of local expertise and knowledge in data collection and analysis of resources, capacities, vulnerabilities and needs. The current and pre-emergency living conditions of displaced and non-displaced people in the area must also be considered.
7. The needs of groups that are at risk of additional harm such as women, children, elderly people, physically and mentally disabled people must be considered. Gender roles within the social system need to be identified.
8. Thinking and analysis concerning the post-disaster recovery period should be part of the initial assessment, so that interventions to meet immediate emergency requirements can serve to foster recovery among the affected population.

Analysis standard 2: monitoring and evaluation

The performance of the water supply and sanitation programme, its effectiveness in responding to health problems related to water and sanitation, and changes in the context are monitored and evaluated.

Key indicators

- The information collected for monitoring and evaluation is timely and useful; it is recorded and analysed in an accurate, logical, consistent and transparent manner.
- Systems are in place that enable systematic collection of information on:
 - Water consumption.
 - Water quality.
 - Water supply system and operation.
 - Access to water points.
 - Access to toilets.
 - Activities in vector control, solid waste management and drainage.
- The use of water and sanitary facilities and goods is monitored.
- Access to water and sanitation, and water supply and sanitation-related health problems for the population surrounding the emergency settlement, are monitored.
- There is regular analytical reporting on the impact of the water supply and sanitation programme on the affected population. There is also reporting of any contextual changes and other factors that may necessitate adjustment to the programme.
- Systems are in place that enable an information flow between the programme, other sectors, the affected population, the relevant local authorities, donors and others as needed. There is a regular exchange of information between the water supply and sanitation

sector and the health information system. (See Health Services, chapter 6.)

- Monitoring activities provide information on the effectiveness of the programme in meeting the needs of target groups within the affected population.
- The programme is evaluated with reference to stated objectives and agreed minimum standards to measure its overall effectiveness and impact on the affected population.

Guidance notes and critical issues

1. Emergencies are volatile and dynamic by definition. Regular and current information is therefore vital in ensuring that programmes remain relevant. Information derived from continual monitoring of programmes should be fed into reviews and evaluations. In some circumstances, a shift in strategy may be required to respond to major changes in the context or needs. See Appendix 3 for suggesting reading on assessment, monitoring and evaluation.
2. Information generated by the assessment process is used as an initial baseline for the health information system (see Health Services, chapter 6) and for monitoring and evaluation activities for the water supply and sanitation programme. Monitoring and evaluation activities require close cooperation with other sectors.
3. Information collected should be directly relevant to the programme, in other words it should be useful and should be used. It should also be shared as needed with other sectors and agencies, and with the affected populations. The means of communication used (dissemination methods, language and so on) must be appropriate for the intended audience.
4. Evaluation is important because it measures effectiveness, identifies lessons for future preparedness, mitigation and assistance, and promotes accountability. Evaluation refers here to two, linked processes:
 - a) Internal programme evaluation is normally carried out by staff as part of the regular analysis and review of monitoring

information. The agency must also evaluate the effectiveness of all its programmes in a given disaster situation or compare its programmes across different situations.

- b) External evaluation may by contrast be part of a wider evaluation exercise by agencies and donors, and may take place, for example, after the acute phase of the emergency. When evaluations are carried out it is important that the techniques and resources used are consistent with the scale and nature of the programme, and that the report describes the methodology employed and the processes followed in reaching conclusions. Outcomes of evaluations should be disseminated to all the humanitarian actors, including the affected population.

2 Excreta Disposal

Proper disposal of human excreta creates the first barrier to excreta-related disease, helping to reduce disease transmission through direct and indirect routes. Excreta disposal is therefore a first priority, and in most emergency situations should be addressed with as much speed and effort as water supply. Appropriate facilities for defecation are one of a number of emergency interventions essential for people's dignity, health and well-being.

Excreta disposal standard 1: access to, and numbers of toilets

People have sufficient numbers of toilets, sufficiently close to their dwellings to allow them rapid, safe and comfortable access at all times of the day and night.

Key indicators

- Maximum of 20 people per toilet.
- Use of toilets is arranged by household(s) and/or segregated by sex.
- Toilets are no more than 50 metres from dwellings, or no more than one minute's walk.
- Public toilets are available in public places (markets, distribution centres, health centres etc).

Excreta disposal standard 2: design and construction

People have access to toilets which are designed, constructed and maintained in such a way as to be comfortable, hygienic and safe to use.

Key indicators

- Technically sound design and construction specifications, approved by the intended users, are used for all forms of household and public toilets.
- Cleaning and maintenance routines for public toilets are in place and function correctly.
- Toilets are designed, built and located to have the following features:
 - They are easy to keep clean enough to invite use and not to present a health hazard.
 - They are accessible and easy to use by all sections of the population including children, old people, pregnant women and handicapped people.
 - They are lit at night if necessary.
 - Hand washing facilities are close by.
 - They minimise fly and mosquito breeding.
 - They allow for the disposal of women's sanitary protection, or provide women with the necessary privacy for washing and drying sanitary protection cloths.
 - They provide a degree of privacy in line with the norms of the users.
- Latrines and soakaways in most soils are at least 30 metres from any groundwater source and the bottom of any latrine is at least 1.5 metres above the water table. Drainage or spillage from defecation systems does not run towards any surface water source or shallow groundwater source.

- People are provided with tools and materials for constructing, maintaining and cleaning their own toilets if appropriate.

Guidance notes and critical issues

1. **Acceptable facilities:** successful excreta disposal programmes are based on an understanding of peoples' varied needs, and on the participation of the users in the use of facilities they may not be accustomed to and which they may not find easy or attractive to use. Design, construction and location of toilets must take account of the preferences of the intended users.
2. **Children's faeces:** particular attention should be given to children's faeces, which are commonly more dangerous than those of adults. Parents need to be involved, and facilities should be designed and installed with children in mind.
3. **Anal cleansing:** water should be provided for people who use it. For other people it may be necessary to provide some sort of paper or other material for anal cleansing. Users should be consulted on the most appropriate materials.
4. **Hand washing:** users should have the means to wash their hands after defecation, with soap or an alternative, and should be encouraged to do so if necessary. This provides an important barrier to the spread of disease.
5. **Menstruation:** women and girls of reproductive age should have access to suitable materials for the absorption and disposal of menstrual blood. If these materials are to be provided by the agency, women should be consulted on what is appropriate. Where cloths are washed, dried and re-used, women should have access to a private place to do this in a hygienic way.
6. **Hygienic toilets:** if toilets are not kept clean they may be a focus for disease transmission and people will prefer not to use them. Cleaning and maintenance of all types of toilet should be addressed. Toilets are more likely to be kept clean if users have a sense of ownership. This is encouraged by having them close to where people sleep, avoiding large blocks and involving users, where

possible, in decisions about their design and construction.

7. **Shared facilities:** it is not possible to provide one toilet per 20 people or per family immediately. In the short term, shared facilities are usually needed. Access to these shared facilities can be ensured by working with the intended users to decide who will have access to the toilet and how the sharing and responsibility for cleaning will be organised. It may be that men and women use different toilets, or that several families all use the same toilet. As the numbers of toilets are increased the sharing arrangements will change. In some situations it may be necessary to provide, clean and maintain public toilets for some or all of the population. It is important both that sufficient numbers of toilets are available and that every person can identify and gain access to a toilet when necessary.
8. **Distance of defecation systems from water sources:** the distances given above may be increased for fissured rocks and limestone, or decreased for fine soils. Groundwater pollution may not be a concern if the groundwater is not consumed.

3 Water Supply

Water is universally essential for drinking, cooking and personal and domestic hygiene. In extreme situations, there may not be enough water available to meet physiological needs, and in these cases a survival level of potable drinking water is probably the most urgent and important priority of all. In most cases however, the main health problems associated with inadequate water supply are caused by poor hygiene due to lack of water, and by the consumption of water that is contaminated at some stage.

Water supply standard 1: access and water quantity

All people have access to a sufficient quantity of water for drinking, cooking and personal and domestic hygiene. Public water points are sufficiently close to shelters to allow use of the minimum water requirement.

Key indicators

- At least 15 litres of water per person per day is collected.
- Flow at each water collection point is at least 0.125 litres per second.
- There is at least 1 water point per 250 people.
- The maximum distance from any shelter to the nearest water point is 500 metres.

Water supply standard 2: water quality

Water at the point of collection is palatable, and of sufficient quality to be drunk and used for personal and domestic hygiene without causing significant risk to health due to water-borne diseases, or to chemical or radiological contamination from short term use.

Key indicators

- There are no more than 10 faecal coliforms per 100 ml at the point of delivery for undisinfected supplies.
- Sanitary survey indicates low risk of faecal contamination.
- For piped water supplies to populations over 10,000 people, or for all water supplies at times of risk or presence of diarrhoea epidemic, water is treated with a residual disinfectant to an acceptable standard (eg residual free chlorine at the tap is 0.2-0.5 mg per litre and turbidity is below 5 NTU).
- Conductivity is no more than 2,000 $\mu\text{S}/\text{cm}$ and water is palatable to users.
- No significant negative health effect due to chemical or radiological contamination from short term use, or from the planned duration of use of the water source, is detected (including carry-over of treatment chemicals), and assessment shows no significant probability of such an effect.

Water supply standard 3: water use facilities and goods

People have adequate facilities and supplies to collect, store and use sufficient quantities of water for drinking, cooking and personal hygiene, and to ensure that drinking water remains sufficiently safe until it is consumed.

Key indicators

- Each family has two water collecting vessels of 10-20 litres, plus water storage vessels of 20 litres. Water collection and storage vessels have narrow necks and/or covers.
- There is 250g of soap available per person per month.
- Where communal bathing facilities are necessary, there are sufficient bathing cubicles for bathing at an acceptable frequency and at an acceptable time, with separated cubicles for men and for women.
- Where communal laundry facilities are necessary, there is 1 washing basin per 100 people.

Guidance notes and critical issues

1. **Needs:** the exact quantities of water needed for domestic use may vary, according to the climate, the sanitation facilities available, people's normal habits, the food they cook, the clothes they wear etc. In some situations water may be needed in large quantities for specific purposes, for instance for pour-flush toilets, to keep an existing sewer system or urban water distribution system functioning, or to water animals which may be vital to the livelihoods and well-being of the people affected by the disaster. Quantities needed for these uses are not included in the standards and should be added to the minimum figure if necessary. Quantities of water needed for health centres, therapeutic feeding centres, orphanages etc are not included in the standard figures, and should be added if necessary. See Appendix 2 for guidance on the additional quantities needed.
2. **Microbiological water quality:** in most emergency situations, water-related disease transmission is due as much to insufficient water for personal and domestic hygiene as to contaminated water supplies. When applying standards for microbiological water quality in an emergency situation, consideration should be given to the risk of *excess* infection from water-borne disease posed by the water supplied, and what other water sources people may be likely to use.

3. **Water disinfection:** water should be treated with a residual disinfectant such as chlorine if there is a significant risk of water source or post-collection contamination. This risk will be determined by conditions in the settlement, such as population density, excreta disposal arrangements, hygiene practices, the prevalence of water-borne disease etc. As a general rule, any piped water supply for a large and concentrated population should be treated with a residual disinfectant such as chlorine, and in the case of a threat or existence of a diarrhoea epidemic, all drinking water supplies should be treated before distribution or in the home.
4. **Chemical and radiological contamination:** where hydrogeological records or knowledge of industrial activity suggest that water supplies may carry chemical or radiological health risks, those risks should be assessed rapidly. A decision that balances short term public health risks and benefits should then be made. A decision about using possibly contaminated water for longer term supplies should be made on the basis of a more thorough assessment and analysis.
5. **Palatability:** while taste is not a direct problem for health, if the safe water supply does not taste good to the consumers they may drink from unsafe sources and put their health at risk. This may also be a risk when chlorinated water is supplied. Palatability depends on what the consumer is used to and should therefore be verified in the field to make a final decision on whether or not the water is acceptable, or whether promotional activities are needed to ensure that only safe supplies are used.
6. **Water quality for health centres:** apart from small quantities of very pure water needed for some medical equipment, water supplied to health centres does not need to be of better quality than that supplied to the general population, unless the concentration of certain chemicals is particularly high. However, given the likely numbers of pathogenic organisms present in health centres and the vulnerability of patients, water should be disinfected with chlorine or another residual disinfectant, and water storage equipment designed and managed to control contamination. Very young children may be susceptible to certain chemical contaminants and this should be checked with medical staff.

7. *Quality / quantity:* during the emergency attention must be given to the quantity of water that is available as well as its quality. Until minimum standards for both quantity and quality are met, the priority should be to provide equitable access to an adequate quantity of water of intermediate quality, rather than to provide an inadequate quantity of water which meets the minimum standard for quality. If there are serious doubts about the microbiological quality of the water, it should be treated with a residual disinfectant as a first measure to improve quality.
8. *Access and equity:* even if a sufficient quantity of water is available to meet minimum needs, additional measures may be needed to ensure that access is equitable. Unless water points are sufficiently close to their dwellings, people will not be able to collect enough water for their needs. In urban situations, it may be necessary to have water supplied into individual buildings to ensure that toilets continue to function. Water may need to be rationed to ensure that everyone's basic needs are met.
9. *Water use facilities:* people need vessels to collect water, to store it and to use it for washing, cooking and bathing. These vessels should be hygienic and appropriate to local needs and habits, in terms of size, shape and design. People may also need a space where they can bathe in privacy. If this is not possible at the family shelter, some central facilities may be needed. Washing clothes is an essential activity for hygiene, particularly for children, and cooking and eating utensils need washing. It is not possible to define universal standards relating to these activities, but if some facilities are needed for them to be carried out then they should be available. The design, numbers and location of these facilities should be decided in consultation with the intended users.

4 Vector Control

Vector-borne diseases are a major cause of sickness and death in many emergency situations. Although malaria is probably the vector-borne disease of greatest public health concern, a number of others can pose a major threat to health. Flies may play an important role in the transmission of diarrhoeal disease. The control of vector-borne disease involves efforts in several areas, including health services, shelter, site selection and planning, and environmental health services, including water supply, excreta disposal, solid waste management and drainage. Although the nature of vector-borne disease is complex and addressing vector-related problems often demands specialist attention, there is much that can be done with simple and effective measures once the disease, the vector and their interaction with the beneficiary population have been identified.

Although not of primary public health concern, so-called nuisance pests, such as bed bugs, can cause significant discomfort and loss of sleep and are often worthy of attention for their indirect impact on health.

Vector control standard 1: individual and family protection

People have the means to protect themselves from disease vectors and nuisance pests when they are estimated to be a significant risk to health or well-being.

Key indicators

- All populations associated with a vector-borne disease risk have access to shelters equipped with insect control.

- Control of human lice is carried out to an agreed standard where louse-borne typhus or relapsing fever are a threat.

Vector control standard 2: physical, environmental and chemical protection measures

The number of disease-bearing vectors and nuisance pests that pose a risk to people's health and well-being are kept to an acceptable level.

Key indicators

- Vulnerable populations are settled outside the malarial zone.
- The population of malaria-bearing mosquitoes is kept low enough to avoid the risk of excessive malaria infection.
- Vector breeding or resting sites are modified where necessary and practicable.
- Rats, flies and other mechanical and nuisance pests are kept within acceptable levels.
- Intensive fly control is carried out in high density settlements when there is a risk or presence of diarrhoea epidemic.

Vector control standard 3: good practice in the use of chemical vector control methods

Vector control measures that make use of pesticides are carried out in accordance with agreed international norms to ensure that staff, the people affected by the disaster and the local environment are adequately protected, and to avoid creating resistance to pesticides.

Key indicators

- Personnel are protected by the provision of training, protective clothing, supervision and a restriction on the number of hours handling pesticides.

- The purchase, transport, storage and disposal of pesticides and application equipment follows international norms, and can be accounted for at all times.
- People are protected during and after the application of pesticides according to internationally agreed procedures.
- The choice of pesticide and application method conform to national and international protocols.
- The quality of pesticide and of treated bednets conforms to international norms.

Guidance notes and critical issues

1. For further information see Chavasse, D C and Yap, H H (1997), listed in Appendix 4.
2. **Links with other sectors:** site selection is important in limiting the exposure of the population to vector-borne disease risk. The risk of vector-borne disease is one of the key questions considered when choosing possible sites. Health service activities may help reduce pathogen prevalence by effective treatment, immunisation or prophylaxis, and vector-borne disease control should be undertaken with activities in both the health sector and the water supply and sanitation sector. Both health service and nutrition activities can help reduce vector-borne disease incidence by their impact on general health and nutritional status.
3. **Defining vector-borne disease risk:** decisions about vector control interventions should be based on an assessment of excess disease risk, as well as on clinical evidence of a vector-borne disease problem. Factors influencing this risk include:
 - Immune status – previous exposure, nutritional stress and other stresses.
 - Pathogen type and prevalence – in both vectors and humans.
 - Vector species and ecology.
 - Vector numbers (season, breeding sites etc).

– Existing individual protection and avoidance measures.

4. **Individual protection measures:** it is recommended that if there is a risk of excess malaria, individual protection measures such as treated bednets are provided systematically and at an early stage. Impregnated bednets have the added advantage of giving some protection against lice, bedbugs and sandflies. Other individual protection measures which may be appropriate and which are commonly used already by people familiar with mosquitoes include the use of long sleeved clothing, household fumigants, mosquito screens and repellents. It is vital to ensure that users can accept and use these individual protection measures if they are to be effective.
5. **Environmental and chemical vector control:** there are a number of basic environmental engineering measures which can be taken to reduce the opportunities for vector breeding within the settlement. These include disposal of human and animal excreta and refuse for controlling flies, and drainage of standing water for controlling mosquitoes. Most priority environmental health measures such as excreta disposal and refuse disposal will have some impact on the populations of some vectors, but not all. However, it may not be possible to have sufficient impact on all the breeding, feeding and resting sites within and nearby the settlement, even in the longer term, and localised chemical control measures or individual protection measures may be needed. In some circumstances, space spraying may be justified and effective in reducing numbers of adult insects, for example for reducing fly numbers in anticipation of, or during, a diarrhoea epidemic.
6. **Household and personal insecticide treatment:** household treatment with residual insecticide can be effective in controlling the spread of malaria. Louse-borne typhus and relapsing fever may be avoided by personal treatment for the control of body lice by means of a mass campaign, and as newly displaced people arrive in a settlement.
7. **Indicators for vector control programmes:** the simplest indicators for measuring the impact of most vector control activities are disease incidence and parasite counts (for malaria). However, these

are insensitive indicators which should be used with caution and interpreted in the light of other factors.

8. *Designing a response:* vector control programmes may have no impact on disease if they target the wrong vector, use ineffective methods, or target the right vector in the wrong place or at the wrong time. Health data can help identify and monitor a vector problem, but designing an effective response requires more detailed study and, often, expert advice. This advice should be discussed with national and international health organisations, to ensure that national and international protocols are followed to identify the appropriate response and to ensure the correct choice and application of any chemicals used. Local advice should be sought on local disease problems, breeding sites, seasonal variations in vector numbers etc.

5 Solid Waste Disposal

If organic solid waste is not disposed of, the major risks posed are fly and rat breeding (see vector control) and surface water pollution. Uncollected and accumulating solid waste and the debris left after a natural disaster or conflict may also create a depressing and ugly environment, discouraging efforts to improve other aspects of environmental health. Solid waste may block drainage channels and lead to environmental health problems associated with stagnant and polluted surface water.

Solid waste disposal standard 1: solid waste collection and disposal

People have an environment that is acceptably free of solid waste contamination, including medical wastes.

Key indicators

- Domestic refuse is removed from the settlement or buried on site before it becomes a nuisance or a health risk.
- There are no contaminated or dangerous medical wastes (needles, glass, dressings, drugs etc) at any time in the living area or public spaces.
- There is a correctly designed, constructed and operated incinerator with deep ash pit within the boundaries of each health facility.
- There are refuse pits, bins or specified areas at markets and slaughtering areas, with a daily collection system.
- Final disposal of solid waste is carried out in such a place and in such a way as to avoid creating health and environmental problems.

Solid waste disposal standard 2: solid waste containers/pits

People have the means to dispose of their domestic waste conveniently and effectively.

Key indicators

- No dwelling is more than 15 metres from a refuse container or household refuse pit, or 100 metres from a communal refuse pit.
- One 100 litre refuse container is available per 10 families where domestic refuse is not buried on site.

Guidance notes and critical issues

1. *Refuse type and quantity:* refuse in emergency settlements varies widely in composition and quantity, according to the amount and type of economic activity and the staple foods consumed. The extent to which solid waste has an impact on people's health should be assessed in a logical manner to identify whether action is needed and what that action should be. If solid waste is recycled within the community this should be encouraged, as long as it presents no significant health risk. Distribution of commodities that produce a large amount of solid waste because of the way they are packaged or processed on site should be avoided.
2. *Participation:* most solid waste management programmes depend on the participation of the population concerned for placing their refuse in containers provided, or burying it where appropriate. Parents and children should be made aware of the dangers of playing with or recycling medical wastes.
3. *Medical waste:* special provision is needed for medical waste. It should be disposed of within the perimeter of a medical facility, cholera isolation centre, feeding centre etc, and not mixed in with the general settlement refuse. Responsibility for disposing of medical waste should be clearly defined.

4. **Market waste:** most market waste can be treated in the same way as domestic refuse. Slaughter house waste may need special treatment and special facilities to deal with the liquid wastes produced, and to ensure slaughtering is carried out in hygienic conditions.
5. **The dead:** mortality rates are often high during the early stages of emergencies, demanding mass management of dead bodies. In special cases such as during cholera or typhus epidemics, human remains may pose special health risks. However, in general, families should be allowed to bury or cremate their own dead in their traditional way. Cemeteries or cremation facilities should be planned for and provided early on in the life of a new settlement, in consultation with members of the affected population. Provision should be made for monitoring funerals for mortality data. It may be necessary to provide cloth or other materials for families to wrap their dead before burial or cremation.
6. **Disposal of solid waste:** whatever means of final disposal is chosen, for instance burial or incineration, this should be done in a location and in such a way as to avoid creating health and environmental problems.

6 Drainage

Surface water in and near emergency settlements may come from household and water point wastewater, leaking latrines and sewers, rain water and rising floodwater. The main health problems associated with this water are contamination of water supplies and the living environment, damage to latrines and shelters, vector breeding and drowning. Surface water in and near the settlement may provide health and other benefits, enabling people to wash themselves, their cooking utensils and their clothes. An appraisal of the benefits and risks presented should be made when deciding whether or not to drain such water bodies. This section addresses small scale drainage problems and activities. Large scale drainage is generally determined by site selection and development. (See Shelter and Site Planning, chapter 5.)

Drainage standard 1: drainage works

People have an environment that is acceptably free from risk of water erosion and from standing water, including storm water, flood water, domestic wastewater and wastewater from medical facilities.

Key indicators

- There is no standing wastewater around water points or elsewhere in the settlement.
- Storm water flows away.
- Shelters, paths and water and sanitation facilities are not flooded or eroded by water.

Drainage standard 2: installations and tools

People have the means (installations, tools etc) to dispose of domestic wastewater and water point wastewater conveniently and effectively, and to protect their shelters and other family or communal facilities from flooding and erosion.

Key indicators

- Sufficient numbers of appropriately designed tools are provided to people for small drainage works and maintenance where necessary.
- Water point drainage is well planned, built and maintained. This includes drainage from washing and bathing areas as well as water collection points.

Guidance notes and critical issues

1. *Site selection and planning:* the most effective way to avoid drainage problems is in the choice and lay out of the emergency settlement. (See Shelter and Site Management, site selection standards, in chapter 5). It may not be practicable to address the drainage problems of some sites, or of nearby water bodies.
2. *Promotion:* where small scale drainage works are necessary to protect latrines and shelters, and to avoid stagnating household and water point wastewater, it may be appropriate to involve the population concerned. Technical support and tools may then be needed. It may also be necessary to provide information and alternatives if nearby water bodies pose health risks such as schistosomiasis or hazards from consumption of the water.
3. *Drainage and excreta disposal:* special care is needed to ensure that latrines and sewers are protected from flooding in order to avoid structural damage and leakage.

7 Hygiene Promotion

Hygiene behaviour is a crucial factor in the transmission of water and sanitation-related disease, and hygiene promotion is widely considered to be an essential element of an effective emergency water supply and sanitation response. It is difficult to measure the impact of hygiene promotion programmes in emergencies. However, such programmes may be effective if they are assessed, planned and implemented in a systematic way, and if they focus on a very small number of important practices which can be rapidly influenced. It must be stressed that hygiene promotion should never substitute for good sanitation and water supplies, which are the key to good hygiene.

Definition of hygiene promotion

Hygiene promotion is defined here as the mix between the population's knowledge, practice and resources, and agency knowledge and resources which together enable risky hygiene behaviours to be avoided. Effective hygiene promotion relies on an exchange of information between the agency and the affected community in order to identify key hygiene problems, and to design, implement and monitor a programme to promote hygiene practices that will deal with these problems. This definition recognises that hygiene behaviour and the material means for healthy living should be promoted together.

Hygiene promotion standard 1: hygiene behaviour and use of facilities

All sections of the affected population are aware of priority hygiene practices that create the greatest risk to health and are able to change them. They have adequate information and resources for the use of water and sanitation facilities to protect their health and dignity.

Key indicators

1. Excreta disposal

- People use the toilets available and children's faeces are disposed of immediately and hygienically.
- People use toilets in the most hygienic way, both for their own health and for the health of others.
- Household toilets are cleaned and maintained in such a way that they are used by all intended users and are hygienic and safe to use.
- Parents (mothers and fathers) demonstrate awareness of the need to dispose of children's faeces safely.
- Families and individuals participate in a family latrine programme by registering with the agency, digging pits or collecting materials.
- People wash their hands after defecation and handling children's stools and before cooking and eating.

2. Water supply

- People use the highest quality of readily available water.
- Public hygiene facilities (showers, laundry basins etc) are used appropriately and equitably.
- Average water use for drinking, cooking and personal hygiene in any household is at least 15 litres per person per day.
- Covers (where provided) are placed on water containers.
- Mean faecal contamination in potable water containers is indicated by less than 50 faecal coliforms per 100 ml.

3. Vector control

- People with treated mosquito nets keep, use and retreat them correctly.
- People avoid exposure to mosquitoes during biting times using the means available to them.
- Containers which may be mosquito breeding sites are removed, emptied of water regularly or covered.

- Bedding and clothing is aired and washed regularly.

4. Solid waste disposal

- Waste is put in containers daily for collection, or buried in a specified refuse pit.
- Parents and children are aware of the danger of playing with needles and dressings from medical facilities, in cases where the minimum standard for the disposal of medical waste is not met.

5. Drainage

- Areas around shelters and water points are free of standing wastewater, and local stormwater drains are kept clear.
- There is a demand for tools for drainage works.
- People avoid entering water bodies where there is a schistosomiasis risk.

6. Funerals

- People have the resources and information necessary to carry out funerals in a manner which respects their culture and does not create a risk to health.

Hygiene promotion standard 2: programme implementation

All facilities and resources provided reflect the vulnerabilities, needs and preferences of all sections of the affected population. Users are involved in the management and maintenance of hygiene facilities where appropriate.

Key indicators

- Key hygiene risks of public health importance are identified in assessments and in the objectives for hygiene promotion activities.
- The design and implementation process for water supply and sanitation programmes includes and operates a mechanism for representative input from all users.

- All groups within the population have access to the resources or facilities needed to achieve the hygiene practices that are promoted.
- Hygiene promotion activities address key behaviours of importance for public health and they target priority groups.
- Hygiene and behaviour messages, where used, are understood and accepted by the intended audience.
- Users take responsibility for the management and maintenance of water supply and sanitation facilities as appropriate.

Guidance notes and critical issues

1. *Agencies and the affected population share responsibility for hygiene practice:* as with all of the other standards, action by agencies on hygiene promotion will not necessarily be required, but these are points which need monitoring so that action can be taken if necessary. The ultimate responsibility for hygiene practice lies with the affected population. The responsibility of humanitarian agencies is to enable hygienic practice by ensuring that both knowledge and facilities are accessible, and to be able to demonstrate that this is achieved.
2. *Targeting priority hygiene risks and behaviours:* the objectives of hygiene promotion activities and communication strategies should be clearly defined in order to avoid diluting key messages, confusing people or sending messages to the wrong people. The understanding gained through assessing hygiene risks should be used to plan and prioritise material assistance, so that information flows usefully between the agency and the population concerned.

An assessment is needed to identify the key hygiene behaviours to be addressed and the likely success of promotional activity. This assessment should look at resources available to the population as well as behaviours, so that messages do not promote the impossible.

8 Human Resource Capacity and Training

All aspects of humanitarian assistance rely on the skills, knowledge and commitment of staff and volunteers working in difficult and often insecure conditions. The demands placed on them can be considerable, and if they are to conduct their work to a level where minimum standards are assured, it is essential that they are suitably experienced and trained and that they are adequately managed and supported by their agency.

Capacity standard 1: competence

Water supply and sanitation programmes are implemented by staff who have appropriate qualifications and experience for the duties involved, and who are adequately managed and supported.

Key indicators

- All staff working on a water supply and sanitation programme are informed of the purpose and method of the activities they are asked to carry out.
- Assessments, programme design and key technical decision-making are carried out by staff with relevant technical qualifications and previous emergency experience.
- Staff with technical and management responsibilities have access to support for informing and verifying key decisions.
- Staff or volunteers involved in information gathering are thoroughly briefed and quickly checked by an experienced person before starting work.

- Staff or volunteers involved in hygiene education have the ability or aptitude for this activity and receive appropriate training and supervision.
- Staff and volunteers involved in construction and other manual activities are trained, supervised and equipped adequately to ensure their work is carried out efficiently and safely.

Guidance notes

1. See the *People in Aid Code of Best Practice in the Management and Support of Aid Personnel* which is appended in this binder.
2. When programmes are designed, human resource capacity issues must be addressed. Staff and volunteers should demonstrate capabilities equal to their respective assignments; specific training in the relevant areas of expertise must be a prerequisite for engagement of staff. The provision of training and support as a part of emergency preparedness is important to ensure that skilled personnel are available to deliver quality services. Given that emergency preparedness cannot be assured in many countries, humanitarian agencies should ensure that qualified and competent staff are identified and properly prepared before eventual assignment to an emergency situation.

Appendix 1

Initial Needs Assessment Questions, Water Supply and Sanitation

This list of questions is primarily for use to assess needs, identify indigenous resources and describe local conditions. It does not include questions to determine external resources needed in addition to those immediately and locally available.

1. General

- How many people are affected and where are they?
- What are people's likely movements? What are the security constraints?
- What are the current or threatened water and sanitation-related diseases? What is the distribution and expected evolution of problems?
- Who are the key people to consult or contact?
- Who are the vulnerable people in the population?

2. Excreta disposal

- What is the current defecation practice? If it is open defecation, is there a designated area?
- Are there any existing facilities? If so are they used, are they sufficient and are they operating successfully? Can they be extended or adapted?
- Is the current defecation practice a threat to water supplies or living areas?
- Is the current defecation practice a health threat to users?
- Are people familiar with the construction and use of toilets?
- Are people prepared to use latrines, defecation fields, trenches etc?
- What are current beliefs and practices concerning excreta disposal?
- Is there sufficient space for defecation fields, pit latrines etc?

- What is the slope of the terrain?
- What is the level of the groundwater table?
- Are soil conditions suitable for on-site excreta disposal?
- What local materials are available for constructing toilets?
- Do current excreta disposal arrangements encourage vectors?
- Do people have access to water and soap for washing hands after defecation?
- Are there materials or water available for anal cleansing?
- How do women deal with menstruation? Are there materials or facilities they need for this?

3. Water supply

- What is the current water source?
- How much water is available per person per day?
- Is the water available at the source enough for short term and longer term needs?
- Are water collection points close enough to where people live?
- Is the current water supply reliable? How long will it last?
- Do people have enough water containers of the right size and type?
- Is the water source contaminated or at risk of contamination (microbiological and chemical/radiological)?
- Is treatment necessary? Is treatment possible? What treatment is necessary?
- Is disinfection necessary, even if supply is not contaminated?
- Are there alternative sources nearby?
- Are there any legal obstacles to using available supplies?
- Is it possible to move the population if water sources are inadequate?
- Is it possible to tanker water if water sources are inadequate?

- What are the key hygiene issues related to water supply?
- Do people have the means to use water hygienically in this situation?

4. Vector-borne disease

- What are the vector-borne disease risks and how serious are those risks? (See Vector Control standards for determining risk)
- If vector-borne disease risks are high, do people at risk have access to individual protection?
- Is it possible to make changes to the local environment (by drainage, scrub clearance, excreta disposal, refuse disposal etc) to discourage vector breeding?
- Is it necessary to control vectors by chemical means? What programmes, regulations and resources for vector control and use of chemicals are there?

5. Solid waste disposal

- Is solid waste a problem?
- How do people dispose of their waste?
- What type and quantity of solid waste is produced?
- Can solid waste be disposed of on site, or does it need to be collected and disposed of off site?
- Are there medical facilities and activities producing waste? How is this being disposed of? Who is responsible?

6. Drainage

- Is there a drainage problem? (flooding shelters and latrines, vector breeding sites, polluted water contaminating living areas or water supplies)
- Do people have the means to protect their shelters and latrines from local flooding?

Appendix 2

Water Quantities in Addition to the Minimum Standard for Basic Domestic Consumption

Public toilets	1-2 litres/user/day for handwashing 2-8 litres/cubicle/day for cleaning toilet
All flushing toilets	20-40 litres/user/day for conventional flushing toilets 3-5 litres/user/day for pour-flush toilets
Anal washing	1-2 litres/person/day
Health centres and hospitals	5 litres/outpatient 40-60 litres/inpatient Additional quantities may be needed for some laundry equipment, flushing toilets etc
Cholera centres	60 litres/patient/day 15 litres/carer/day, if appropriate
Therapeutic feeding centres	15-30 litres/person/day 15 litres/carer/day, if appropriate
Livestock	20-30 litres/large or medium animal/day 5 litres/small animal/day

Appendix 3

Good Practice in Water Supply and Sanitation Programmes

Emergency water supply and sanitation programmes should have the following good practice features in order to support the implementation of the standards. They:

- Respond to unmet needs identified by an assessment which meets minimum standards (see Analysis standards).
- Are based on clear objectives which address priority public health issues.
- Ensure sustained, equitable application of minimum standards or better within three to six months.
- Are coordinated to ensure that priorities are met and gaps and overlaps are avoided.
- Are phased, addressing immediate needs then achieving minimum standards as quickly as possible, giving priority to the most important needs at the time.
- Are routinely and systematically monitored to ensure the progress of planned activities and to allow timely programme changes where needed (see Analysis standards).
- Involve a representative cross-section of the affected population in decision making and in project implementation (design, construction, operation and maintenance), in line with their capacity to participate in these activities.
- Complement and build on local capacities, respect local programmes and involve local authorities as appropriate.
- Consider the local context – economic, social, political and environmental – in planning and implementation.
- Recognise the needs of local people as well as those directly affected by the disaster.

- Use equipment and provide facilities which are sensitive to the traditional practices of the affected population and which ensure a minimum level of dignity and comfort.
- Are sensitive to the varied needs of different social groups, at the household level and at the population level, and the impact of the programme on them.
- Are rapid in impact, but long term in perspective, and create favourable conditions for positive developments.
- Ensure the safety of staff, volunteers and other members of the affected population involved in programme implementation and participatory activities.
- Are implemented by staff with appropriate qualifications and experience for the duties involved, and who are adequately managed and supported.
- Use equipment and techniques that may be managed and maintained with local skills and resources.

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The Sphere Project

Humanitarian Charter
and Minimum Standards
in Disaster Response



Minimum Standards in Nutrition

Chapter 3



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Minimum Standards in Nutrition

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Appendix 3: Provisional Nutrient Densities

Appendix 4: Select Bibliography

For the general glossary and acronyms, see chapter 1, appendices 1 and 2.

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Minimum Standards in Nutrition

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Minimum Standards in Nutrition

Introduction

1 The importance of nutrition in emergencies

Access to food and maintenance of adequate nutritional status is a critical determinant of people's survival in the initial stages of an emergency. Malnutrition can be the most serious public health problem and may be a leading cause of death, whether directly or indirectly. Those most commonly affected are children between the ages of six months and five years, though younger infants, older children, adolescents, pregnant women, breastfeeding women and other adults may also be affected.

The purpose of nutrition programmes is to correct and to prevent malnutrition. Programmes aiming to correct malnutrition may consider appropriate feeding, medical treatment and/or supportive care. Preventative programmes aim to ensure that the population has access to food of adequate quantity and quality and has the means to prepare and consume it safely, and that individuals receive nutritional support as required.

2 The Humanitarian Charter and Minimum Standards in nutrition programmes

The aims of nutrition programmes, as well as those of the other sectors, flow from a wider goal which is the cornerstone of humanitarian practices. This goal is to alleviate human suffering brought about by calamity or conflict through protecting life with dignity in ways that support durable recovery.

Translating this goal into practice requires a clear commitment by agencies to humanitarian principles and to the implementation of

minimum standards. The Humanitarian Charter and Minimum Standards together provide the policy and organisational framework to enable this to happen and to ensure systems of accountability.

The Humanitarian Charter reaffirms the importance of fundamental humanitarian principles and the rights of disaster affected communities to humanitarian assistance. Through the Charter, signatory agencies commit themselves to defined minimum standards for the provision of humanitarian services. The standards for nutrition (this chapter), water supply and sanitation (chapter 2), food aid (chapter 4), shelter and site planning (chapter 5), and health services (chapter 6) build on the principles laid out in the Humanitarian Charter and demonstrate how the rights of people affected by disasters should be realised in practice.

The standards set out in this chapter describe what people should have as a minimum for their health and dignity. Agencies should strive to do better wherever possible.

3 Using the standards

The standards apply to any situation where people's normal means for support of life with dignity have failed whether as a result of a natural or human-made disaster in any country, on any continent. They provide a description of what people have a right to expect from humanitarian assistance. The standards do not focus on disaster preparedness, mitigation or rehabilitation, though these are considered where relevant.

The intention is to provide a tool to help create the conditions for effective interventions and for the achievement of the minimum standards. The standards have been made as specific as possible, but they remain widely applicable to different emergency situations within current operational and policy frameworks.

4 Assumptions

To achieve the minimum standards in a wide variety of emergency contexts, it is assumed that:

- Agencies are driven by humanitarian principles and are committed to best organisational practices as a means to achieving their wider goal.

- There is a shared commitment among all those involved in humanitarian assistance to achieve the minimum standards, and to coordinate their response.
- The agency has acquired sufficient financial, human and material resources to meet the standards.
- There is access to the affected population.
- All other sectors are meeting their standards (as described in other chapters).

5 Structure of this chapter

After this introduction the chapter is divided into the following sections:

1. Analysis
2. General Nutritional Support to the Population
3. Nutritional Support to Those Suffering From Malnutrition
4. Human Resource Capacity and Training

Sections 1 to 3 reflect the logical process which nutritionists usually follow in responding to a new emergency. Firstly, they need to understand the nature of the problem. Secondly, they deal with the largest group (ie the general population) to avoid further deterioration and thirdly, they take steps to reduce the risks of death and illness for those who are already malnourished. The fourth section applies to all work and deals with issues related to the human capacity required to implement effective nutrition programmes.

Each of the sections includes the following components:

- **The standards:** these specify the minimum acceptable levels to be attained in each area.
- **Key indicators:** these are 'signals' that show whether the standard has been attained. They provide a way of measuring and communicating both the impact, or result, of programmes as well as the process, or methods, used. The indicators may be qualitative

or quantitative.

- **Guidance notes and critical issues:** these explain why each standard is important and may include: specific points to consider when applying the standard in different situations; guidance on tackling practical difficulties; advice on priority issues.

Critical issues might relate to the standard or indicators, and describe dilemmas, controversies or gaps in current knowledge. Filling these gaps will help improve the minimum standards for nutrition in the future.

There are four appendices giving: the definitions of terms and acronyms; minimum nutritional requirements for emergency affected populations; minimum nutrient densities for minerals not included in Appendix 2; and a select bibliography.

6 Links with other sectors

Reference to other sectors' technical standards is made where relevant. The purpose of this is to highlight how work in one sector is closely linked to work in other sectors, and that progress in one is dependent on progress in other areas.

In particular, there are close connections between the nutrition sector standards and those in food aid. The two sectors overlap in terms of the types of information required for assessment of the situation and identification of needs. There is also commonality with respect to defining nutritional (and hence food) requirements.

The two have been kept as separate chapters for three reasons. Firstly, nutrition in emergencies is concerned with more than simply making decisions about food aid needs. Secondly, food aid programming carries with it specific requirements regarding financial and logistical management procedures; merging the two sectors would have made the chapter too long and too broad. Thirdly, food aid might be one component of a food security response and further standards are needed to cover this area.

The Minimum Standards

1 Analysis

Nutrition is not a subject that can be considered in isolation from others. Health, agriculture, water, economics, religious and traditional beliefs, social practice and welfare systems are some of the most important factors affecting nutritional status. Analysis of the underlying causes of malnutrition may be a complex process but it is vital if we are to ensure that effective programmes are put in place.

Programmes that meet the needs of disaster affected populations must be based on a clear understanding of the situation. The people affected by the disaster, agencies, donors and local authorities need to know that interventions are appropriate and effective. Analysis of the effects of the disaster, its impact on those factors which affect nutritional status and, eventually, the impact of the programme itself are therefore critical. If the problem is not correctly identified and understood then it will be difficult, if not impossible, to make the right response.

Standardised methods of analysis that are used across the sectors have great potential to identify rapidly acute humanitarian needs and to ensure that resources are appropriately directed. This section sets out agreed standards and indicators for collecting and analysing information to identify needs, to design programmes and to monitor and evaluate their effectiveness.

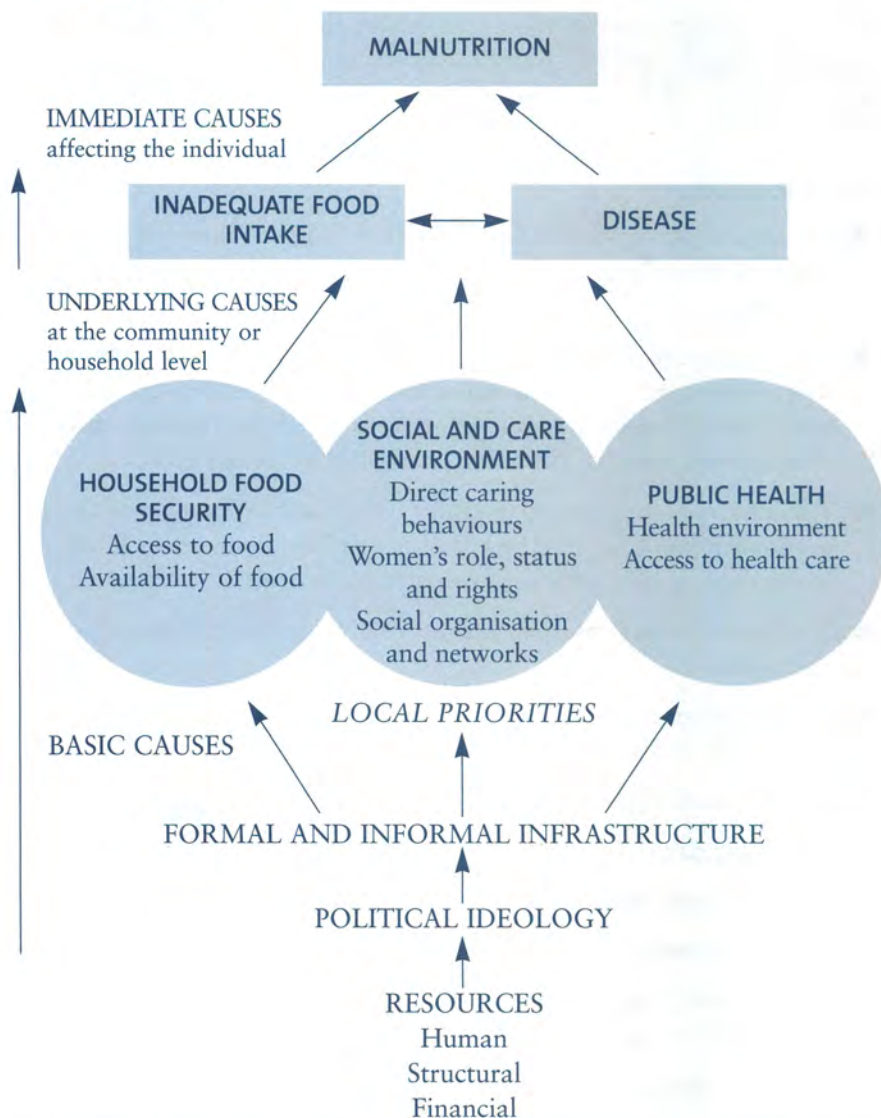
The analysis standards apply before any programme takes place and throughout the programme cycle. Analysis starts with an immediate initial assessment that identifies the impact of the disaster and whether and how to respond. It continues with monitoring, which identifies how well the programme is responding to needs and determines whether changes are required; and with evaluation, which determines the overall effectiveness of the programme and identifies lessons for the future.

The sharing of information and knowledge among all those involved, including the affected populations, is fundamental to achieving a full understanding of the problem and coordinated assistance. Documenting and disseminating information from the analysis process contributes to a broad understanding of the adverse public health and other consequences of disasters and assists in the development of improved disaster prevention and mitigation strategies.

The UNICEF conceptual framework for nutrition in emergencies has been used as a basis for the standards in this section: see the diagram opposite.

Before reading the standards please see the definitions for *access*, *food security*, *malnutrition* and the *social and care environment* in Appendix 1.

Conceptual Model of the Causes of Malnutrition in Emergencies



Source: Oxfam (1997 draft), Food Security – An Oxfam Perspective. Theory and Practice of Assessment and Analysis in Emergencies. (Adapted from the UNICEF Framework of Underlying Causes of Malnutrition and Mortality). Oxfam, Oxford.

Analysis standard 1: assessment

Before any programme decisions are made, there is a demonstrated understanding of the basic nutritional situation and conditions which may create risk of malnutrition.

Key indicators

- An immediate initial assessment that follows internationally accepted procedures is carried out by appropriately experienced personnel.
- The assessment is conducted in cooperation with a multi-sectoral team (water and sanitation, nutrition, food, shelter, health), local authorities, representatives of the affected population and humanitarian agencies intending to respond to the situation.
- The information gathered considers the national standards for nutrition in the country where the disaster has occurred, or in the country where humanitarian assistance is provided, if different.
- The needs of groups that are at risk of additional harm are considered.
- The information is gathered and presented in a way that allows for transparent and consistent decision making.
- An assessment report is produced, covering the following areas:

- *Basic causes of malnutrition:*

- Human, structural, natural and economic resources.

- The political climate.

- Formal and non-formal infrastructure in beneficiary and host populations.

- Population movements.

- *Underlying causes of malnutrition:*

- Food security.

Public health.

Social and care environment.

– *Outcomes of nutritional stress:*

Malnutrition.

Mortality.

Morbidity.

- Recommendations are made on whether or not external assistance is needed.
- Assessment findings are shared with other sectors, national and local authorities, representatives of the affected population and participating agencies.

Guidance notes and critical issues

1. Timeliness is of the essence for the initial assessment, which should be carried out as soon as possible after the disaster. As a general rule, a report should be generated within a week of arrival at the site of the disaster, though this depends on the particular event and the wider situation.
2. People who are able to collect information from all groups in the affected population in a culturally acceptable manner should be included, especially with regard to gender and language skills.
3. The procedure for conducting the assessment should be agreed upon by all participants before field work begins and specific tasks contributing to the assessment should be assigned accordingly.
4. Information for the assessment report can be compiled from existing literature, relevant historical material, pre-emergency data and from discussions with appropriate, knowledgeable people including donors, agency staff, government personnel, community leaders, women, elders, participating health staff, teachers, traders and so on. Appropriate sources of pre-emergency data may be found from documents such as: health and nutrition surveillance data; demographic and health survey reports from the country of

origin (produced by Macro International); refugee nutrition information system reports (ACC/SCN); data bases (eg MEDLINE) for published literature and documents within relevant line ministries or universities; and material from UN, donor and non-governmental agencies already working with the population. National or regional level preparedness plans may also be an important source of information.

5. The assessment report should make clear how information was gathered and what gaps remain to be filled in the next stage of programme design. In the discussion on the underlying causes of malnutrition, it is valuable to highlight whether any pre-existing nutritional problems, including micronutrient deficiencies, are likely to have been worsened by the emergency, and whether there are particular groups which may be experiencing greater nutritional stress (eg women, children, elderly people, physically and mentally disabled people).
6. The assessment and subsequent analysis should demonstrate an awareness of underlying structural, political, economic and environmental issues operating in the area. It is imperative that prior experience and the views of people affected by the disaster are taken into consideration when analysing the dynamics and impact of the new emergency. This requires inclusion of local expertise and knowledge in data collection and analysis of resources, capacities, vulnerabilities and needs. The current and pre-emergency living conditions of displaced and non-displaced people in the area must be considered. Gender roles within the social system also need to be taken into account.
7. Thinking and analysis concerning the post-disaster recovery period should be part of the initial assessment, so that interventions to meet immediate emergency requirements can serve to foster recovery among the affected population.

Analysis standard 2: response

If a nutrition intervention is required, there is a clear description of the problem(s) and a documented strategy for the response.

Key indicators

- Information on the following underlying causes of malnutrition is available and is analysed with regard to the nature and severity of the problem(s) and those worst affected:
 - Food security (regional, sub-group, household, individual): eg markets, production, livestock, assets, remittances, employment, food gathering, sufficiency of food (see Appendix 2 for population based nutritional requirements), food preparation, fuel, breastfeeding, endemic micronutrient deficiencies etc.
 - Public health: eg disease patterns (see Health Services, chapter 6); health care services; environmental risk factors: water, sanitation, vector-borne diseases, average parasite load; hygiene measures; traditional medicinal practices etc.
 - Social and care environment: especially with respect to: marginalised or separated groups; pregnant women; breastfeeding mothers; infant and young child feeding practices; shelter/crowding conditions; social support systems etc.
- Implementation strategies incorporate consideration of:
 - The estimated number of people affected and demographic characteristics.
 - The social and political structure of the population.
 - Special attention to groups at risk.
 - Access to the affected population.
 - Security.
 - Existing policies concerning nutrition.
 - Local capacity and resources.

- Local infrastructure and existing facilities and services.
- The possible long term implications and environmental impact of the situation and interventions proposed.

Guidance notes and critical issues

1. See also guidance notes and critical issues for Nutrition Analysis standard 1, above.
2. Sources of information for these indicators might include: the initial assessment report; minutes of coordination meetings; project proposals; analysis of relevant existing data, eg health and nutrition surveillance; burial counts and so on. This information may be followed up with quantitative and/or qualitative data gathering exercises to enable a more thorough analysis of the problem. Basic principles of transparency, validity and reliability must be respected and there are many different types of assessment protocol available which enable adherence to these principles. When anthropometric surveys are conducted, results must always be interpreted in the light of other factors relating to food security, public health and the social and care environment.
3. The indicators for programme design are presented separately but in practice many types of information may have to be considered concurrently. For example, information that informs commodity selection in a food aid programme would need to be considered alongside those factors that inform the method of distribution. The system of assessment and analysis is flexible rather than rigid, and there are many linkages and overlaps that must be understood and accommodated.
4. Information and sound methods must be accompanied by documented analysis. Assessment conclusions need to be internally coherent, clearly based on the information collected and linked to existing theory. (See Nutrition Analysis standard 1 and the UNICEF conceptual framework, above).
5. In order to assess the extent to which people are managing to meet their nutritional needs, it is necessary to have some reference for comparison.

This is drawn from current WHO, UNHCR and WFP average requirements for population groups (see Appendix 2). However, there are two important points to consider before these requirements are used:

Firstly, the mean per capita requirements for population groups incorporate the requirements of all age groups and both sexes. They are therefore not specific to any single age/sex group and should not be used to assess requirements for an individual.

Secondly, these requirements are based on a series of assumptions which, unless true for the particular population, will lead to errors. Calculations for the requirements were based on a particular demographic profile:

Group	% of population
0-4 years:	12.37
5-9 years:	11.69
10-14 years:	10.53
15-19 years:	9.54
20-59 years:	48.63
60+ years:	7.24
pregnant:	2.4
lactating:	2.6
male/female:	50.84 / 49.16

See WFP/UNHCR (1997), and WHO (1997), listed in Appendix 4)

As the demographic structure of different populations varies, this will affect the nutritional requirements of the population concerned. For example if 26% of a refugee population were under 5 year olds, and the population was 50% males and 50% females, the requirement is reduced to 1,940 kcs.

Estimates of requirements must therefore be used with reference to information that is specific to the context. This enables the validity of the underlying assumptions to be tested. The following information is needed:

- Size of the population.
- The demographic structure of the population, in particular the percentage of under 5s and the percentage of females.
- Mean adult weights and actual, usual or desirable body weight. Requirements will increase if the mean body weight for adult men exceeds 60kg and the mean body weight for adult females exceeds 52kg.
- Activity levels to maintain productive life. Requirements will increase if activity levels exceed light (ie $1.55 \times$ Basal Metabolic Rate for men and $1.56 \times$ Basal Metabolic Rate for women).
- Average temperature, and shelter and clothing capacities. Requirements will increase if the mean ambient temperature is less than 20°C.
- Non-nutritional needs which affect food needs: ie the potential role of food as a social and economic resource. Requirements will increase if there are any non-nutritional food needs such as religious festivals.
- The nutritional status of the population. Requirements will increase if the population is malnourished and has extra requirements for catch-up growth.

If it is not possible to incorporate this kind of information into the initial assessment, the figures in Appendix 1 may be used as a minimum in the first instance.

6. There are currently no estimates for population-level (rather than individual) requirements for most of the minerals, despite evidence highlighting their importance. As an interim guide, and pending further expert consultation by WHO, minimum nutrient densities (per 100 kcal) are proposed in Appendix 3.

For populations dependent on food aid, the choice of commodities

(including decisions on fortification levels), should be based on the requirements of the population and the availability of foods which the population can access independently. Some of the food rations used currently for populations that are fully dependent on food aid may not be sufficient to meet requirements (particularly vitamin B2, niacin, vitamin C, iron and folic acid). All micronutrients are vital to maintain healthy life. Therefore where the assessment suggests that certain micronutrient requirements will not be met by the population themselves, the intervention must plan to meet the shortfall.

Even if the foods provided to a population meet the specified requirements, this cannot be taken as a proxy of adequate intake and utilisation by the body of micronutrients. Discrepancies that can occur at ration distribution or as a result of meal sharing within households affect the quantity of food eaten by individuals. Micronutrient losses can occur in other ways as well. For example losses can occur during transportation and storage of food; during processing (eg the reduction of B vitamins during milling); as a result of prolonged cooking, particularly for the water-soluble vitamins; and as a result of nutrients combining with binding agents in the diet which prohibit their absorption in the gut (eg phytates impair the absorption of iron originating from vegetable sources). Losses may also occur as a consequence of disease, in particular parasite loads, where the body's ability to access and utilise the nutrients is restricted. It is therefore essential that monitoring of nutritional status is a component of all programmes.

See also Human Resource Capacity standard 1.

Analysis standard 3: monitoring and evaluation

The performance and effectiveness of the nutrition programme and changes in the context are monitored and evaluated.

Key indicators

- The information that is collected for monitoring and evaluation is timely and useful; it is recorded and analysed in an accurate, logical, consistent and transparent manner.
- Systems are in place that enable the impact (positive or negative) of the intervention on people's nutritional status to be monitored. This might include an active surveillance system if micronutrient deficiencies have been observed. (See Health Services, Analysis standards for the health information system, in chapter 6.)
- There is regular analytical reporting on the impact of the emergency and of the programme on the nutrition situation. There is also reporting of any contextual changes and other factors that may necessitate adjustment to the programme.
- Systems are in place that enable an information flow between the programme, other sectors, the affected population, the relevant local authorities, donors and others as needed.
- Monitoring activities provide information on the effectiveness of the programme in meeting the needs of different groups within the affected population.
- The programme is evaluated with reference to stated objectives and agreed minimum standards to measure its overall effectiveness and impact on the affected population.

Guidance notes and critical issues

1. Emergencies are volatile and dynamic by definition. Regular and current information is therefore vital in ensuring that programmes remain relevant. Information derived from continual monitoring of programmes should be fed into reviews and evaluations. In some

circumstances, a shift in strategy may be required to respond to major changes in the context or needs.

2. Information generated by the assessment process is used as an initial baseline for the health information system (see Health Services, chapter 6) and for monitoring and evaluation activities for the nutrition programme. Monitoring and evaluation activities require close cooperation with other sectors.
3. Information collected should be directly relevant to the programme, in other words it should be useful and should be used. It should also be shared as needed with other sectors and agencies, and with the affected populations. The means of communication used (dissemination methods, language and so on) must be appropriate for the intended audience.
4. Monitoring activity can be constrained by the difficulty of gathering reliable, valid information in a volatile and changing situation. For example, when a population is in a continual state of flux, moving to and fro across a border, over a prolonged period of time, there can be no assurance that measurements made in one instance relate to the same population in a different place or time. In such situations, therefore, data needs to be interpreted very carefully.
5. Evaluation is important because it measures effectiveness, identifies lessons for future preparedness, mitigation and assistance, and promotes accountability. Evaluation refers here to two, linked processes:
 - a) Internal programme evaluation is normally carried out by staff as part of the regular analysis and review of monitoring information. The agency must also evaluate the effectiveness of all its programmes in a given disaster situation or compare its programmes across different situations.
 - b) External evaluation may by contrast be part of a wider evaluation exercise by agencies and donors, and may take place, for example, after the acute phase of the emergency. When evaluations are carried out it is important that the techniques

and resources used are consistent with the scale and nature of the programme, and that the report describes the methodology employed and the processes followed in reaching conclusions. Outcomes of evaluations should be disseminated to all the humanitarian actors, including the affected population.

2 General Nutritional Support to the Population

This section considers the nutritional resources and services required to ensure that the needs of the general population are met. Unless and until these needs are met, any targeted nutrition interventions are likely to have limited impact since those who recover would return to a context of inadequate nutritional support. They would therefore be likely to deteriorate once again.

Before reading the standards, please see the definitions for *the International Unit* (IU) and *malnutrition* in Appendix 1.

General nutritional support standard 1: nutrient supply

People's nutrient needs are met.

Key indicators

- Levels of moderate malnutrition are stable at, or declining to, acceptable levels.
- There are no cases of scurvy, pellagra or beri-beri.
- Rates of xerophthalmia or iodine deficiency disorders are not of public health significance (see guidance notes below).
- There is access to a range of foods – staple (cereal or tuber), pulses

(or animal products), fat sources etc.

- There is access to vitamin C rich or fortified foods or appropriate supplements.¹
- There is access to iodised salt for the majority (>90%) of households where iodine deficiency disorders are endemic.
- There is access to vitamin A rich or fortified foods or appropriate supplements.
- There is access to additional sources of niacin (eg pulses, nuts, offal) if the staple is maize or sorghum.
- There is access to additional sources of thiamine (eg pulses, nuts, eggs) if the staple is polished rice.
- Infants under six months have access to breastmilk (or recognised substitute).
- Children aged from about six months² have access to nutritious energy dense foods.
- There is no indication that the extra nutritional needs of pregnant women and breastfeeding mothers are not being met.

Guidance notes

1. **Malnutrition rates:** improving trends in malnutrition might be indicated by health centre records, growth monitoring (health centre or community based), random sample nutrition surveys, results from screening, reports from the community or reports by community workers.

Nutrition survey results provide an estimate of the prevalence of malnutrition. The most widely accepted practice is to assess the level of malnutrition in children under five years old as a proxy for the rest of the population. When there is reason to believe that other specific groups may be unduly affected, then they should also be assessed.

1. Access to vitamin C is important not only to avoid scurvy but to enhance iron absorption.

2. World Health Assembly Resolution 47.5.9 May 1994 (A47/VR/11).

Deciding whether levels of malnutrition are acceptable (see General Nutritional Support standard 1) requires analysis of the current situation in the light of local norms. These might include levels of malnutrition in the population before the emergency; or levels of malnutrition in the host population if the affected population is displaced into a context where environmental and other external factors which increase mortality risk differ from those of their home area. Thus acceptable levels of malnutrition are those that are not associated with excess risk of mortality.

The risks associated with inadequate nutrient intakes for pregnant and breastfeeding women include: pregnancy complications, maternal mortality, low birth weight and impaired lactation performance. It is assumed that food allocations within households account for these extra nutritional needs (pregnant women on average require an extra 285 kcal per day; lactating mothers require an extra 500 kcal). In some situations though, this may not be valid and women may need to be monitored, particularly with respect to iron, folic acid and vitamin A status. The prevalence of low birth weight babies (below 2.5kg) may also be a useful monitoring tool in some contexts. WHO recommend that if the prevalence exceeds 15%, then this should trigger a public health response.

2. ***Micronutrient deficiencies:*** the indicators for General Nutrition standard 1 serve to highlight the importance of dietary quality. If these indicators are met, then deterioration of the micronutrient status of the population should be prevented.

There are a range of possible options for prevention of micronutrient deficiencies. These include: increasing the quantity of food in the general ration to allow more food exchanges; improving the nutritional quality of the ration; local purchase of commodities to provide nutrients otherwise missing in the ration; measures to promote local production of foods contributing nutrients estimated to be low; provision of micronutrient rich food stuffs as a supplement to rations; appropriate fortification of staple foods or blended foods; and/or medicinal supplementation.

Three micronutrient deficiencies (scurvy, pellagra and beri-beri)

have been highlighted as these are the most commonly observed deficiencies to have resulted from inadequate humanitarian assistance. They are specified here because they are avoidable. Individual cases of scurvy, pellagra and beri-beri presenting at health centres, for example, are likely to be a result of restricted access to certain types of food and are therefore probably indicative of a population-wide problem. As such, they should be tackled by population-wide interventions. (In any context where there is clear evidence that these micronutrient deficiencies are an endemic problem, levels should be reduced to at least those that would have been expected had the emergency not occurred.)

Iron deficiency anaemia is one example of other micronutrient deficiencies which may be important contributors to mortality. The emergency may or may not have elevated the prevalence of the deficiency. In situations where a chronic endemic situation is exacerbated by the emergency, special attention must be paid to possible prevention and correction measures (see above and Targeted Nutritional Support standard 3). Indicators of programme performance will be context specific.

Tackling micronutrient deficiencies within the first phase of an emergency is complicated by difficulties in identifying them (see Targeted Nutritional Support standard 3). The exceptions are xerophthalmia and goitre for which clear 'field-friendly' identification criteria are available. These deficiencies can be tackled by population level interventions (ie high-dose supplementation for children (see below) and salt iodisation respectively).

Indicators of clinical vitamin A deficiency (xerophthalmia) in children 6-71 months of age

(prevalence of one or more indicators signifies a public health problem)

Indicator	Minimum prevalence
Night blindness (XN) (present at 24-71 months)	>1%
Conjunctival xerosis with Bitot spots (XIB)	>0.5%
Corneal xerosis / ulceration / keratomalacia (X2, X3A, X3B)	>0.01%
Corneal scars (XS)	>0.05%

(See Sommer, A (1995), listed in Appendix 4)

When measles or other immunisation is carried out, which is often routine in emergencies resulting in displacement, it is usual practice to provide a vitamin A supplement (200,000 IU orally) to all children under five years of age. (See Health Services standards for measles control, in chapter 6). This helps reduce mortality associated with measles. Furthermore, it is recommended where feasible that mothers receive a high dose of vitamin A (200,000 IU orally) as soon as possible after delivery and within 8 weeks.

Indicators of iodine deficiency – goitre

(prevalence of (ideally) two indicators signifies a public health problem)

Indicator	Target population	Severity of public health problem (prevalence)		
		Mild	Moderate	Severe
Goitre grade >0	school age children*	5.0-19.9%	20.0-29.9%	≥30.0%
Thyroid volume >97th centile by ultra sound	school age children	5.0-19.9%	20.0-29.9%	≥30.0%
Median urinary iodine level (µg/l)	school age children	50-99	20-49	>20
Thyroid Stimulating Hormone >5U/l whole blood	neonates	3.0-19.9%	20.0-39.9%	≥40.0%
Median Thyroglobulin (ng/ml serum)	children and adults	10.0-19.9	20.0-39.9	≥40.0

*preferably children aged 6-12 years

(See WHO/UNICEF/ICCIDD. *Indicators for assessing iodine deficiency disorders and their control through salt iodisation*).

These indicators of iodine deficiency may be problematic: the biochemical indicators may not be possible in many emergency contexts, and the clinical assessments risk high levels of inaccuracy. Nevertheless, while assessment of urinary iodine is necessary to get a full picture of iodine status, a rough indication of the severity of the situation can be obtained by clinical examination of a valid sample of children aged 6 to 12 years.

3. **Dietary quality:** the indicators measure the quality of the diet but do not quantify nutrient availability. This is impracticable as it would impose unrealistic requirements for information collection.

Indicators can be measured using information from various sources gathered by different techniques. These might include: monitoring the food basket at the household level; assessing food prices and food availability on the markets; monitoring the routes along which food is moved; assessing the nutrient content of distributed food using food composition tables (or Nutcalc, see Appendix 4); examination of food aid distribution plans and records; conducting food security assessments; household surveys and/or reviewing existing literature, eg agency reports.

4. **Infant feeding:** breastfeeding is the healthiest way to feed a baby in most circumstances, particularly in emergencies when normal hygiene procedures may have been disrupted and rates of infection may have increased.

In situations where some mothers are not breastfeeding their infants there are three options:

- a) Relactation, where mothers are informed, supported and encouraged by experienced individuals.
- b) Formula feeding, if the milk can be prepared safely and where supplies can be guaranteed.
- c) Traditional alternative feeding, supporting other methods mothers may be familiar with to ensure they are safe and appropriate.

It is normally very rare for mothers not to be able to produce milk (only 1 or 2 per 10,000 mothers). However mothers may die or be separated from their infant. If it is not possible for the infant to have access to breastmilk (either from the mother, a wet nurse or a milk bank), then the provision of infant formula will be necessary. Whenever food commodities such as baby milk formula or commercial weaning foods are distributed, an intensive educational component must be an integral part of the work. This might involve intensive support for the infants' carers on methods for safe feeding (see General Nutritional Support standard 4); training of health

professionals in lactation management; and promotion of, and support for, pregnant women and mothers of new-borns to breastfeed.

When infant formula is provided, there must be a guarantee that its provision can continue for as long as the infant needs it. The procurement of infant formula in emergencies must also adhere to the stipulations of the International Code of Marketing of Breastmilk Substitutes (WHO, 1981) which protects breastfeeding from commercial interests.

Young children require energy dense foods since they are unable to eat large meals but have relatively high requirements given their body size. It is recommended that 30% of the energy content of their diet comes from fat sources. In cases where infants aged 6-24 months do not have access to breastmilk, nutritious energy dense foods must be sufficient to fully replace the nutrients that would have been derived from breastmilk and complementary foods.

Critical issues

1. The implications of severe malnutrition, trauma and stress on the capacity of the mother to breastfeed are not known. Although the breastfeeding mechanism itself is robust, research has shown clearly that the psychological state of the mother can affect the release of milk. In situations where the breastfeeding mother is affected by severe malnutrition, trauma or stress, she should, in the first instance, receive adequate support in order to encourage lactation.
2. Research has shown that the HIV virus can be transmitted from mother to infant. A child stands the greatest risk – believed to be 20% – of vertical or mother-to-child transmission during the time of late pregnancy and child birth. There is an additional risk that an infant will become infected through breastmilk. However in situations where sanitation is inadequate and families are poorly resourced, death from diarrhoea is 14 times higher in artificially fed infants than in those who are breastfed. In an emergency context, these risks must be carefully considered. It is important that breastfeeding is not undermined, particularly in situations where the HIV status of the mother is unknown.

General nutritional support standard 2: food quality and safety

Food that is distributed is of sufficient quality and is safely handled so as to be fit for human consumption.

Key indicators

- There are no outbreaks of food-borne diseases caused by distributed food.
- There are no complaints about the quality of foods distributed – from recipients or programme staff.
- Suppliers of food commodities carry out regular quality control and produce commodities which meet the official government standards or Codex Alimentarius Standards (eg with regard to packaging, labelling, shelf life etc).
- All foods supplied are systematically checked by independent quality surveyors.
- All food received in the country of distribution, for the disaster affected population, has a minimum six-month shelf life (except fresh produce and whole maize meal) and is distributed to the population before the expiry date.
- Adequate storage structures (in line with current recommendations) are in place and proper management of stores is conducted (see Food Aid standard 6, resource management, in chapter 4).
- Staff demonstrate knowledge about potential health hazards caused by improper handling, storage and distribution of food.

Guidance notes

1. Information to find out whether the indicators have been achieved may be obtained from: quality control inspection reports, food labels, warehouse reports and protocols etc.
2. The purchase of commodities is best done by specialists, for

example at headquarters, regional offices or in specialised agencies (see Food Aid standard 6, logistics, in chapter 4). If errors are made, they are extremely difficult to correct at field level.

3. Whole maize meal has a shelf life of 6-8 weeks. Milling should therefore take place immediately prior to consumption. Alternatively, low extraction milling can be used; this removes the germ, the oil and enzymes which cause rapid rancidity.
4. For storage see also D J Walker (ed) (1992), listed in Appendix 4.

General nutritional support standard 3: food acceptability

Foods that are provided are appropriate and acceptable to the population.

Key indicators

- People are consulted on the acceptability and appropriateness of the foods being distributed and results are fed into programme decisions.
- Foods distributed do not conflict with the religious or cultural traditions of the recipient or host populations (this includes any food taboos for pregnant or breastfeeding women).
- The staple food distributed is familiar to the population.
- Complementary foods for young children are palatable and digestible.
- There is no distribution of free or subsidised milk powder to the general population.
- People have access to culturally important condiments (eg sugar or chilli).

Guidance notes

1. In any humanitarian intervention which involves the distribution of foods, it is important to monitor any sales and reasons why these are occurring. This would help interpret any change in trends as well as monitor effects on the local economy.
2. Looting or theft of food, for example before distribution to families when bulk quantities might be stolen, could indicate that the commodity is seen as more valuable economically than nutritionally. If the staple food is looted, this may have important implications for the viability of the food aid programme. All looting incidents should be reported to the coordinating authorities immediately. (See Food Aid standard 6, resource management, in chapter 4.)
3. In populations where the habitual practice in infant feeding was to use breastmilk substitute, and where processed commercial products were given as weaning foods to young children, it might be necessary to support mothers in adopting new techniques during the emergency. Particularly important are measures to promote and support breastfeeding (see General Nutritional Support standard 1). In this sense, the emergency can sometimes provide an opportunity to change practices which pose health risks. However, an emergency is rarely the right time to encourage behavioural change which is not an absolute necessity.
4. Powdered or modified milks that have not been mixed with other commodities should not be included in a general food distribution because their indiscriminate use could result in serious problems. Of particular concern are the potential health hazards that are likely to occur as a consequence of inappropriate dilution, germ contamination or lactose intolerance.

General nutritional support standard 4: food handling and safety

Food is stored, prepared and consumed in a safe and appropriate manner, both at household and community level.

Key indicators

- There are no outbreaks of food-borne disease linked to a local food distribution site occurring as a consequence of hazardous food preparation.
- The coordinating body has received no reports from representatives of the affected population concerning difficulties in storing, preparing, cooking and consuming the food being distributed.
- Every household has access to at least one cooking pot, enough fuel for food preparation, water containers to store 40 litres; and 250g soap per person per month. (See Shelter and Site Planning standard 4, household items, in chapter 5; and Water Supply and Sanitation standard 3, water supply, in chapter 2.)
- Individuals who cannot prepare food or cannot feed themselves have access to a carer who can prepare appropriate food in a timely manner and administer feeding where necessary.
- Where food is distributed in cooked form, staff demonstrate knowledge about potential health hazards caused by improper storage, handling and preparation of commodities (see Human Resource Capacity standard 1).
- Adequate milling or other processing facilities are available reasonably close to home if required, for example if whole grain is distributed.

Guidance notes

1. Sources of information for these indicators might include programme monitoring systems and rapid household surveys.

2. If access to cooking fuel is inadequate, foods requiring less cooking time should be distributed (eg cereal flour rather than whole grain, parboiled pulses or rice). Where these foods are unfamiliar to the population, advice and support will need to be provided to ensure their proper use. If it is not possible to change the food commodities, then external sources of fuel supply should be established to fill the gap. (See Shelter and Site Planning, chapter 5.)
3. In the unusual situation of infants being fed formula milk, bottles should not be used as they are difficult to keep clean. Open cups (as opposed to feeding cups with a 'lip'), may be used instead. There should be capacity for boiling water and for the thorough sterilisation of the cup (and spoon or saucer). Individuals administering infant formula to babies should have an excellent knowledge of its proper and safe use. (See General Nutritional Support standard 1.)
4. People's changed circumstances may disrupt their normal hygiene practices. It may therefore be necessary to promote food hygiene messages and measures compatible with local conditions and disease patterns (see Water Supply and Sanitation standard 7, hygiene promotion, in chapter 2). It is also important to provide information to caregivers on the optimal use of household resources for child feeding and safe methods for food preparation.
5. Access to grinding mills, as well as other facilities such as clean water, is very important not only for food processing but to enable people to use their time in the best way. Caregivers spending excessive amounts of time waiting for these services could otherwise be preparing food, feeding children and engaging in other care-related tasks that have a positive effect on nutritional outcomes.

3 Nutritional Support to those Suffering from Malnutrition

This section presents minimum standards for programmes aiming to correct existing malnutrition, including deficiencies in vitamins and minerals.

Malnutrition is associated with increased risk of death. The strength of this association largely depends on the patterns of disease and infection which, in turn, are influenced by the local environment. There is a synergistic relationship between malnutrition and infection, and their impact on mortality. In other words, the combined impact of malnutrition and infection is greater than would be expected from their total individual contributions to mortality. Understanding the underlying causes of malnutrition is vital in defining the appropriate form of assistance, whether in nutrition or in the other sectors.

Before reading the standards, please see the definitions for *Body Mass Index*, *defaulter from a therapeutic feeding programme*, *exits from a feeding programme* and *malnutrition* in Appendix 1.

Targeted nutritional support standard 1: moderate malnutrition

The public health risks associated with moderate malnutrition are reduced.

Key indicators

- There is no increase in levels of severe malnutrition and/or there is no increase in numbers registered for therapeutic care.
- Surveillance systems are established to monitor malnutrition trends.
- Programme objectives reflect understanding of the causes of malnutrition and clear identification of the target group(s).
- All staff who have regular contact with mothers of young children are trained in the principles of infant and young child feeding in the emergency context. (See Human Resource Capacity standards.)
- From the outset, feeding programmes have clearly defined and agreed criteria for closure of the programme.

Guidance notes

1. Information for monitoring adherence to this standard can be gathered from a wide variety of sources, including: programme monitoring data (including data from outside the nutrition sector); anthropometric surveys; feeding centre records (including rates of coverage); staff training protocols (particularly in anthropometric measurements); and/or project proposals.
2. Demonstrating a change in the indicator for the level of severe malnutrition may be difficult when the prevalence of severe malnutrition is low. Given the confidence intervals around the prevalence estimate, it may not be possible to demonstrate a statistically significant change.
3. In contrast to the correction of severe malnutrition (see Targeted Nutritional Support standard 2), moderate malnutrition can be addressed in many different ways. Programme design must be based

on an understanding of the complexity and dynamics of the nutrition situation, and the factors contributing to and affecting it.

4. Surveillance is an important component of information gathering and monitoring of the situation. The information gathered must be analysed in the light of seasonal and disease patterns and used to initiate appropriate responses and inform other programmes.
5. Supplementary feeding programmes may be implemented in the short term before General Nutritional Support standard 1 and Targeted Nutritional Support standard 2 are met. An assessment of the situation must justify a decision to close a programme, but if the other standards have been achieved a supplementary feeding programme should not last longer than six months.

Targeted nutritional support standard 2: severe malnutrition

Mortality, morbidity and suffering associated with severe malnutrition are reduced.

Key indicators

- Proportion of exits from a therapeutic feeding programme who have died is <10%.
- Proportion of exits from therapeutic feeding programme recovered is >75%.
- Proportion of exits from therapeutic feeding programme defaulted <15%.
- There is a mean weight gain of >8g per kg/person/day.
- Nutritional and medical care is provided to people who are severely malnourished, according to clinically proven therapeutic care protocols.
- Discharge criteria include non-anthropometric indices such as: good appetite; no diarrhoea, fever, parasitic infestation or other untreated illness; and no micronutrient deficiencies.

- Nutrition worker to patient ratio is at least 1:10.
- All carers of severely malnourished individuals are able to feed and care for them.

Guidance notes

1. The time needed to achieve the indicators for a therapeutic feeding programme is between one and two months.
2. Achieving the indicators for therapeutic feeding depends on the achievement of the indicators and of the standards in other sectors (eg the existence of a functioning water and sanitation system). All information required to assess achievement of the standard will be available from records kept at the site of the therapeutic feeding and also reports from follow-up home visits.
3. Adherence to this standard and Targeted Nutritional Support standard 1 will have a positive impact on the levels of severe malnutrition in a population, if coverage of therapeutic feeding is maintained at a high level. An indicator for coverage has not been stipulated as it is influenced by many context specific factors. Individuals cannot be forced to take up a service, but its use can be promoted and encouraged. Nevertheless it must be remembered that very low coverage (such as less than 30-40%) will be indicative of a poorly designed programme.
4. Mean weight gain on exits > 8g per kg per person per day applies to adults and children who receive therapeutic care. Similar rates of weight gain can be achieved in adults as in children when they are given similar diets. This indicator however may mask situations where patients are not improving and are not being discharged.
5. As a rule of thumb, most cases of severe malnutrition should recover and be discharged after 30 to 40 days in a programme. HIV and TB may result in some malnourished individuals failing to recover. Such cases need to be documented and consideration of longer term treatment or care should be made in conjunction with the health programme.
6. See also WHO (1998), listed in Appendix 4.

Targeted nutritional support standard 3: micronutrient deficiencies

Micronutrient deficiencies are corrected.

Key indicators

- There are no cases of scurvy, pellagra or beri-beri.
- Rates of xerophthalmia are not of public health significance (see General Nutritional Support standard 1).
- Rates of iodine deficiency disorders are not of public health significance (see General Nutritional Support standard 1).
- Appropriate WHO micronutrient supplementation protocols are implemented for individuals admitted to feeding programmes.
- All clinical cases of deficiency diseases presenting at health centres are treated using WHO micronutrient supplementation protocols.
- All children under five years old presenting at health centres with diarrhoeal disease receive Vitamin A supplements. (See Health Services standard 2, measles control, in chapter 6.)
- All children under five years old presenting at health centres with hookworm, and who are not severely malnourished, receive iron supplements in conjunction with treatment for disease.
- Procedures to respond efficiently to micronutrient deficiency to which the population may be vulnerable are established. These might include active searching for cases, tracing and campaigning to raise public awareness.

Guidance notes and critical issues

1. Sources of information to measure the indicators might include: health centre records, feeding programme records, nutrition surveys and case definitions for deficiency diseases.
2. Recognition of some micronutrient deficiencies (eg iodine and

vitamin A) is possible through simple clinical examination. Such indicators can then be incorporated into health or nutritional surveillance systems, although careful training of staff is required to ensure that assessment is accurate. Other micronutrient deficiencies cannot be identified without bio-chemical examination (eg iron deficiency anaemia). For these reasons, case definition of micronutrient deficiencies in emergencies is problematic and can often only be determined through the response to supplementation by individuals who present themselves to health staff.

3. Pregnant and breastfeeding women should receive daily supplements of iron and folic acid. This is to address nutritional anaemias and to prevent neural tube defects in babies. In emergencies, however, the provision of supplementation is problematic as women's compliance with the daily supplementation protocols has been shown to be very difficult to maintain.

4 Human Resource Capacity and Training

All aspects of humanitarian assistance rely on the skills, knowledge and commitment of staff and volunteers working in difficult and often insecure conditions. The demands placed on them can be considerable, and if they are to conduct their work to a level where minimum standards are assured, it is essential that they are suitably experienced and trained and that they are adequately managed and supported by their agency.

Capacity standard 1: competence

Nutrition interventions are implemented by staff who have appropriate qualifications and experience for the duties involved, and who are adequately managed and supported.

Key Indicators

- All staff working on a nutrition programme are informed of the purpose and methods of activities they are asked to carry out.
- Assessments, programme design and key technical decision making are carried out by staff with relevant technical qualifications and previous emergency experience.
- Staff or volunteers involved in information gathering are thoroughly briefed and quickly checked by an experienced person before starting work.
- Staff with technical and management responsibilities have access to support for informing and verifying key decisions.

- Staff responsible for assessing the nutritional status of individuals are trained and regularly supervised in the necessary techniques (weight, height/length, MUAC and use of appropriate indices) for children, adolescents and/or adults.
- Introduction of new equipment (for assessment of nutritional status, preparation of foods, testing of food quality etc) is accompanied by training and testing in their use.
- Food aid programme staff have the demonstrated ability to advise members of the affected population on safe and appropriate use and preparation of blended foods, if these are included in a general ration.
- Targeted feeding interventions have clear written guidelines and protocols.
- All staff involved in targeted feeding have been thoroughly trained and tested on application of the protocols.
- The treatment of severely malnourished people is supervised by a medically qualified, experienced practitioner with specific training in this area.
- Health, nutrition and/or outreach workers who have contact with moderately malnourished individuals or their carers (at home, in feeding centres, in clinics etc), have the demonstrated ability to provide appropriate advice and support as appropriate.
- Health staff have the demonstrated ability to advise mothers and carers on appropriate infant and young child feeding practices.
- Health staff have the demonstrated ability to identify key micronutrient deficiencies correctly – through clinical examination and/or biochemical analysis if available.

Capacity standard 2: support

Members of the disaster affected population receive support to enable them to adjust to their new environment and to make optimal use of the assistance provided to them.

Key indicators

- Carers are trained in how to care for severely malnourished individuals after recovery and discharge to the home environment.
- Families are advised on preparation methods for blended foods, and their contribution to the family diet, particularly for young children.
- Mothers identified for relactation receive support, advice and encouragement on a regular basis.
- Pregnant women and mothers of new-borns are advised on the benefits of breastfeeding and are provided with the necessary support.
- All members of the emergency affected population are informed about the range, location and timing of facilities and services.

Capacity standard 3: local capacity

Local capacity and skills are used and enhanced by emergency nutrition programmes.

Key indicators

- Members of the disaster affected population are included in the implementation of nutrition programmes.
- Selection criteria for international staff recruitment include a commitment to building local capacities for long term benefit.

- The skills base within existing local partners and institutions is tapped and strengthened during the course of the humanitarian assistance programme.

Guidance notes

1. See the *People in Aid Code of Best Practice in the Management and Support of Aid Personnel* which is appended in this binder.
2. When programmes are designed, human resource capacity issues must be addressed. Staff and volunteers should demonstrate capabilities equal to their respective assignments; specific training in the relevant areas of expertise must be a prerequisite for engagement of staff. The provision of training and support as a part of emergency preparedness is important to ensure that skilled personnel are available to deliver quality services. Given that emergency preparedness cannot be assured in many countries, humanitarian agencies should ensure that qualified and competent staff are identified and properly prepared before eventual assignment to an emergency situation.

Appendix 1

Definitions

Access

This term describes the availability of enough food (eg through production, markets, gathering in the wild, gift etc), and people's ability to acquire it (through their own labour, purchase, exchange etc). Access is central to the concept of food security (defined below) and should take account of seasonal dynamics and supply mechanisms.

ACC/SCN

United Nations Administrative Committee on Coordination / Subcommittee on Nutrition.

BMI

Body Mass Index: $\frac{\text{weight (kg)}}{\text{height (m)}^2}$ (a nutritional index for adults)

Defaulter from a therapeutic feeding programme

An individual who has not attended the feeding programme for more than 48 hours.

Exits from a feeding programme

Exits from a feeding programme are those no longer registered. The population of exited individuals is made up of those who have defaulted, recovered (those who are referred) and died.

Food security

The World Bank's definition is used: access by all people at all times to enough food for an active, healthy life.

IU

The International Unit measures Vitamin A: 1 IU=0.3 µg Retinol Equivalent.

Malnutrition

Malnutrition is wasting (thinness) and/or nutritional oedema. Although micronutrient deficiencies are also forms of malnutrition, these are referred to specifically. Stunting is also a form of malnutrition but in disaster affected populations is an indication of longer term nutritional problems which preceded the disaster event. Correction of wasting and oedema reduces the risk of death. For these reasons, the nutrition standards only apply to nutrition activities which correct wasting and oedema (as well as micronutrient deficiencies).

Definitions of malnutrition

	Total malnutrition	Moderate malnutrition	Severe malnutrition
Children 6.0-59.9 months	<ul style="list-style-type: none"> • <-2Z scores WFH or • 80% median WFH or • <12.5cm MUAC +/-or • nutritional oedema 	<ul style="list-style-type: none"> • -3 to <-2 Z scores WFH or • 70% to <80% median WFH or • 11.0 to <12.5 cm MUAC 	<ul style="list-style-type: none"> • <-3Z scores WFH or • <70% median WFH or • <11.0 cm MUAC +/-or • nutritional oedema
Children 5-9.9 years	<ul style="list-style-type: none"> • <-2Z scores WFH or • <80% median WFH +/-or • nutritional oedema 	<ul style="list-style-type: none"> • -3Z to <-2 Z scores WFH or • 70% to <80% median WFH 	<ul style="list-style-type: none"> • <-3Z scores WFH or • <70% median WFH +/-or • nutritional oedema
Adults 20.0-59.9 years	<ul style="list-style-type: none"> • BMI <17 +/-or • nutritional oedema 	<ul style="list-style-type: none"> • 16 to <17 BMI 	see <i>Critical Issues</i> below

Children

Guidance notes

Weight-for-height indicators use the NCHS/CDC reference data.

MUAC is one of the best predictors of death, partly as it is biased towards younger children. MUAC is often used for screening to select those most at risk.

WFH is the most commonly used indicator for assessing the severity of a nutritional problem. It is the preferred tool for assessments and surveys.

Critical issue

There are no agreed anthropometric cut-offs for malnutrition in infants below six months, apart from the presence of nutritional oedema. The NCHS/CDC growth references are not useful since they are drawn from a population of artificially fed babies – whereas breastfed babies grow at a different rate. For this reason, it is important to assess infant feeding practices, particularly access to breastmilk, and the implications for support of the lactating woman, in order to determine whether malnutrition in this age group is a potential problem.

Adolescents

Critical issue

There is no clear, tested, agreed definition of malnutrition in adolescents (defined as 10.0-19.9 years by WHO). Indicators currently used include:

BMI-for-age, which is not applicable in contexts where growth retardation is prevalent and age is difficult to determine. In these circumstances, BMI-for-height could be used. Provisional cut-offs for both these indicators are given below. Maturational indicators, specifically menarche and adult voice, improve interpretation of BMI reference data as the peak in the adolescent growth spurt occurs prior to these milestones. However, the BMI cut-offs have NOT been validated yet and should be used with

caution. It is imperative that any assessment of nutritional status in adolescents is accompanied by clinical assessment.

Provisional definitions of malnutrition in adolescents¹

Total malnutrition	Moderate malnutrition	Severe malnutrition
<ul style="list-style-type: none"> • $<-2Z$ scores BMI-for-age or • $<-2Z$ scores BMI-for-ht +/or nutritional oedema 	<ul style="list-style-type: none"> • -3 to <-2 Z scores BMI-for-age or • -3 to $<-2Z$ scores BMI-for-ht 	<ul style="list-style-type: none"> • $<-3Z$ scores BMI-for-age or • $<-3Z$ scores BMI-for-ht +/or nutritional oedema

These indicators use the NCHS/CDC reference standards.

It may also be possible to assess adolescents with respect to stage of maturation (rather than age or height), making it possible to use local patterns of maturation and thus negating the need for reference data. However, this is as yet at the concept stage and requires further investigation and validation.

Adults

Guidance note

Any assessment of severe malnutrition in adults should always be accompanied by clinical examination since, as with children, malnutrition associated with infection carries higher risks of death.

Critical issues

The cut-offs for adult malnutrition are indicators of chronic energy deficiency. There are no agreed cut-offs for rapid-onset malnutrition in adults, but evidence suggests that cut-offs for severe malnutrition could be lower than a BMI of 16. The cut-off must distinguish between those who require specialised food to recover (ie rapid-onset, severe, malnutrition) and those who do not (ie those chronically energy deficient). This needs verification. Furthermore, a universal cut-off for BMI has limited application since there are large variations in BMI between populations, occurring independently of nutritional status. Such variations would have to be corrected for.

There are also dangers in using BMI as a tool for screening, since there are large variations in BMI within populations caused by body shape and not nutritional status. For this reason, adults should also be assessed with MUAC and appropriate cut-offs created.

MUAC may be used as a screening tool for pregnant women (eg as a criterion for entry into a feeding programme). Given their additional nutritional needs, pregnant women may be at greater risk than other groups in the population (see Nutrition Analysis standard 2). MUAC does not change significantly through pregnancy. MUAC <20.7 cm (severe risk) and <23.0cm (moderate risk) has been shown to carry a risk of growth retardation of the foetus.² The risk is likely to vary according to the population.

Elderly people

Critical issue

There is currently no agreed criterion of malnutrition in the elderly and yet this group may be at risk of malnutrition in emergencies. WHO suggests that BMI thresholds for adults may be appropriate for elderly people aged 60-69 years. Measurement accuracy is problematic because of spinal curvature (stooping) and compressing of the vertebrae. Arm span (the measurement from the tip of the middle finger on one hand to the tip of the middle finger on the other when arms are extended) can be used instead of height, but the multiplication factor to calculate height varies according to the population. BMI could be used on those elderly people able to stand up straight. MUAC may be a useful tool for measuring malnutrition in the elderly but research on appropriate cut-offs is currently in progress.

Mean weight gain (g/kg/d)

Calculated as follows: (weight on exit (g) minus lowest weight recorded during recovery (g)) ÷ (lowest weight recorded during recovery(kg)) x number of days between lowest weight recorded and exit.

MUAC

Mid Upper Arm Circumference

NCHS/CDC

National Center for Health Statistics/Centers for Disease Control,
USA 1975

Nutritional oedema

Bilateral, symmetrical pitting oedema which cannot be accounted for by heart failure, gross proteinuria, renal or cardiac failure, liver disease or pre-eclampsia.

Proportion of exits defaulted

$$\frac{\text{number of defaulters in the programme}}{\text{number of exits}} \times 100\%$$

Proportion of exits died

$$\frac{\text{number of deaths in the programme}}{\text{number of exits}} \times 100\%$$

Proportion of exits recovered

$$\frac{\text{number of individuals successfully discharged in the programme}}{\text{number of exits}} \times 100\%$$

Recovered

To classify an individual as recovered from severe malnutrition he/she must be free from medical complications and have achieved and maintained sufficient weight gain (eg for two consecutive weighings). Cut-offs for weight gain (expressed as a nutritional index) at discharge from therapeutic care will depend on whether the patient is being referred to another feeding programme for the moderately malnourished (ie 'recovered' here includes those individuals who are referred to supplementary feeding); the type of

programme; and the nature of the nutritional problem. Established protocols suggest appropriate discharge criteria for therapeutic care. These discharge criteria should be strictly adhered to, in order to avoid the risks associated with premature exit from the programme. Similarly, protocols define limits for the mean length of stay for patients in therapeutic feeding, aimed at avoiding prolonged recovery periods (eg typical lengths of stay may be 30-40 days).

Social and care environment

The provision in the household and community of time, attention and support to meet the physical, mental and social needs of household members.³ Social norms and support mechanisms are important in considering the potential role and impact of individuals as carers in their household. There are six types of activities practised by caregivers: 1) care for women; 2) breastfeeding and feeding of young children; 3) stimulation of children and adolescents and support for their development; 4) food preparation and food storage practices; 5) hygiene practices; and 6) home health practices.

WFH

Weight for height (a nutritional index for children). In children below 85cm (or under two years of age), recumbent length is taken instead of standing height.

Notes

1. WHO (1997, draft), *The Management of Nutrition in Major Emergencies*. WHO. Geneva.
2. WHO (1995), *Physical Status: The Use and Interpretation of Anthropometry*. WHO. Geneva.
3. Based on definitions in: 1) International Conference on Nutrition (1992). *Plan of Action for Nutrition*. Rome. 2) Enle, P L, Mennon, P and Haddad, L (1997). 3) UNICEF (April 1997). See Select Bibliography in Appendix 4.

Appendix 2

Nutritional Requirements

The following figures can be used for planning purposes in the initial stage of an emergency:

Nutrient	Mean population requirements
Energy	2100 kcaIs
Protein	10-12% total energy (52-63g), but < 15%
Fat	17% of total energy (40g)
Vitamin A	1666 IU (or 0.5mg RE)
Thiamine (B1)	0.9mg (or 0.4mg per 1000 kcal intake)
Riboflavin (B2)	1.4mg (or 0.6mg per 1000 kcal intake)
Niacin (B3)	12.0mg (or 6.6mg per 1000 kcal intake)
Vitamin C	28.0mg
Vitamin D	3.2 - 3.8 µg calciferol
Iron	22mg (low bioavailability (ie 5-9%))
Iodine	150 µg

Adapted from: WHO (1997, draft) and WFP/UNHCR (1997), listed in Appendix 4.

Appendix 3

Provisional Nutrient Densities

In the absence of population requirements for these essential nutrients, the following nutrient densities are proposed as a provisional tool for planning purposes. Expert consultations in 1998 may result in new recommendations.

The Desirable Nutrient Densities relate to a refugee diet. The Lower Threshold Density is suggested as the minimum value below which the nutrient density of the whole diet should not fall.

	Unit	Desirable Nutrient Density	Lower Threshold Density
Minerals: all values are per 100Kcal			
POTASSIUM (K)	mg	190	74
SODIUM (Na)	mg	60	26
MAGNESIUM (Mg)	mg	30	10
CALCIUM (Ca)	mg	84	28
PHOSPHORUS (P)	mg	70	21
ZINC (Zn)	mg	0.9	0.4
COPPER (Cu)	µg	95	28
SELENIUM (Se)	µg	3.6	1.85
MANGANESE (Mn)	µmol	0.3	
CHROMIUM (Cr)	nmol	2.0	
MOLYBDENUM (Mo)	nmol	5.0	
FLOURINE (Fl)	µmol	<1	

Source: Golden, M H N, Briend, A and Grellety, Y (1995), listed in Appendix 4.

Appendix 4

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Other resources

Nutcalc is a simple software package for analysis of food rations run on MS DOS and developed by Action Contre la Faim (ACF).





The Sphere Project

Humanitarian Charter
and Minimum Standards
in Disaster Response



Minimum Standards in Food Aid

Chapter 4



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Minimum Standards in Food Aid

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Appendix 1: Other Critical Issues

Appendix 2: Select Bibliography

For the general glossary and acronyms, see chapter 1, appendices 1 and 2.

The Sphere Project

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Minimum Standards in Food Aid

Sector Manager: Harlan Hale

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Minimum Standards in Food Aid

Introduction

1 The importance of food in emergencies

All people need access to adequate quantities of food of sufficient quality for their health and well-being. If a community's normal means of accessing food is compromised by disaster, a food aid intervention may be required. When people are unable to access enough food, they are more likely to engage in short term survival strategies, such as excessive disposal of household assets, which can lead to destitution, ill health and other long term negative consequences. Food aid can thus act as an important mechanism to help develop people's self-reliance and restore their capacity to respond to future shocks.

Without enough food, other humanitarian interventions are likely to be less effective. Cases of observable malnutrition will increase, despite the existence of nutrition programmes; health interventions alone will not be enough to prevent illnesses that are compounded by lack of adequate nutritional intake; and even if there are adequate hygiene facilities, people will continue to be susceptible to risk of disease because of weakened immune systems and diminished bodily reserves.

The purpose of food aid programmes is to:

- Sustain life by ensuring adequate availability and access to food by people affected by disaster. (See also Minimum Standards in Nutrition, chapter 3.)
- Provide sufficient food resources to eliminate the need for survival strategies which may result in long term negative consequences to human dignity, household viability, livelihood security and the environment.

- Provide a short term income transfer or substitution to people to allow household resources to be invested in recovery and longer term development.

2 The Humanitarian Charter and Minimum Standards in food aid programmes

The aims of food aid programmes, as well as those of the other sectors, flow from a wider goal which is the cornerstone of humanitarian practices. This goal is to alleviate human suffering brought about by calamity or conflict through protecting life with dignity in ways that support durable recovery.

Translating this goal into practice requires a clear commitment by agencies to humanitarian principles and to the implementation of minimum standards. The Humanitarian Charter and Minimum Standards together provide the policy and organisational framework to enable this to happen and to ensure systems of accountability.

The Humanitarian Charter reaffirms the importance of fundamental humanitarian principles and the rights of disaster affected communities to humanitarian assistance. Through the Charter, signatory agencies commit themselves to defined minimum standards for the provision of humanitarian services. The standards for food aid (this chapter), water supply and sanitation (chapter 2), nutrition (chapter 3), shelter and site planning (chapter 5), and health services (chapter 6) build on the principles laid out in the Humanitarian Charter and demonstrate how the rights of people affected by disasters should be realised in practice.

The standards set out in this chapter describe what people should have as a minimum for their health and dignity. Agencies should strive to do better wherever possible.

3 Using the standards

The standards apply to any situation where people's normal means for support of life with dignity have failed whether as a result of a natural or human-made disaster in any country, on any continent. They provide

a description of what people have a right to expect from humanitarian assistance. The standards do not focus on disaster preparedness, mitigation or rehabilitation, though these are considered where relevant.

The intention is to provide a tool to help create the conditions for effective interventions and for the achievement of the minimum standards. The standards have been made as specific as possible, but they remain widely applicable to different emergency situations within current operational and policy frameworks.

4 Assumptions

To achieve the minimum standards in a wide variety of emergency contexts, it is assumed that:

- Agencies are driven by humanitarian principles and are committed to best organisational practices as a means to achieving their wider goal.
- There is a shared commitment among all those involved in humanitarian assistance to achieve the minimum standards, and to coordinate their response.
- The agency has acquired sufficient financial, human and material resources to meet the standards.
- There is access to the affected population.
- All other sectors are meeting their standards (as described in other chapters).

5 Structure of this chapter

After this introduction the chapter is divided into the following sections:

1. Analysis
2. Participation
3. Coordination
4. Requirements
5. Targeting

6. Resource Management

7. Logistics

8. Distribution

9. Human Resource Capacity and Training

Each of the sections includes the following components:

- **The standards:** these specify the minimum acceptable levels to be attained in each area.
- **Key indicators:** these are 'signals' that show whether the standard has been attained. They provide a way of measuring and communicating both the impact, or result, of programmes as well as the process, or methods, used. The indicators may be qualitative or quantitative.
- **Guidance notes and critical issues:** these explain why each standard is important and may include: specific points to consider when applying the standard in different situations; guidance on tackling practical difficulties; advice on priority issues.

Critical issues might relate to the standard or indicators, and describe dilemmas, controversies or gaps in current knowledge. Filling these gaps will help improve the minimum standards for food aid in the future.

Other critical issues are highlighted in Appendix 1 and a select bibliography is provided in Appendix 2.

The standards have been developed and arranged in a deliberate sequence. The first three sections deal with the analysis of the problem, participation of the people affected by the disaster and the coordination of efforts of all involved in the food programme. These three aspects are critical to the success of any humanitarian food programme. If the problem is correctly identified, the solution is more likely to be effective. If the people affected by the disaster are involved in the programme, gains made are more likely to endure. If there is coordination, resources are likely to be used efficiently and to maximum benefit. The remaining sections follow in a logical progression and cover the main aspects of the food aid programme.

Section 8 applies to all work and deals with issues related to the human capacity required to implement effective food aid programmes.

6 Links with other sectors

Reference to other sectors' technical standards is made where relevant. The purpose of this is to highlight how work in one sector is closely linked to work in other sectors, and that progress in one is dependent on progress in other areas. In particular, there are close links to the nutrition chapter with regard to analysis and provision of general nutritional support to the population.

The Minimum Standards

1 Analysis

Programmes that meet the needs of disaster affected populations must be based on a clear understanding of the situation. The people affected by the disaster, agencies, donors and local authorities need to know that interventions are appropriate and effective. Analysis of the effects of the disaster and of the impact of the food aid programme itself are therefore critical. If the problem is not correctly identified and understood then it will be difficult, if not impossible, to make the right response.

Analysis of the need to provide food aid to a disaster affected population presents special difficulties. Disaster may reduce people's access to food directly, by affecting production or household food stocks; or it may reduce access indirectly, by preventing access to markets, for example. In some situations, food aid may be only one of a number of ways of restoring people's access to food; alternatives might include road repair after an earthquake or the sale of food to stabilise market prices.

With the exception of specific cases of population displacement where people probably have no access to food at all, disaster affected populations are often able to find part of their own food supply from their own resources. No practical assessment technique exists which can discriminate precisely between the different food aid needs of households within a population. It is therefore impossible to determine accurately the food aid needs of a population, except when people are wholly dependent on food aid for survival. Nevertheless, an agreed population estimate must be established. There are also practical limitations to the accuracy with which food aid can be targeted to those in need. It is important to be aware of these practical difficulties when using the analysis standards.

These standards apply before any programme takes place and throughout the programme cycle. Analysis should start with an immediate initial assessment that identifies the impact of the disaster and whether and how to respond. It continues with monitoring, which identifies how well the programme is meeting needs and determines whether changes are required; and with evaluation, which determines the overall effectiveness of the programme and identifies lessons for the future.

Given that techniques for assessing food needs in a disaster are limited, the sharing of information and knowledge among all those involved, including the affected populations, is fundamental to achieving a full understanding of the problem and coordinated assistance. Documenting and disseminating information from the analysis process contributes to a broad understanding of the adverse public health and other livelihood consequences of disasters and assists in the development of improved disaster prevention and mitigation strategies.

Analysis standard 1: assessment

Before any programme decisions are made, there is a demonstrated understanding of the basic conditions that create risk of food insecurity and the need for food aid.

Key indicators

- An immediate initial assessment that follows internationally accepted procedures is carried out by appropriately experienced personnel.
- The assessment is conducted in cooperation with a multi-sectoral team (water and sanitation, nutrition, food, shelter, health), local authorities, representatives of the affected population and humanitarian agencies intending to respond to the situation.
- The information is gathered and presented in a way that allows for transparent and consistent decision making.

● The information collected should include:

- The extent and nature of any population displacement.
- Information on people's access to food before the disaster including:

The affected population's normal means of access to food prior to the disaster, including any seasonal considerations.

Social, economic and political factors that influenced the affected population's access to food prior to the disaster, including variations within and between populations in the area concerned.

- Information on, and analysis of, the effects of the disaster on people's access to food including:

Morbidity and malnutrition.

Direct effects of the disaster on households of different economic types.

Indirect effects on the wider economy and political economy including changes in market supply, demand and price; changes in political control of food supply.

Evidence that households are unable to meet food deficits.

The relative needs of different groups within the population.

The extent to which intervention is required to prevent impoverishment through the loss of productive assets or adoption of extreme measures to earn income.

The possible negative impact of food aid.

● Recommendations are made on whether or not external assistance is needed and the options available. If assistance is required, recommendations are made on priorities, a strategy for intervention and resources needed. There is reference to:

- The size, scope and duration of a food aid programme.
- The estimated number of people affected and demographic

characteristics.

- The social and political structure of the population.
 - Local capacity and resources.
 - The needs of groups at risk.
 - Access to the affected population and the best methods for making food available.
 - The length of time food aid may be required.
 - The necessary logistical requirements and resources to support the effective delivery of food aid; local infrastructure and existing facilities and services.
 - Security.
 - The possible immediate negative effects of food aid including: population movements to food distribution sites; increased insecurity around food aid sites; depopulation of agricultural production sites; disruption of local markets; decreased agricultural production.
 - The possible long term implications and environmental impact of the interventions proposed.
- An assessment report is produced that covers key areas and appropriate recommendations.
 - Assessment findings are shared with other sectors, local authorities, representatives of the affected population and participating agencies.

Guidance notes and critical issues

1. Timeliness is of the essence for the initial assessment, which should be carried out as soon as possible after the disaster. As a general rule, a report should be generated within a week of arrival at the site of the disaster, though this depends on the particular event and the wider situation.
2. People who are able to collect information from all groups in the affected population in a culturally acceptable manner should be

included, especially with regard to gender and language skills.

3. The procedure for conducting the assessment should be agreed upon by all participants before field work begins and specific tasks contributing to the assessment should be assigned accordingly.
4. There are many different techniques for information gathering and these should be chosen carefully to match the situation and the type of information required. As a general rule, information should be gathered more frequently when the situation is changing more rapidly, and when there are critical developments such as new population movements or an epidemic outbreak of diarrhoea. Initial assessments may be quick and unrefined but analysis improves as more time and data are available. Checklists are a useful way of ensuring that all the key questions have been examined.
5. It is important to access information that is already available. This includes existing literature, relevant historical material and pre-emergency data. Discussions with appropriate, knowledgeable people including community leaders, women, elders, health staff, teachers, traders, government personnel, donors, agency staff and so on are also useful. Other sources of information include early warning systems and vulnerability assessments, and national or regional level preparedness plans.
6. The assessment and subsequent analysis should demonstrate an awareness of underlying structural, political, economic and environmental issues operating in the area. It is imperative that prior experience and the views of the people affected by the disaster are taken into consideration when analysing the dynamics and impact of the new emergency. This requires inclusion of local expertise and knowledge in data collection and analysis of resources, capacities, vulnerabilities and needs. The current and pre-emergency living conditions of displaced and non-displaced people in the area must also be considered.
7. The needs of groups that are at risk of additional harm such as women, children, elderly people, physically and mentally disabled people must be considered. Gender roles within the social system need to be identified.

8. Thinking and analysis concerning the post-disaster recovery period should be part of the initial assessment, so that interventions to meet immediate emergency requirements can serve to foster recovery among the affected population.

Analysis standard 2: monitoring and evaluation

The performance and effectiveness of the food aid programme and changes in the context are monitored and evaluated.

Key indicators

- The information collected for monitoring and evaluation is timely and useful; it is recorded and analysed in an accurate, logical, consistent and transparent manner.
- Systems are in place that enable stock levels, movements and distributions to be monitored.
- Supply chain monitoring is established, and identifies problems that require corrective action.
- The quality of the food distribution system is monitored.
- End-user monitoring through household-level visits and interviews ensures people can provide feedback on the effectiveness of the food aid intervention.
- There is regular analytical reporting on the impact of the emergency and of the programme on the nutrition situation. There is reporting of any contextual changes and other factors that may necessitate adjustment to the programme.
- Systems are in place that enable an information flow between the programme, other sectors, the affected population, the relevant local authorities, donors and others as needed.
- Monitoring activities provide information on the effectiveness of the programme in meeting the needs of different groups within the affected population.

- The programme is evaluated with reference to stated objectives and agreed minimum standards to measure its overall effectiveness and impact on the affected population.

Guidance notes and critical issues

1. Agencies carrying out food aid programmes are entrusted with a considerable resource for the benefit of people whose ability to access food has been severely compromised. As with other resources, agencies have a duty to monitor how food aid and programme funds are used.
2. Emergencies are volatile and dynamic by definition. Regular and current information is therefore vital in ensuring that programmes remain relevant. Information derived from continual monitoring of programmes should be fed into reviews and evaluations. In some circumstances, a shift in strategy may be required to respond to major changes in the context or needs.
3. Information generated by the assessment process is used for monitoring and evaluation activities for the food aid programme.
4. Monitoring activities may include: regular audit review of inventory documents and reporting on commodity movements; independent checks on the quantity and equity of the distribution; review of distribution records and random checks on rations received; and random visits to households receiving food aid to ascertain the acceptability and usefulness of the ration.
5. Monitoring through sample household visits provides information concerning the acceptability of the ration and how people use it. Household visits also enable identification of people who meet the selection criteria but who are not receiving food aid.
6. Monitoring should consider the effect of the food distribution system on: the agricultural cycle, market conditions, availability of agricultural inputs and agricultural activities.
7. Information collected should be directly relevant to the programme, in other words it should be useful and should be used. It should also be shared as needed with other sectors and agencies,

and with the affected populations. The means of communication used (dissemination methods, language and so on) must be appropriate for the intended audience.

8. Evaluation is important because it measures effectiveness, identifies lessons for future preparedness, mitigation and humanitarian assistance, and promotes accountability. Evaluation refers here to two, linked processes:
 - a) Internal programme evaluation is normally carried out by staff as part of the regular analysis and review of monitoring information. The agency must also evaluate the effectiveness of all its programmes in a given disaster situation or compare its programmes across different situations.
 - b) External evaluation may by contrast be part of a wider evaluation exercise by agencies and donors, and may take place, for example, after the acute phase of the emergency. When evaluations are carried out it is important that the techniques and resources used are consistent with the scale and nature of the programme, and that the report describes the methodology employed and the processes followed in reaching conclusions. Outcomes of evaluations should be disseminated to all the humanitarian actors, including the affected population.

2 Participation

The participation of disaster affected people in all aspects of a food aid intervention is essential. Their understanding and interpretation of their own needs should provide the basis on which programmes are designed and implemented, and special effort should be made to ensure the participation of women. People should also have the opportunity to take part in decision making, particularly where ration levels and selection criteria are concerned. Such involvement helps to ensure that programmes are equitable and effective.

Participation in the food aid programme may also serve to reinforce people's sense of dignity and worth in times of crisis. It generates a sense of ownership which can help ensure the safety and security of those who are receiving the aid, as well as those who are responsible for its distribution.

Participation standard

Recipients of food aid have the opportunity to participate where possible in the design, management and monitoring of the programme.

Key indicators

- Representatives from across the disaster affected population are consulted and are involved in decision making that relate to needs assessment and programme design.
- People from the affected population (both women and men) participate in the management and implementation of the food aid programme.

Guidance notes and critical issues

1. Distribution committees help ensure people's involvement in the food aid programme. Gender, ethnicity and socio-economic status should be taken into consideration in order to ensure that committees adequately represent the affected population. Acknowledged political leaders, traditional community leaders and religious leaders should also be represented. The roles and functions of the distribution committee should be agreed upon when it is set up. (See also, Distribution standard, guidance note 1.)
2. Participation can also be achieved through regular polling and discussions. This can take place during distribution, through home visits or when addressing individual concerns.
3. People can be involved in the food programme in different ways. For example: through provision of paid and volunteer labour for handling and distribution; through participation on distribution committees; through involvement in decision making on ration levels and selection criteria; by disseminating information about food distributions; by supplying household lists; by assisting in crowd control and security.
4. Gender balance should be actively sought within food aid programmes, given women's key role in maintaining the well-being of the household. In most situations where people have been displaced, there is an increased number of female-headed households, and these may be made more vulnerable if they are disenfranchised within their own society. Finding culturally appropriate ways to involve disenfranchised or minority groups can be facilitated by means of a good analysis of the social and cultural systems within the affected population. Participatory appraisal techniques are useful in this regard.

3 Coordination

Food aid represents a significant resource transfer to people whose assets and income have been severely compromised by the disaster. All organisations involved in providing food aid must therefore be committed to coordinated assistance. Improperly coordinated food aid programmes can result in inequities that may exacerbate existing problems or create new ones. Some groups may be over-served, while others are under-served. Different ration scales, food baskets and/or selection criteria may result in people moving to where they think they can receive the most benefit. Working together to agree on food aid policies and activities helps ensure that interventions are effective and also serves to stabilise an often volatile situation.

Coordination standard

Agencies, local authorities, the affected population and donors coordinate their efforts in the design and implementation of the food aid programme.

Key indicators

- There is consensus among the organisations involved in providing food aid regarding:
 - The estimated population requiring food aid.
 - Selection criteria for eligibility to receive food aid.
 - The strategy for provision of food aid.
 - Roles and responsibilities of the organisations and groups involved.

- Reporting and information channels.
- Monitoring and surveillance systems.
- An acknowledged organisation or committee with responsibility for coordination is identified and agreed.
- Agencies' areas of operation are clearly defined and there is no duplication of services.
- Locations for coordination, information sharing and problem-solving activities are identified.
- There is a demonstrated understanding of the roles and activities of other organisations involved in the food aid intervention.
- There is a demonstrated awareness of the possible negative effects of the food aid intervention and a coordinated cross-sectoral approach to mitigating these effects.

Guidance notes and critical issues

1. Local authorities should have the primary responsibility for coordinating humanitarian interventions. This is often done in conjunction with a lead UN agency. Food aid programmes are generally coordinated by the UN World Food Programme.
2. All agencies involved in food aid programmes should establish regular meetings where information is exchanged, issues and problems are discussed and solutions are identified.
3. It is essential to coordinate significant local purchases of food commodities. Failure to do so can create problems such as agencies bidding against each other and increasing prices. Excess purchases may create shortages and generate price increases for the non-recipient population.
4. Coordination is especially critical in providing logistical support to deliver food aid to the affected population. (See the Logistics standard below.)

4 Requirements

The initial assessment and analysis of the emergency situation should identify people's own food and income sources, and indicate the quantity and type of food assistance required to maintain adequate nutritional status for the general population.

The standard for food aid requirements is based on WHO's planning estimate for a typical population (for further details see Nutrition, appendix 2, in chapter 3).

Food aid requirements may be established for:

A general ration: to provide a complete basket of food commodities in quantities sufficient to meet requirements (see indicators below).

A complementary ration: to provide one or two food commodities to complement existing foods available and accessible to the affected population (for example, pulses and oil might be provided to complement locally accessible cereals).

A supplementary ration: to provide specific foods as a supplement to the general ration, in order to cover the needs of particular groups. Typically such groups would include malnourished individuals, young children and/or pregnant or nursing mothers.

Requirements standard

The food basket and rations are designed to bridge the gap between the affected population's requirements and their own food sources.

Key indicators

- Requirements are based on the following WHO initial planning estimates:
 - 2,100 kcs per person per day.
 - 10-12% of total energy is provided by protein.
 - 17% of total energy is provided from fat.
 - Adequate micronutrient intake through fresh or fortified foods.
- Estimates of people's food and income sources include consideration of:
 - Market and income opportunities.
 - Foraging and wild food potential.
 - Agricultural seasons and access to productive assets.
 - Sources of income and coping strategies.
- Ration scales include consideration of:
 - General nutritional requirements.
 - Specific needs of vulnerable groups.
 - Access to alternative sources of food and/or income.
- Commodity selection includes consideration of:
 - Local availability and market impact.
 - Local acceptability and preparation.
 - Fitness and nutritional composition.
 - Fuel requirements for cooking.
 - Other nutritional factors (see General Nutritional Support standard 3).

Guidance notes and critical issues

1. It is recommended that the initial reference value of 2,100 kcal per person per day is used as a planning figure when the adjustment factors are not yet known. The ICRC uses a ration requirement of 2,400 kcals per person per day as their reference point. The additional 300 kcals allows the needs of specific groups under the care of supplementary feeding programmes to be met. (See Nutrition standards in chapter 3. See also WFP and UNHCR guidelines on estimating food and nutritional needs in emergencies, listed in Appendix 2.)
2. Populations affected by natural disasters may adopt strategies that enable them to provide for a significant part of their food requirements (eg early harvesting/salvage of crops, livestock sales, cash labour). In this case the ration level may be adjusted down from the initial reference value.
3. An early use of food aid to meet expected shortfalls in response to slow-onset disasters can result in a need for less food aid later on and less household decapitalisation, making recovery easier.
4. When assessing food requirements, a fuel assessment should be undertaken so that recipients can cook their food in ways that avoid adverse effects to their health or degradation of the environment.
5. It is important to ensure that there is adequate provision of essential non-food items, such as soap. A lack of these may result in recipients of food aid trading food commodities to meet their needs.
6. Additional food commodities may be provided during selected times of the year (eg planting season) or for specific periods of increased activity to meet caloric requirements. In cases of food insecurity, it may be advisable to distribute food commodities at the same time as seed distribution. This serves to ensure that seed is not eaten, bartered or sold to obtain food, and provides additional energy for clearing and planting fields.
7. See Appendix 1 for discussion of issues relating to supporting recovery.

5 Targeting

Targeting standard

Recipients of food aid are selected on the basis of food need and/or vulnerability to food insecurity.

Key indicators

- Targeting objectives are agreed between the coordinating authorities, representatives of the affected population and implementing agencies.
- Targeting criteria are clearly documented, whether in terms of population group(s) or geographical location.
- The distribution system is monitored to ensure that the targeting criteria are respected.

Guidance notes

1. The objectives of targeting food aid assistance may include any of the following:

Saving lives, if nutritional status is of immediate concern.

Strengthening food security and/or the local economy.

Protecting the nutritional/health status of specific sub-groups within a population who are physiologically vulnerable (such as young children, nursing mothers, pregnant women or elderly people).

Preserving households' assets (if these are being sold to cover food needs).

Protecting those whose food need is caused by social/political

vulnerability (eg separated minors, refugees or displaced persons, female-headed households and ethnic or religious minority groups).

Effectively using limited available resources, whether this is available food, logistical infrastructure, experienced personnel, transportation and so forth.

2. Once objectives have been agreed, the specific criteria to be used for targeting should emerge logically. If, for example, the objective is to save lives, physiological criteria are required – typically this will be nutritional status. Alternatively, if the objective is the protection of socially or politically vulnerable groups, targeting criteria will be based on the identity of the groups concerned (this then requires some form of registration process).
3. Targeting sub-groups or individuals within a population is more costly to administer than a general distribution. Thus, if the objective of the targeting is to manage limited resources, the relative costs of the targeting have to be weighed against potential savings.
4. The objectives and criteria for targeting may need to be changed to respond to contextual changes. Any modifications should be clearly communicated to all stakeholders.

6 Resource Management

Food commodities, like all resources entrusted to humanitarian agencies, must be managed in an effective and accountable way. Many agencies have standardised commodity or inventory management procedures and accounting systems that are based on principles of sound, transparent resource stewardship. Inventory systems are essential for producing reports for donors. More importantly, they provide programme planners and managers with information to make decisions about service priorities for the people receiving food aid.

Agencies are expected to take all reasonable measures to safeguard the food commodities in their care. The theft or diversion of food aid cannot be tolerated, so third party contractors acting on behalf of agencies, such as transporters and forwarding agents, must accept liability for commodities in their care.

Resource management standard

Food aid commodities and programme funds are managed, tracked, and accounted for using a transparent and auditable system.

Key indicators

- Safe stewardship practices are maintained to ensure that all commodities are safeguarded until distribution to recipient households:
 - Storage is safe and clean, and protects food commodities from damage and loss.
 - Third party service providers assume total liability for food commodities in their care and agree to reimburse any losses.
 - Food commodities are inspected and unfit commodities are

certified and disposed of in accordance with standard procedures.

- Damaged commodities are inspected and salvaged to the best possible extent.
 - Physical inventory counts are periodically reconciled with stock balances.
- Contracting for goods and services is transparent and fair.
 - Inventory accounting and reporting systems are established:
 - Waybills document commodity transactions.
 - Stock ledgers provide summaries of receipts, issues and balances.
 - All losses are identified and accounted for.
 - Summary inventory reports are compiled and made available.

Guidance notes and critical issues

1. Most bilateral and multilateral donors of food aid specify reporting requirements for food aid. Agencies should be aware of these requirements and establish the means to meet them.
2. *Generally Accepted Commodity Accountability Principles*, published by Food Aid Management, provides guidance in establishing a food aid accounting system. (See Appendix 1.)
3. Various guidelines and manuals that detail warehouse and commodity management and storage practices are available. (See Appendix 2.)
4. Where possible, commodities purchased for distribution should be accompanied by phytosanitary certificates or other inspection certificates that confirm fitness for human consumption.
5. If commodities are shown by qualified inspection to be unfit for human consumption, every effort must be made to ensure that they do not enter local markets. Methods of disposal may include sale for animal feed, burial or incineration.
6. Fair and open contracting procedures are essential to avoid the

impression of favouritism or personal financial reward and should be followed. Most agencies have contracting and procurement guidelines that meet requirements for non-profit or charitable status.

7. Experienced food aid managers should be recruited to all food aid programmes in order to manage and train permanent staff, and/or to establish inventory management systems.
8. A sufficient stock of inventory management documentation and forms (waybills, stock ledgers, reporting forms) must be available at locations where food aid is received, stored, and/or dispatched in order to maintain a documented audit trail of commodity transactions.
9. The use of local media or traditional methods for disseminating news should be considered as a way of keeping people informed about food aid supplies and operations. This reinforces transparency.

7 Logistics

Agencies must have sufficient capacity to manage the logistics of food aid programmes. If food aid is available, but agencies do not have adequate resources and systems to deliver it to the affected population, the programme will have failed. The goal of logistics management is to deliver the right goods, to the right location, in the right condition, at the right time and for the right price.

The weight and volume of food aid required to sustain a large population severely affected by disaster may measure thousands of tons. The physical movement of food commodities to point of distribution involves an extensive network of purchasers, forwarding agents, transporters and receivers, and involves multiple handling and transfers from one mode of transport to another. These networks, or supply chains, are put together using a series of contracts and agreements which define roles and responsibilities and establish liability and compensation among the contracting parties.

Establishing the supply chain entails cooperation between donors, humanitarian agencies and local authorities. Each party has specifically defined roles and responsibilities, serving as a link, or series of links, in the supply chain. As a chain is only as strong as its weakest link, all parties involved in food aid logistics share equal responsibility for maintaining the flow of sufficient commodities to meet distribution targets and schedules established by the food aid programme.

Logistics standard

Agencies have the necessary organisational and technical capacity to manage the procurement, receipt, transport, storage and distribution of food commodities efficiently and effectively.

Key indicators

- The supply chain is established and includes procurement, documentation, transport, storage and handling from point(s) of origin to final destination(s) or distribution site(s).
- Local purchases of food commodities and contracting for logistics resources and services are coordinated; impact on the local market is taken into consideration.
- Information on food aid stock levels, expected arrivals, distributions and any other information relevant to planning, forecasting and managing the flow and availability of food aid is shared between agencies.
- Special staff are assigned responsibility for logistics management (eg planning and control, importation and clearance, primary and secondary logistics, warehouse and inventory management, transport planning and management, contract management and supervision).
- Delays in distribution arising from a commodity shortfall are no longer than two weeks.

Guidance notes and critical issues

1. Sources of food aid commodities may include: diversion (loan or reallocation) from existing programmes using food aid (agency programmes or government grain reserves); loans from, or swaps with, commercial suppliers; commercial purchases (locally, regionally, internationally); direct supply of food from bilateral and multilateral donor agencies.
2. In large scale disasters, WFP usually plays a key role in the

mobilisation of food aid and in primary logistics. WFP may be responsible for all food aid logistics up to the Extended Delivery Point (EDP), an inland destination close to the affected area. Implementing partners (humanitarian agencies or government) assume responsibility for transportation from the EDP to the distribution site and distribution to recipient households.

3. Local or regional freight forwarders and/or transport brokers can provide general logistics services to a client under contract and are a valuable source of knowledge on local regulations and procedures.
4. Tracking and forecasting of stock levels along the supply chain highlights anticipated shortfalls or problems with the supply of food commodities. Alternatives and solutions need to be sought to avoid or reduce problems in the supply chain.
5. Logistics accounting and inventory systems generate valuable information for measuring performance. For example:

Food distribution plans can be compared with actual food deliveries. Extreme deviations from the plan can direct managers' attention to problems or bottle-necks in the logistics system.

Budgeted and actual costs for each activity in the logistics system (eg handling, clearance, storage, transportation, distribution) can be compared to assess cost control within the logistics system. Extreme deviations from the budget can direct managers' attention to inefficiencies and/or economies of scale within the logistics system.

Tonne kilometres are frequently used to measure performance and productivity in trucking fleets. Extreme deviations from an acceptable range of activity can direct managers' attention to problems in truck tasking and/or transit and turn-around times.

'Throughput' measures the volume of goods handled and moved through the warehouse. It is useful for identifying the number of staff needed for a specific level of activity, and can be used to produce cost-savings and to increase productivity.

'Pipeline analysis' views the logistics network, from origin(s) to destination(s), as a network of pipelines through which food commodities move. It is useful for producing an estimation of the expected duration of existing food aid stocks, and a schedule of delivery dates for shipments (to avoid stocks dropping below requirement). Pipeline analysis is key to forecasting potential problems and to planning procurement and delivery schedules.

6. The principles of good logistics management, accountability and transparency apply equally to the planning and delivery of materials and supplies for water and sanitation programmes, shelter and household support and health services. The logistics of food aid operations differ only from the other services in being quantitatively larger.

8 Distribution

An appropriate distribution method is central to the design of the food aid programme and is key to its success. Distribution must therefore be considered during the initial assessment. Food aid may be distributed freely to the general population, or to specific segments or groups within a population. It may also be distributed as payment for work, or may be sold on the commercial market to address problems of supply.

Equity in the distribution process is of primary importance and the involvement of people from the disaster affected population in decision making and implementation should be encouraged wherever possible. People should be informed about the quantity and type of food rations to be distributed, and they should feel assured that the distribution process is fair and that they receive what has been promised. Any differences between rations, for example adjusted rations provided to groups at risk, must be explained and understood.

Distribution standard

The method of food distribution is fair, equitable and appropriate to local conditions. Recipients are informed of their ration entitlement and of the rationale for the levels provided.

Key indicators

- People are aware of the quantity and type of ration to be distributed for each distribution cycle, and reasons for any differences from established norms are provided.
- People receive the quantities and types of commodities planned.

- The method of distribution is fair, readily accessible and minimises disruption to everyday activities.
- When deciding the frequency of distributions (monthly or more frequently) there is consideration of:
 - The cost of transporting commodities from the distribution centre.
 - The time spent travelling to and from the distribution centre.
 - The security of recipients and commodities once distributed.

Guidance notes and critical issues

1. The extent to which people feel able to be involved in the distribution depends on the effect of the disaster on their social structures. Communities affected by slow-onset drought or other natural disasters may remain intact and continue to function well, enabling them to participate fully in the distribution process. By contrast, communities that are severely affected by war and civil strife may not at first be able to assume a significant role in the distribution process; they are more likely to do so as the situation stabilises and civil structures emerge. Participation in distribution committees may also serve to stimulate civil society. (See the Participation standard.)
2. Formal registration of households receiving food aid should be carried out in the initial stages. Independent registration should be carried out wherever possible by the agency concerned. Lists developed by local authorities and community-generated family lists may also be used. In situations where registration is impossible at the initial stage, it should nonetheless be completed after three months when the population has stabilised and if there is an expectation that food aid will be required for longer periods.
3. Random weighing of rations collected by households leaving the distribution site measures the accuracy and competence of distribution management. It also helps to ensure equity.
4. Distribution of food aid should be equitable: variation of 20% between distribution targets (households or communities) is within the acceptable range.

5. The method of distribution should evolve over time. In the early stages, community managed distribution based on family lists or population estimates provided by local communities may be the only way possible to get food aid distributed among the affected population. Community managed distributions should be monitored closely by the responsible agency to ensure that norms are met.
6. Changes in the food basket or ration level caused by insufficient availability of food aid must be discussed with the recipients through the distribution committee, or community leadership, and a course of action should be jointly developed. The distribution committee can inform the population of the change and why this has come about.
7. WFP/UNHCR distribution guidelines recommend that the following substitution ratios are used for periods of less than one month when all commodities in the food basket are not available:

Blended food and beans 1:1

Sugar and oil 2:1

Cereals and beans 2:1

Cereal for oil 3:1

9 Human Resource Capacity and Training

All aspects of humanitarian assistance rely on the skills, knowledge and commitment of staff and volunteers working in difficult and often insecure conditions. The demands placed on them can be considerable, and if they are to conduct their work to a level where minimum standards are assured, it is essential that they are suitably experienced and trained and that they are adequately managed and supported by their agency.

Capacity standard 1: competence

Food aid programmes are implemented by staff who have appropriate qualifications and experience for the duties involved, and who are adequately managed and supported.

Key indicators

- All staff working on a food aid programme are informed of the purpose and methods of activities they are asked to carry out.
- Assessments, programme design and key technical decision making are carried out by staff with relevant technical qualifications and emergency experience.
- Staff with technical and management responsibilities have access to support for informing and verifying key decisions.
- Food programme managers and supervisors have experience in resource management, safe stewardship, logistics and/or using food as a resource in humanitarian assistance or development programmes.

- Staff and volunteers involved in information gathering are thoroughly briefed and quickly checked by an experienced person before starting work.
- Food aid programme staff have the demonstrated ability to advise members of the affected population on safe and appropriate use and preparation of foods if these are included in a general ration.
- Targeted feeding interventions have clear written guidelines and protocols.
- All staff involved in targeted feeding have been thoroughly trained and tested on application of the protocols.
- Training and supervision mechanisms are in place.

Capacity standard 2: local capacity

Local capacity and skills are used and enhanced by food aid programmes.

Key indicators

- Members of the disaster affected population are included in the implementation of food programmes.
- Selection criteria for international staff recruitment include a commitment to building local capacities for long term benefit.
- The skills base within existing local partners and institutions is tapped and strengthened during the course the humanitarian assistance programme.

Guidance notes

1. See the *People in Aid Code of Best Practice in the Management and Support of Aid Personnel* which is appended in this binder.
2. When programmes are designed, human resource capacity issues must be addressed. Staff and volunteers should demonstrate

capabilities equal to their respective assignments; specific training in the relevant areas of expertise must be a prerequisite for engagement of staff. The provision of training and support as a part of emergency preparedness is important to ensure that skilled personnel are available to deliver quality services. Given that emergency preparedness cannot be assured in many countries, humanitarian agencies should ensure that qualified and competent staff are identified and properly prepared before eventual assignment to an emergency situation.

Appendix 1

Other Critical Issues

This section refers in brief to a number of issues that need consideration when food aid is provided. In practice they will be addressed in different ways, according to the specific context and the needs of the people affected by the disaster.

1. Preparedness and early warning

Agencies should strive to prevent as well as to respond to humanitarian emergencies. Monitoring of early warning information and a continual state of preparedness are critical.

Early warning information should be used to guide programming and to advocate for action and resources on behalf of the affected population. Information about increased levels of food insecurity should be communicated as a matter of course to local authorities and other humanitarian agencies.

Agencies working in disaster-prone areas or with populations vulnerable to disasters should identify and make use of all appropriate early warning systems. These may include locally based agricultural and meteorological monitoring systems and extension networks, national monitoring systems or regional or international early warning systems such as VAM, GIEWS and FEWS. They may monitor specific phenomena such as hurricane development or more general issues such as food security or crop production.

2. Supporting recovery

Food aid programmes provide the affected population with time to recover from an event that has threatened life and livelihood, to consolidate resources and to start to re-establish the conditions for a normal life.

Programming that aims to improve the availability, access and utilisation of food resources should be put in place at the same time as food aid distributions in order to support recovery of food production capability, initiation of income generating activities and/or recovery of health status.

People congregate at distribution sites, so these provide a natural focus for communication and dissemination of information – such as health and safety awareness, or ration entitlements – adding value to that provided by food distribution activities.

The food distribution infrastructure can be used to support rehabilitation of local trade and markets, and to distribute other material resources, thereby avoiding duplication of costs and effort. Seeds, agricultural tools, other productive materials and non-food assistance items (jerry cans, kitchen sets, soap, shelter materials and blankets) can be distributed in this way.

3. Transition and exit strategies

Agencies that respond to a disaster or emergency are expected to define in advance their area of operation, the duration of their involvement and the desired outcomes of the intervention. They should also define a strategy for ending the programme, or making a transition to activities that provide support for further recovery, should this be required, when acute needs have been met.

Local people have a right to know the extent of an agency's commitment so that they can make better decisions about how to employ household resources. By discussing with them the objectives of the programme, indicators of success and outcomes, problems that would otherwise result from differing expectations can be avoided.

Agencies have a vital role in helping to identify and support appropriate community and household investments that strengthen self-reliance and interdependence.

4. Interpreting nutritional data

Indicators of improved nutritional status must be interpreted with great care and should be used in conjunction with information relating to the population's food security status. Figures showing significantly improved levels of nutrition may mean that the ration mix, the quantities provided and the distribution of food have been effective. They should not be interpreted to mean that people's independent access to food has improved. If people are still unable to provide for their own minimum household food requirements, terminating the aid programme may result in an erosion of the nutritional gains that have been made and precipitate a return to emergency conditions.

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http://wfp.org/studies/catalog_fa/index.htm

WFP Vulnerability and Analysis Mapping web site:

<http://www.wfp.it/vam/vahmhome/htm>





The Sphere Project

Humanitarian Charter
and Minimum Standards
in Disaster Response



Minimum Standards in Shelter and Site Planning

Chapter 5



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Minimum Standards in Shelter and Site Planning

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2. Housing (Family Shelter)

3. Clothing

4. Household Items

5. Site Selection

6. Human Resource Capacity and Training

Appendix 1: Select Bibliography

For the general glossary and acronyms, see chapter 1, appendices 1 and 2.

The Sphere Project

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Minimum Standards in Shelter and Site Planning

Sector Manager: Philip Wijmans

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Minimum Standards in Shelter and Site Planning

Introduction

1 The importance of shelter and site planning in emergencies

Along with water supply, sanitation, nutrition, food and health care, shelter is a critical determinant of survival in the initial stage of an emergency. Beyond survival, good shelter enhances resistance to disease and provides protection from the environment. It is also important for human dignity and to sustain family and community life as far as possible in difficult circumstances.

The purposes of shelter, site selection and physical planning interventions therefore are to:

- Meet the physical needs of individuals, families and communities for safe, secure and comfortable living space.
- Meet their primary social needs, incorporating as much self-sufficiency and self-management into the process as possible.

Interventions must be designed and delivered in such a way as to minimise any negative impact on the host population or on the environment.

Three possible scenarios dictate the basic shelter needs of people directly affected by a disaster. These scenarios are determined by the type of disaster, the number of people involved, the political context and the ability of the community to cope.

Scenario A: people stay at home

People in communities directly affected by a natural disaster almost always want to stay in or near their homes. Even if homes are destroyed or damaged, assistance to people 'where they are' is more sustainable, and helps restore normality more quickly than assistance which causes them to move away in search of temporary shelter. Inputs directed into the area where people live and know each other help them to maintain social structures and allow them to continue life as normally as possible. In the extreme emergency phase, people may have to be assisted with temporary lodging in schools, places of worship or even large tents, but one member of the family often remains behind to guard property and land. If this scenario is handled well by local authorities and humanitarian agencies it is likely that the emergency will be short-lived and normality will be restored quickly.

Scenario B: people are displaced and stay in host communities

During military conflict, and after some natural disasters such as extensive flooding, entire communities may be forced to flee their homes and home area. In this situation, it is much better if displaced populations are absorbed into a local host community, possibly with family members or people who share historical, religious or other ties. Local authorities and humanitarian agencies should consider providing assistance to the entire population according to need, since both resident and displaced people are affected by the disaster. Security considerations, the long term effects on the environment and the possibilities of sharing shelter facilities such as clinics, schools and shops all militate in favour of an integrated approach to assistance. Such assistance can have a lasting positive effect on the host communities even after the displaced people have returned home.

However, registration, distribution of materials and provision of medical assistance to dispersed populations present considerable difficulties. Security problems can be difficult to monitor and respond to. In situations where the displaced population greatly exceeds the host population, the local infrastructure will be severely strained and, if humanitarian agencies do not move quickly enough to support the hosts, their resentment at being overwhelmed can undermine longer term objectives.

Scenario C: people are displaced and stay in clusters

The temporary settlement for refugees or displaced populations is the least preferred scenario, and may arise as a result of political problems, or because the number of displaced people is too large for the host population to absorb. There may be immediate security problems, or the displaced people may fear persecution and violence from elements within their own group or the host community. Self-settled camps generally need similar infrastructural support to planned camps, but additional problems arising from poor site location, imposition on previous land-users, high density occupation and lack of infrastructure will need to be dealt with.

Often in these situations the site has been selected, usually around a water point, by the local authorities, the displaced people themselves or by the first assistance agency to arrive. It may be necessary to choose more permanent and suitable sites, leaving the old one as a transit camp, or abandoning it altogether. Ideally, camps should be planned and the infrastructure installed before people settle, but this rarely happens. If there are no alternative sites the initial site may have to be re-organised to achieve the minimum standards.

If attention is not given to their situation, the host community is likely to suffer from the strain on the local economy and the environment. Increased health hazards, perceived and real, may become an issue. For their part, the displaced people are likely to become dependent on external assistance.

This chapter first addresses the standards needed for the provision of shelter, clothing and household items, which are common to all three scenarios. It then addresses standards for site selection and planning, which are relevant to the third scenario.

2 The Humanitarian Charter and Minimum Standards in shelter and site programmes

The aims of shelter and site programmes, as well as those of the other sectors, flow from a wider goal which is the cornerstone of humanitarian practices. This goal is to alleviate human suffering brought about by calamity or conflict through protecting life with dignity in ways that support durable recovery.

Translating this goal into practice requires a clear commitment by agencies to humanitarian principles and to the implementation of minimum standards. The Humanitarian Charter and Minimum Standards together provide the policy and organisational framework to enable this to happen and to ensure systems of accountability.

The Humanitarian Charter reaffirms the importance of fundamental humanitarian principles and the rights of disaster affected communities to humanitarian assistance. Through the Charter, signatory agencies commit themselves to defined minimum standards for the provision of humanitarian services. The standards for shelter and site planning (this chapter), water supply and sanitation (chapter 2), nutrition (chapter 3), food aid (chapter 4) and health services (chapter 6) build on the principles laid out in the Humanitarian Charter and demonstrate how the rights of people affected by disasters should be realised in practice.

The standards set out in this chapter describe what people should have as a minimum for their safety, health and dignity. Agencies should strive to do better wherever possible.

3 Using the standards

The standards apply to any situation where people's normal means for support of life with dignity have failed whether as a result of a natural or human-made disaster in any country, on any continent. They provide a description of what people have a right to expect from humanitarian assistance. The standards do not focus on disaster preparedness, mitigation or rehabilitation, though these are considered where relevant.

The intention is to provide a tool to help create the conditions for

effective interventions and for the achievement of the minimum standards. The standards have been made as specific as possible, but they remain widely applicable to different emergency situations within current operational and policy frameworks.

4 Assumptions

To achieve the minimum standards in a wide variety of emergency contexts, it is assumed that:

- Agencies are driven by humanitarian principles and are committed to best organisational practices as a means to achieving their wider goal.
- There is a shared commitment among all those involved in humanitarian assistance to achieve the minimum standards, and to coordinate their response.
- The agency has acquired sufficient financial, human and material resources to meet the standards.
- There is access to the affected population.
- All other sectors are meeting their standards (as described in other chapters).

5 Structure of this chapter

After this introduction the chapter is divided into the following sections:

1. Analysis
2. Housing (Family Shelter)
3. Clothing
4. Household Items
5. Site Selection
6. Human Resource Capacity and Training

This reflects the division of activities and responsibilities that

commonly occurs in emergency situations. Section 6 applies to all work and deals with issues related to the human capacity required to implement effective shelter and site programmes.

Each of the sections includes the following components:

- **The standards:** these specify the minimum acceptable levels to be attained in each area.
- **Key indicators:** these are ‘signals’ that show whether the standard has been attained. They provide a way of measuring and communicating both the impact, or result, of programmes as well as the process, or methods, used. The indicators may be qualitative or quantitative.
- **Guidance notes and critical issues:** these explain why each standard is important and may include: specific points to consider when applying the standard in different situations; guidance on tackling practical difficulties; advice on priority issues.

Critical issues relate to the standard or indicators, and describe dilemmas, controversies or gaps in current knowledge. Filling these gaps will help improve the minimum standards for shelter and site planning in the future.

A select bibliography is provided in Appendix 1.

6 Links with other sectors

Reference to other sectors’ technical standards is made where relevant. The purpose of this is to highlight how work in one sector is closely linked to work in other sectors, and that progress in one is dependent on progress in other areas.

The Minimum Standards

1 Analysis

Programmes that meet the needs of disaster affected populations must be based on a clear understanding of the situation. The people affected by the disaster, agencies, donors and local authorities need to know that interventions are appropriate and effective. Analysis of the effects of the disaster and of the impact of the shelter and site programme itself are therefore critical. If the problem is not correctly identified and understood then it will be difficult, if not impossible, to make the right response.

Standardised methods of analysis that are used across the sectors have great potential to identify rapidly acute humanitarian needs and to ensure that resources are directed accordingly. This section sets out agreed standards and indicators for collecting and analysing information to identify needs, to design programmes and to monitor and evaluate their effectiveness.

The analysis standards apply before any programme takes place and throughout the programme cycle. Analysis starts with an immediate initial assessment that identifies the impact of the disaster and whether and how to respond. It continues with monitoring, which identifies how well the programme is meeting needs and determines whether changes are required; and with evaluation, which determines the overall effectiveness of the programme and identifies lessons for the future.

The sharing of information and knowledge among all those involved, including the affected populations, is fundamental to achieving a full understanding of the problem and coordinated assistance. Documenting and disseminating information from the analysis process contributes to a broad understanding of the adverse public health and other consequences of disasters and assists in the development of

improved disaster prevention and mitigation strategies.

The analysis standards below apply to all three scenarios described in the introduction to this chapter, and to the standards for shelter, clothing, household items, site selection and site planning which follow.

Analysis standard 1: assessment

Programme decisions are based on a demonstrated understanding of the emergency situation and on a clear analysis of people's needs for shelter, clothing and household items.

Key indicators

- An immediate initial assessment that follows internationally accepted procedures is carried out by appropriately experienced personnel.
- The assessment is conducted in cooperation with a multi-sectoral team (water and sanitation, nutrition, food, shelter, health), local authorities, representatives of the affected population and humanitarian agencies intending to respond to the situation.
- The information is gathered and presented in a way that allows for transparent and consistent decision making.
- The information gathered identifies needs for shelter, clothing and household items, and baseline data for monitoring and evaluation. The initial assessment considers the following:
 - The profile of the displaced population including:
 - Health and nutritional profile (see Health Services, chapter 6 and Nutrition, chapter 3).
 - Demographic profile (by gender, age, social grouping).
 - Extent of integration with, or segregation from, the local population.
 - Attitudes to external assistance, gender and religion.
 - Traditional means of support, and whether people are rural

or urban in origin.

Traditional lifestyle in terms of use of space, cooking and food storage, child care and hygiene practices.

Traditional building skills and construction methods.

The type of shelter adopted by the displaced population, where relevant.

The needs of groups that are at risk of additional harm.

Actual or potential threats to the security of, and within, the displaced population.

– **The social and economic profile of the host population** including:

Attitudes towards the influx of displaced people, taking into consideration social, ethnic and/or trade links.

Previous use of sites proposed for temporary settlement.

Usage of surrounding natural resources and agricultural land.

Local building typologies and the market for, and sources of, construction materials.

– **Local infrastructural, natural and material resources** including:

Level and condition of access including roads, potential supply airstrips, railheads and ports.

Quantities of wood required for fuel and construction, and of water that can be extracted in a sustainable way.

Heavy plant already in the area, such as bulldozers and graders, for road-building and site preparation.

– **Physical information** including:

Topography of the area of land available, and suitable for, settlement and agriculture.

Variety and protection of potential water sources. (See Water Supply and Sanitation, chapter 2.)

Areas in the environment that are vulnerable to over-

exploitation.

Seasonal variations including rainfall, snowfall, temperature variation, high winds, flooding.

Endemic diseases, vectors and pests. (See Water Supply and Sanitation, chapter 2 and Health Services, chapter 6.)

- The assessment considers the national standards for shelter in the country where the disaster has occurred, or in the country where humanitarian assistance is provided, if different.
- Recommendations are made on whether or not external assistance is needed. If assistance is required, recommendations are made on priorities, a strategy for intervention and resources needed. An assessment report is produced that covers key areas and appropriate recommendations.
- Assessment findings are shared with other sectors, national and local authorities, representatives of the affected population and participating agencies.

Guidance notes and critical issues

1. For further details of assessment requirements for site selection and planning, see Site standard 1, site selection. The guidance notes for this standard provide details of the information needed for physical and environmental assessments.
2. Use of early warning information and emergency preparedness should be supported wherever possible as they can contribute to the assessment. Preparedness includes personnel training and stockpiling of supplies, such as shelter materials, in strategic positions. If there is an early warning that a population movement is likely to take place, relevant information needs to be collected immediately and analysed: an inventory of the response capacity of local authorities, the UN system and agencies on the ground should be made; there should be awareness of available experienced personnel, of development plans and of supplies and equipment that can be diverted until replacements are available.

3. Timeliness is of the essence for the initial assessment, which should be carried out as soon as possible after the disaster. If required, there should be an immediate response to critical needs at the same time. As a general rule, a report should be generated within a week of arrival at the site of the disaster, though this depends on the particular event and the wider situation.
4. People who are able to collect information from all groups in the affected population in a culturally acceptable manner should be included, especially with regard to gender and language skills.
5. The procedure for conducting the assessment should be agreed upon by all participants before field work begins and specific tasks contributing to the assessment should be assigned accordingly. A shelter and construction specialist should be included in the assessment team if possible.
6. There are many different techniques for information gathering and these should be chosen carefully to match the situation and the type of information required. As a general rule, information should be gathered more frequently when the situation is changing more rapidly, and when there are critical developments such as new population movements or an epidemic outbreak of diarrhoea. Initial assessments may be quick and unrefined but analysis improves as more time and data are available. Checklists are a useful way of ensuring that all the key questions have been examined.
7. The socio-economic assessment can be based on techniques such as Participatory Rural Appraisal (PRA) and People-Oriented Planning (POP). If it is not possible to allocate resources to this approach, unstructured interviews and observation should be used.
8. Information for the assessment report can be compiled from existing literature, relevant historical material, pre-emergency data and from discussions with appropriate, knowledgeable people including donors, agency staff, government personnel, community leaders, women, elders, participating health staff, teachers, traders and so on. National or regional level preparedness plans may also be an important source of information.

9. The assessment and subsequent analysis should demonstrate an awareness of underlying structural, political, economic and environmental issues operating in the area. It is imperative that prior experience and the views of the people affected by the disaster are taken into consideration when analysing the dynamics and impact of the new emergency. This requires inclusion of local expertise and knowledge in data collection and analysis of resources, capacities, vulnerabilities and needs. The current and pre-emergency living conditions of displaced and non-displaced people in the area must also be considered.
10. The needs of groups that are at risk of additional harm such as women, children, elderly people, physically and mentally disabled people must be considered. Gender roles within the social system need to be identified.
11. Thinking and analysis concerning the post-disaster recovery period should be part of the initial assessment, so that interventions to meet immediate emergency requirements can serve to foster recovery among the affected population.

Analysis standard 2: monitoring and evaluation

The performance and effectiveness of the shelter and site programme and changes in the context are monitored and evaluated.

Key indicators

- The information collected for monitoring and evaluation is timely and useful; it is recorded and analysed in a logical, consistent and transparent manner.
- Systems are in place that enable systematic collection of information on the impact (positive or negative) of the intervention on shelter, clothing and household needs, and on the environment.
- The use of household items and goods is monitored.
- There is regular analytical reporting on the impact of the shelter and site programme on the affected population. There is also reporting

of any contextual changes and other factors that may necessitate adjustment to the programme.

- Monitoring activities provide information on the effectiveness of the programme in meeting the needs of different groups within the affected population.
- Systems are in place that enable an information flow between the programme and other sectors, the affected population, the relevant local authorities, donors and others as needed.
- The programme is evaluated with reference to stated objectives and agreed minimum standards to measure its overall effectiveness and impact on the affected population.

Guidance notes and critical issues

1. Emergencies are volatile and dynamic by definition. Regular and current information is therefore vital in ensuring that programmes remain relevant. Information derived from continual monitoring of programmes should be fed into reviews and evaluations. In some circumstances, a shift in strategy may be required to respond to major changes in the context or needs. Evaluation of the shelter situation after a period of around six months allows for decisions to be made as to whether and how the programme should continue. On the basis of this information it becomes possible to plan for sustainable activities, long term involvement of agencies, and to address issues of repatriation and reintegration.
2. Information generated by the assessment process is used for monitoring and evaluation of the shelter and site programme. It may also contribute to an initial baseline for the health information system. Monitoring and evaluation activities require close cooperation with other sectors.
3. Information collected should be directly relevant to the programme, in other words it should be useful and should be used. It should also be shared as needed with other sectors and agencies, and with the affected populations. The means of communication used (dissemination methods, language and so on) must be appropriate for the intended audience.

4. Evaluation is important because it measures effectiveness, identifies lessons for future preparedness and humanitarian assistance, and promotes accountability. Evaluation refers here to two, linked processes:

- a) Internal programme evaluation is normally carried out by staff as part of the regular analysis and review of monitoring information. The agency must also evaluate the effectiveness of all its programmes in a given disaster situation or compare its programmes across different situations.
- b) External evaluation may by contrast be part of a wider evaluation exercise by agencies and donors, and may take place, for example, after the acute phase of the emergency. When evaluations are carried out it is important that the techniques and resources used are consistent with the scale and nature of the programme, and that the report describes the methodology employed and the processes followed in reaching conclusions. Outcomes of evaluations should be disseminated to all the humanitarian actors, including the affected population.

2 Housing

(Family Shelter)

The purpose of shelter interventions is to help:

Scenario A: the repair of homes that have been damaged by the disaster, initially creating minimum habitable space, and later rebuilding both homes and infrastructure. If communal buildings are being used for shared accommodation, they first need to be adapted for the residents, and later renovated in order to return the buildings to their previous function(s).

Scenario B: the settlement of displaced people within existing communities by providing needed materials and skills, and by supporting the local construction and building materials industry where appropriate.

Scenario C: the construction of temporary shelters in the emergency phase, and maintenance of temporary shelter over the life of the settlement.

The number of people needing urgent assistance and the limited availability of resources at the early stage of an emergency may well limit what can be achieved in the short term. Even so, every effort must be made to work progressively towards achieving the minimum standards.

Housing standard 1: family living quarters

At the onset of the emergency, people have sufficient covered space to provide protection from adverse effects of the climate. They have sufficient warmth, fresh air, security and privacy to ensure their dignity, health and well-being.

Key indicators

- The covered area available per person averages 3.5-4.5m².
- In warm, humid climates, shelters allow optimal ventilation and provide protection from direct sunlight.
- In hot, dry climates, shelter material is heavy enough to ensure high thermal capacity. If only plastic sheeting or tents are available, provision of a double-skinned roof or an insulating layer is considered.
- In cold climates, shelter material and construction ensures optimal insulation. A temperature that is comfortable to the occupants is achieved by means of insulated shelter combined with sufficient clothing, blankets, bedding, space heating and calorific intake.
- If plastic sheeting is provided for shelter, it meets the specifications defined by MSF and UNHCR.

Guidance notes and critical issues

1. Shelter can have political implications: structures that appear to be more permanent could be interpreted by host authorities to mean that displaced people have firmly settled. Good communication must be maintained with host authorities to ensure that provision of a temporary settlement is not construed in this way.
2. For indicators on minimum and maximum distances to, and number of, water points and toilets, see Water Supply and Sanitation standard 1, excreta disposal, in chapter 2.
3. Shelter standards depend on the climate and the size of the family. In a cold climate people need more interior space, as they spend more time inside than in a hot climate. Older people, women and young children generally spend more time inside the covered area.
4. In warm, humid climates, shelters must be oriented and designed to maximise ventilation and prevent entry of direct sunlight, so the door and windows should preferably face north and south. The roof should have a good slope for rainwater drainage and have large overhangs. The construction of the shelter should be light, as

low thermal capacity is required. Appropriate orientation is important to maximise airflow; it should not be obstructed, for example, by neighbouring shelters. Shaded space outside the shelter is recommended for cooking and air-drying cooking utensils. Frequent monsoon seasons should be taken into account and surface water drainage is extremely important. (See Water Supply and Sanitation standard 6, drainage, in chapter 2.)

5. In hot, dry climates, construction must be heavy enough to ensure high thermal capacity, allowing changes in night and day temperatures to cool and heat the interior alternately. Windows should be small. If only plastic sheeting or tents are available, a double-skinned roof with ventilation between the layers to prevent radiant heat transfer should be considered. Alternatively, use of insulation materials should be supported. In a light structure, maximum ventilation is not an objective but should be easily controlled (eg by opening opposite doors) to prevent heating by hot winds and radiation from the surrounding ground, and to prevent sand coming into the shelter. Shade can be gained from surrounding shelters or trees.
6. In cold climates, it is essential to provide well-insulated shelters. However, good quality shelters alone are not sufficient to ensure adequate body warmth, which depends on a combination of factors. Key factors are: the external temperature; wind; insulation of the shelter; heating arrangements; available clothes and blankets; and calorific intake.

The chill factor can be minimised by ensuring that air flow through the shelter is kept to the minimum necessary for personal comfort and safety, and to prevent respiratory problems caused by space heaters or fires for cooking. A minimum level of ventilation must be ensured. Doors should be designed to minimise drafts.

Space heaters are essential and must be appropriate to the shelter. Ideally, air intake and exhaust from cookers or space heaters should be contained in flues.

Conduction through the floor is a major issue and needs attention to ensure that people do not lose a lot of body heat during the night.

This can be addressed by ensuring that the floor is insulated, as well as the shelter itself, and/or by providing bed mats or mattresses.

7. Reinforced sheets of polyethylene are generally supplied in the early stage of the emergency, occasionally with rope and support materials such as local bush poles, galvanised steel, aluminium or high density paper. Assistance in harvesting materials should be considered, as should local purchase of materials. The provision of shelter systems should be considered if harvesting of materials is expected to damage the local economy or the environment.

The average family of five people should receive at least one 4 x 6 metres sheet of plastic. This is best imported in rolls for easy transportation, storage and distribution (4 x 60 metres for 10 families). However, sheets of 4 x 7 metres per family would give more head clearance. (See Davis, J and Lambert, R, (1995); UNDP, (1995); and MSF, (1997) listed in Appendix 1).

8. Plastic sheeting provided for shelter should meet specifications defined by MSF and UNHCR. Plastic sheeting for weather-proofing damaged buildings should follow different performance specifications.
9. Accommodation shared between families should only be considered for short periods, and only if sufficient privacy for individual families can be assured.

Housing standard 2: environmental impact

Sheltering of disaster affected people has minimal negative impact on the local environment. Appropriate corrective measures are taken if a negative impact is identified.

Key indicators

- e If high demand for construction materials is expected to cause deforestation, some or all basic materials are supplied to families within two days of their arrival.

- There is immediate protection of vegetation important for erosion control, wind breaks or shade.
- Forest conservation and replanting takes place during the assistance programme.

Guidance notes and critical issues

1. A high level of demand for construction materials in the early stage of the emergency may cause deforestation in the immediate vicinity of the temporary settlement, which may in turn lead to soil erosion, wind damage and raised ambient temperatures caused by lack of shade. This should be considered as part of the assessment so that basic materials can be provided as a preventive measure.
2. The choice of materials provided for emergency shelter should take into consideration longer term shelter needs over the duration of the displacement to minimise environmental and financial costs at a later stage. Materials should be chosen that can be re-used by the displaced population for future shelter construction, or for reconstruction work on damaged buildings.
3. It may be necessary to distribute tools to people who are able to make their own supports or structures, provided that harvesting can be sustained by the environment.

3 Clothing

People displaced by disaster often do not have enough clothes – because of poverty or because they were unable to carry sufficient clothing with them. Those who are still close to their homes may have enough clothes, but these may well have been spoilt.

Clothing standard

The people affected by the disaster, including host families, have sufficient blankets, clothing and footwear to provide protection from the climate and to ensure their dignity and well-being.

Key indicators

- Displaced and host families have access to sufficient blankets.
- Men and boys over 14 years old have 1 full set of clothing in roughly the correct size, appropriate to the culture, season and climate.
- Women and girls over 14 years old have 2 full sets of clothing, including new underwear, in roughly the correct size, appropriate to the culture, season and climate. They have a regular supply of sanitary protection.
- Children between 2 and 14 years old have 1 full set of clothing in roughly the correct size, appropriate to culture, season and climate, and according to sex.
- Children up 2 years old have 1 towel, 1 face towel, 1 baby shawl, 2 full sets of clothing, 6 napkins with safety pins, baby soap, baby powder, baby oil and 3 plastic pants. Alternatively these are supplied as a module (layette).
- Culturally appropriate burial cloth is available as required.

- There is planning for blankets and clothing to be replaced after three years.
- All people have access to footwear if necessary.

Guidance notes and critical issues

1. The initial assessment report should indicate climatic and cultural factors in order to ensure that blankets and clothing are appropriate to men, women and children, and to age. They should be supplied separately, not in mixed bales.
2. Women need specialised clothing for reasons of hygiene and personal dignity. They must also receive appropriate material for their monthly sanitary needs. It is important that these materials are appropriate and discrete, or women will not use them. Given the sensitivity of this issue, women must be involved in making decisions about what is provided. (See Water Supply and Sanitation standard 2, excreta disposal, in chapter 2.)
3. The insulation capacity of blankets and clothes decreases significantly when they are wet (10 to 15 times) and bodies lose more thermal energy.
4. Using many layers of clothing or blankets does not necessarily keep people warmer because with more fabric weight there is less warmth. It is therefore more cost-effective to invest in better quality blankets that will keep people warm rather than larger numbers of cheaper, poorer quality blankets.
5. For guidance on issues relating to thermal resistance and climate see UNDP (1995), listed in Appendix 1.

4 Household Items

People who have been displaced from their homes often arrive with only the things they can carry. When setting up a household at a new site, families need basic supplies and these should be identified by the initial assessment. The assessment should also take into consideration needs of the local host community, since they may require assistance as well as those who have been displaced by the disaster. Steps must also be taken to ensure minimal damage to the environment.

The household items described below are the minimum required to help families become more self-reliant, and will help them to prepare for their return and reintegration into their home communities.

Household items standard 1: items for households and livelihood support

Families have access to household utensils, soap for personal hygiene and tools.

Key indicators

- Displaced and host families have appropriate household items: 1 cooking pot with lid, 1 basin, 1 kitchen knife, 2 wooden spoons, and 2 water collection vessels of 1-20 litres plus water storage vessels of 20 litres.
- Each person has: 1 eating plate, 1 metal spoon and 1 mug.
- Each person has access to 250g of soap per month.
- There is planning for durable items to be replaced after three years.
- Each family has access to appropriate tools and materials to support livelihood activity as soon as possible.

- Tools and materials supplied are appropriate and familiar to the population, and are of a similar technological level to that which people were used to before the disaster. Items are appropriate to the conditions in which they are to be used.

Guidance note

1. See also Water Supply and Sanitation, Water Supply standard 3, water use facilities and goods, for indicators relating to water storage, soap and washing containers; and Solid Waste Disposal standard 2: solid waste containers/pits, for requirements for refuse containers.
2. As soon as feasible, people need to be given the opportunity to develop current and future self-reliance by means of food production, training or other activities that contribute to their general health and well-being. This needs to be considered when planning family space requirements.
3. Technical items can be paid for in cash or by means of labour supplied, or on the basis of a loan. Wherever possible materials should be supplied and procured locally, preferably by the people themselves on a family-to-family basis. More durable items supplied to the population should be technologically simple, and be maintained by the people themselves or locally. For best practice in this area see Chalinder, A (1998), listed in Appendix 1.

Household items standard 2: environmental concerns

Degradation of the local environment is minimised by promoting the use of, and making available, fuel-economic cooking implements and stoves.

Key indicators

- People have access to, and make use of, fuel-economic and low smoke wood stoves (produced locally if possible), gas or kerosene stoves and cooking pots with lids.
- The use and benefit of fuel-economic devices is promoted through community education programmes, if needed.
- People are aware of the benefits of using fuel-economic devices.

5 Site Selection

This section applies to the third scenario described at the beginning of this chapter, where the only available means of providing shelter for a displaced population is a planned temporary settlement.

A well-situated and well-planned temporary settlement provides a healthy environment where people can live in dignity and at peace, and where they can lead as sustainable a family life as possible. In meeting minimum standards, site selection and planning should aim to produce the best living conditions possible under the circumstances, with minimal damage to the environment.

The site selection and planning standards are structured around the assessment process and subsequent steps that should be taken to establish the type and form of settlement appropriate to the needs of the displaced population. Site selection is determined with reference to four types of temporary settlement. Once the preferred option has been identified, information from the physical assessment is then used to decide whether this can be achieved and, if not, what compromises should be made.

Site standard 1: site selection

The site is suitable to host the number of people involved.

Key indicators

- Assessments of the socio-economic profiles of the displaced and host populations and of physical and environmental factors are carried out.
- The appropriate type of temporary settlement required is determined: reception or transit centre; self-settled camp; planned temporary settlement or extension to a temporary settlement.

- The form the settlement should take is determined with reference to:
 - Information generated by the physical assessment.
 - Actual or potential threats to the security of the affected population.
 - The maximum estimated duration of the settlement.
 - The preferred population density of the settlement.
 - The level of integration of the displaced population with the host population.
- Where possible, the site meets the following requirements:
 - It is located at a safe distance from possible external threats to physical security.
 - It is less than 5km from an all-weather road for access by heavy trucks. Light four wheel drive trucks are able to reach distribution areas and construction sites.
 - It is near to existing social and economic facilities where appropriate.
 - There are adequate quantities of water (for drinking, cooking, hygiene and sanitation).
 - It is not less than 3 metres above the anticipated water table in the rainy season.
 - Water rights, and the right to use other natural resources such as wood, stone, sand, are arranged before, or at the same time as, the site is selected.
 - Land rights and permitted use are firmly established prior to occupation.
 - The soil type is suitable for digging and water infiltration.
 - Vegetation: there are grasses, shrubs and trees for shade and to avoid soil erosion.
 - The site is at least 10km from protected or fragile areas.

- The site is not prone to tidal waves or flooding, is not situated on land at risk from landslides, and is not close to an active volcano.

Guidance notes and critical issues

1. When a displaced population settles close to a larger host community it can benefit from access to locally available infrastructure services and livelihood opportunities. More usually, however, the displaced population greatly outnumbers the host communities. This can place great demands on the local infrastructure, economy and environment, which in turn can create animosity between the two communities. Careful site selection and planning are thus critical in minimising possible negative impacts, and determine the effectiveness of the wider humanitarian assistance programme and the security of the affected population.
2. See also Analysis standard 1, assessment, which gives indicators for the socio-economic assessments of both the displaced and host communities. Criteria for the physical assessment are given in note 5 below.
3. The assessments provide information that guide selection of the type of settlement (this note) and the form it takes (note 4). There are four basic types of temporary settlement:
 - a) **Reception or transit centres:** where displaced people or refugees stay for short periods. The centres should be considered as planned camps (c below) when the environment is unable to sustain the demands upon it, or when they have to operate over a longer period.
 - b) **Self-settled camps:** where people have settled spontaneously, yet require partial relocation, provision of infrastructure and sustainable environmental resources.
 - c) **Planned temporary settlements:** where settlements are constructed and serviced by physical planners in advance of arrival of people (eg from reception or transit centres).

- d) **Extensions to temporary settlements:** where extension to the settlement is required to accommodate new arrivals (eg from reception or transit centres).
4. Having identified the type of settlement, the next step is to decide the form it should take. This should take into account information from the socio-economic assessment and the following:
- a) **Security of the displaced population:** whether there are threats from within the displaced population, from the host population or from other parties.
 - b) **The maximum envisaged duration of the settlement,** so that a phased programme can be implemented when resources and time are available. This should determine the form of infrastructural assistance and sustainable limits on the use of environmental resources.
 - c) **The preferred population density of the settlement:** this is key to the level of self-sufficiency that the displaced population is able to maintain. Self-sufficiency can be determined by assessing their culture, the quantity of their livestock and agricultural skills.
 - d) **The level of integration with the host population:** this impacts on the economies of both populations and influences longer term opportunities for the host population.
5. Once the preferred type and form of settlement have been identified, information from the physical assessment should be used to decide whether the preferred option can be achieved and, if not, what compromises should be made. Specialist advice may be required at this stage. The physical site assessment should address the following:
- a) **Access**
 - Proximity and condition of local road infrastructure.
 - Proximity to host service infrastructure and whether siting will affect this positively or negatively.
 - Proximity to airstrips, railheads or ports.
 - Seasonal constraints on access, and vulnerability of access.

b) Topography

Site gradients and expected density of occupation.

Natural hazards including earthquakes, volcanic activity, landslides or flooding.

Permeability of the ground. For example, fissured rock will disperse latrine waste widely; volcanic rock makes latrine construction difficult. (See Water Supply and Sanitation standard 2, excreta disposal, in chapter 2.)

Micro-climactic conditions.

c) Water (see Water Supply and Sanitation, chapter 2)

Availability of sufficient water within a suitable distance throughout the year for displaced people, the host community, agriculture and livestock.

Whether there is more than one source of water, in order to reduce the vulnerability of the water supply.

Height of the water table, whether it risks pollution by sanitation and flooding, and seasonal variations.

d) Space

Whether there is sufficient space for the desired density of the population and dispersal of that population into the number of settlements required.

Whether there is space for extension of the settlement(s), should the population increase.

Current land use and expected impact of the settlement on the land.

The levels and types of agriculture and livestock that can be supported.

e) Environment

Expected temperature, wind and rainfall in terms of their influence on planning, agriculture and livestock.

Existence of environmentally vulnerable or valuable areas nearby.

Availability of sufficient, sustainable quantities of wood for fuel and construction for both the displaced and host populations.

Endemic diseases, pests, risk of disease. (See Health Services standard 3, control of communicable diseases, in chapter 6; Water Supply and Sanitation standard 4, vector control, in chapter 2.)

Throughout this process it is essential that site selection is guided first and foremost by the needs of the affected population(s) rather than by purely technical considerations or the establishment of assistance mechanisms.

6. For an alternative method for site selection, from an engineering perspective, see the site selection matrix in Davis and Lambert (1995), listed in Appendix 1.

Site standard 2: site planning

Site planning ensures sufficient space for household areas and supports people's security and well-being. It provides for effective, efficient provision of services and internal access.

Site standard 3: environmental concerns

Environmental protection measures minimise damage that may be caused by the displaced population and assistance interventions.

Key indicators

- The site provides 45m² space for each person. This includes infrastructure (eg roads, sanitation, schools, offices, water systems, security/fire breaks, markets, storage facilities, shelter locations), but excludes land for agriculture (crops and livestock).
- Clusters of living areas or village groups are established.
- Empty land for possible future expansion is identified.

- There is provision for social facilities such as markets, places of worship, graveyards, health facilities, solid waste disposal, water points, community and nutrition centres, workshops, wood lots and recreational areas.
- There is provision for facilities required by humanitarian agencies such as administrative offices, warehousing and staff accommodation.
- There are firebreaks at least every 300 metres, 50 metres wide. Roads may be used as firebreaks.
- There is a graveyard for each population group and graveyards are appropriately located.
- Quarantine camps are established, or sites are identified and prepared, in isolation from general residential areas, in order to minimise the spread of an epidemic.
- Planning of temporary settlements takes into consideration density and dispersal of the displaced population as a means of controlling access, and minimising damage, to environmental resources:
 - In fragile environments, the displaced population is concentrated in order to contain non-sustainable demand on the environment.
 - In more robust environments, the displaced population is dispersed into a number of settlements.
- Agreed levels of animal husbandry and agricultural activity by the displaced population are environmentally sustainable.
- During site planning, trees are spared as far as possible, and roads and drainage patterns are planned in such a way as to make use of natural contours.
- Measures are taken to protect or conserve forestry, or to promote reforestation where appropriate.
- If possible, the site has a gradient of not less than 2% to enable surface water drainage, but is not more than 6% to avoid landslides, and for ease of habitation.

Guidance notes and critical issues

1. Site preparation should begin with the protection of vulnerable elements within and around the site. This includes water sources, land use by host populations and vegetation important in controlling shade, wind and soil erosion. People with expertise on the environment (forestry, household energy, alternative energy, site planning and development, environmental education), particularly those with local knowledge, should be identified as soon as possible.
2. Wherever possible, the social structure of the displaced population should be reflected in the planning of the temporary settlement, which should take into account needs for markets, meeting places, recreational areas and so on. These facilities are essential in supporting the re-establishment of the displaced communities. Existing forms of social representation should also be supported, given the importance of consultation with displaced people and their involvement in humanitarian interventions.
3. In a transit centre, and in the emergency phase for other temporary settlement types, requirements are different and are based on the need to access vulnerable groups within the displaced population. However, if it is expected that the settlement will continue beyond the emergency phase, space should be allocated in the manner described in note 2 above.
4. The socio-economic, physical and environmental assessments begun during the site selection stage should continue to inform the planning phase, where appropriate (see Site Selection standard 1, above).
5. Planning for self-settled sites often presents numerous difficulties, which can be identified by applying retrospectively the site selection process outlined in the guidance notes to Site Selection standard 1, above. Common problems include the following:
 - They are on unsuitable sites, or are on land used by local populations.
 - They are either too large or too small to be sustainable or to service.

- If there is more than one site, they are too dispersed to service efficiently.
- If concentrated on the area of initial occupation, they are too dense.
- They do not offer equal access to water or other services.
- They do not leave space for roads or service infrastructure.

Common responses to these problems are:

- To relocate, allowing the self-settled camp to act as a transit centre, and allowing the displaced community to re-form.
 - To make improvements in rotation: changes are made to one sector and the neighbouring population is moved into it before changes are made to the next sector.
 - To make piecemeal improvements, which is less invasive.
6. New UNHCR guidelines (unpublished at time of writing) indicate a total space requirement of 45m² per person, which includes a small space for kitchen gardening. Planning should take into account the dynamic evolution and growth of a camp. Population growth and the arrival of more people may see the camp expand by up to 4.5% annually, as has been the case in the past. Early repatriation or reintegration should be planned for as well.
 7. Planning must be driven by the needs of the people affected by a disaster, not by funding, and the disaster affected communities should be involved right from the start. Donors must commit themselves to the entire humanitarian programme, not only to the phase that attracts media attention, as has often been the case. Relatively higher levels of funding may be available at the beginning of an emergency, often as a result of media attention. This should be used wisely by investing in equipment that lasts and that needs little financial input for operation and maintenance.
 8. The impact of displaced people on the environment can be immense. This is not always immediately visible but can take decades to rectify. Habitats and species diversity can be negatively affected. Taking more water from an aquifer than flows into it

causes a lowering of the water table, which can dry up local wells. Using all available grasses, wood and roots for construction and fuel increases soil erosion. Wood harvesting can also become an income-generating activity of the displaced population, often causing environmental damage and conflict with local people. These factors all need to be considered.

9. Limiting space does not encourage people to repatriate, but increases their dependency on the system. Large groups of people in a limited space pose an unacceptable strain on the environment, the local labour market, camp management and security. Limiting space is a false economy. Although initial costs may seem lower, the cost of restoring the environment and continuing to provide care for people will be high in the long term. Paying for these long term costs is likely to be difficult because funding levels later on will be lower than the funding available at the start of the humanitarian intervention. Funds should be invested appropriately right from the start to prevent long term damage to the environment and to people's lives.
10. No matter how much agricultural and habitation land is allocated to each family, people will return to communal areas to collect wood if there are no alternative sources of fuel. On a sustainable basis, it is assumed that 500 people need 1km² of undisturbed forest to cater for their annual fuel wood consumption need of 600-900kg per person. Assuming however that only 20% of forest is undisturbed, only 100 people would be able to access the land.
11. Graveyards must be located more than 30 metres from sources of water for drinking (in soil and more in fractured rock formations), and at least 3 metres above the water table if it is not the source of drinking water. Surface water from graveyards must not enter the settlement. Customs of the local and displaced population should be considered. (See Water Supply and Sanitation, Solid Waste Disposal standard 2, solid waste containers and pits, guidance note 5 relating to the dead, in chapter 2.)
12. The use of the modular 'building block' approach advocated by UNHCR facilitates people's access to needed services and saves planning time.

13. Good maps that indicate land tenure, drainage patterns and available space should be obtained. Often the military have such maps at a scale of 1:50,000. More detailed maps (1:10,000) can be drawn during and after site visits and aerial photographs can be used. Survey information can be transferred on to a map that can be added to as the camp develops.
14. Skill is needed in interpreting data on potential sites, such as topography, water sources, drainage, wooded area, land use, rainfall data, geological and hydro-geological data. It is important to be aware of possible gaps in the information and changes that may have occurred since it was gathered. A specialist is needed to interpret hydro-geological data. The local population should be consulted on all of the above.

Site standard 4: security and planning

Site selection and planning enables the personal liberty and security of all people, particularly groups at risk.

Key indicators

- The site is located at a safe distance from possible external threats to physical security.
- Site planning ensures that safe living areas are provided for groups at risk.
- Social, health, sanitation and other essential facilities are safely accessible, and are lit at night if necessary.
- Cluster planning is used in order to support self-policing by the displaced population.
- The overall size of the settlement population does not exceed a level that makes internal and external security and protection measures ineffective.
- Internal and external security and protection activities are carried out by the host authorities and/or the relevant UN agency.

- The agency assigned responsibility for overall coordination assists with internal security for groups at risk.
- Reasonable steps are taken to ensure that staff are not at risk. In insecure areas an evacuation plan is agreed between agencies.

Guidance notes

1. Security for all people affected by the disaster, and for field staff, is of crucial importance. Careful site planning that takes into account internal and external risks, and identifies the needs of particular groups, especially women, will help reinforce security measures taken by host authorities and UN agencies.
2. Care should be taken to avoid providing a level of humanitarian assistance that exceeds the living standards of the host population as this can lead to resentment and conflict.
3. The coordinating agency should ensure that there is lighting in strategic areas at night and that female headed households and single women are housed closer together, in secure areas near facilities, but not in such a way that 'ghettos' are created.

6 Human Resource Capacity and Training

All aspects of humanitarian assistance rely on the skills, knowledge and commitment of staff and volunteers working in difficult and often insecure conditions. The demands placed on them can be considerable, and if they are to conduct their work to a level where minimum standards are assured, it is essential that they are suitably experienced and trained and that they are adequately managed and supported by their agency.

Capacity standard 1: competence

Shelter and site interventions are implemented by staff who have appropriate qualifications and experience for the duties involved, and who are adequately managed and supported.

Key indicators

- All staff working on a shelter and site programme are informed of the purpose and method of the activities they are asked to carry out.
- Assessments, programme design and key technical decision making are carried out by staff with relevant technical qualifications and previous emergency experience.
- Staff with technical and management responsibilities have access to support for informing and verifying key decisions.
- Staff responsible for site planning are trained and regularly supervised in the necessary techniques.
- Staff and volunteers involved in information gathering are

thoroughly briefed and quickly checked by an experienced person before starting work.

- Staff and volunteers involved in construction and other manual activities are trained, supervised and equipped adequately to ensure their work is carried out efficiently and safely.

Capacity standard 2: local capacity

Local skills and capacity are used and enhanced by shelter and site programmes.

Key indicators

- Members of the disaster affected population are included in the implementation of shelter programmes.
- Selection criteria for international staff recruitment include a commitment to building local capacities for long term benefit.
- The skills base within existing local partners and institutions is tapped and strengthened during the course of the humanitarian assistance programme.

Guidance notes

1. See the *People in Aid Code of Best Practice in the Management and Support of Aid Personnel* which is appended in this binder.
2. When programmes are designed, human resource capacity issues must be addressed. Staff and volunteers should demonstrate capabilities equal to their respective assignments; specific training in the relevant areas of expertise must be a prerequisite for engagement of staff. The provision of training and support as a part of emergency preparedness is important to ensure that skilled personnel are available to deliver quality services. Given that emergency preparedness cannot be assured in many countries, humanitarian agencies should ensure that qualified and competent staff are identified and properly prepared before eventual assignment to an emergency situation.

Appendix 1

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The Sphere Project

Humanitarian Charter
and Minimum Standards
in Disaster Response



Minimum Standards in Health Services

Chapter 6



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The Sphere Project

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Minimum Standards in Health Services

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Minimum Standards in Health Services

Introduction

1 The importance of health services in emergencies

In emergencies, major loss of lives due to injuries and increased incidence of diseases has been documented. Natural disasters (earthquakes, floods, volcanoes etc) warfare and conflicts, and technological disasters contribute to excess mortality and morbidity. Likewise, diseases responsible for such increases have also been identified: measles, diarrhoeas (including dysentery and cholera), acute respiratory infections, malnutrition and malaria (where prevalent). The high incidence of diseases is due to the environmental factors to which populations are exposed, namely overcrowding, insecurity, inadequate quantities and quality of water, poor environmental sanitation, inadequate shelter and inadequate food supply.

The main purpose for provision of health services to a disaster affected population is to prevent excess mortality and morbidity. A further objective is to identify priorities through rapid and proper assessment, and ongoing monitoring and surveillance. It is equally important to ensure that technically sound interventions responding to priorities identified by the initial assessment are planned, implemented and monitored in a coordinated manner.

Priority should be given to primary health care (PHC) measures including multi-sectoral assistance in key areas (water, sanitation, nutrition, food, shelter). The participation of local health authorities and that of qualified members of the affected population including community workers and home visitors is paramount in carrying out primary health care measures.

2 The Humanitarian Charter and Minimum Standards in health programmes

The aims of health programmes, as well as those of the other sectors, flow from a wider goal which is the cornerstone of humanitarian practices. This goal is to alleviate human suffering brought about by calamity or conflict through protecting life with dignity in ways that support durable recovery.

Translating this goal into practice requires a clear commitment by agencies to humanitarian principles and to the implementation of minimum standards. The Humanitarian Charter and Minimum Standards together provide the policy and organisational framework to enable this to happen and to ensure systems of accountability.

The Humanitarian Charter reaffirms the importance of fundamental humanitarian principles and the rights of disaster affected communities to humanitarian assistance. Through the Charter, signatory agencies commit themselves to defined minimum standards for the provision of humanitarian services. The standards for health services (this chapter), water supply and sanitation (chapter 2), nutrition (chapter 3), food aid (chapter 4) and shelter and site planning (chapter 5) build on the principles laid out in the Humanitarian Charter and demonstrate how the rights of people affected by disasters should be realised in practice.

The standards set out in this chapter describe what people should have as a minimum for their health and dignity. Agencies should strive to do better wherever possible.

3 Using the standards

The standards apply to any situation where people's normal means for support of life with dignity have failed whether as a result of a natural or human-made disaster in any country, on any continent. They provide a description of what people have a right to expect from humanitarian assistance. The standards do not focus on disaster preparedness, mitigation or rehabilitation, though these are considered where relevant.

The intention is to provide a tool to help create the conditions for

effective interventions and for the achievement of the minimum standards. The standards have been made as specific as possible, but they remain widely applicable to different emergency situations within current operational and policy frameworks.

4 Assumptions

To achieve the minimum standards in a wide variety of emergency contexts, it is assumed that:

- Agencies are driven by humanitarian principles and are committed to best organisational practices as a means to achieving their wider goal.
- There is a shared commitment among all those involved in humanitarian assistance to achieve the minimum standards, and to coordinate their response.
- The agency has acquired sufficient financial, human and material resources to meet the standards.
- There is access to the affected population.
- All other sectors are meeting their standards (as described in other chapters).

5 Structure of this chapter

After this introduction the chapter is divided into the following sections:

1. Analysis
2. Measles Control
3. Control of Communicable Diseases
4. Health Care Services
5. Human Resource Capacity and Training

Each of the sections includes the following components:

- **The standards:** these specify the minimum acceptable levels to be attained in each area.

- **Key indicators:** these are ‘signals’ that show whether the standard has been attained. They provide a way of measuring and communicating both the impact, or result, of programmes as well as the process, or methods, used. The indicators may be qualitative or quantitative.
- **Guidance notes and critical issues:** these explain why each standard is important and may include: specific points to consider when applying the standard in different situations; guidance on tackling practical difficulties; advice on priority issues.

Critical issues might relate to the standard or indicators, and describe dilemmas, controversies or gaps in current knowledge. Filling these gaps will help improve the minimum standards for health services in the future.

Further relevant information, including a select bibliography, is supplied in the Appendices.

The organisation of the chapter reflects the division of activities and responsibilities that commonly occurs in emergency situations. Action in each of these areas contributes to the overall purpose of addressing priority health needs.

Each of the sections is inter-related. The initial health assessment identifies needs, establishes priorities and provides the data to start priority interventions. Data from the ongoing health information system provides trends in morbidity and mortality which serve to detect new problems or to redirect resources. Both the initial assessment and the health information system serve to identify health problems such as injuries, malnutrition or communicable diseases that are addressed and controlled using standards outlined in the Control of Communicable Diseases and the Health Care Services sections. Section 5, Human Resource Capacity and Training, applies to all work and deals with issues related to the human capacity required to implement effective health interventions.

Progress in achieving standards in one area determines the importance of progress in other areas. For instance, a good health information system identifies problems and then leads to appropriate control, preventative and curative activities.

6 Links with other sectors

Reference to other sectors' technical standards are made where relevant. The purpose of this is to highlight how work in one sector is closely linked to work in other sectors, and that progress in one is dependent on progress in other areas. For example, provision of clean water will reduce diarrhoea, provision of sufficient and appropriate foods will reduce nutritional problems.

The Minimum Standards

1 Analysis

Interventions that meet the needs of disaster affected populations must be based on a clear understanding of the situation. The people affected by the disaster, agencies, donors and local authorities need to know that interventions are appropriate and effective. Analysis of the effects of the disaster and of the impact of the proposed health interventions is therefore critical. If the problem is not correctly identified and understood then it will be difficult, if not impossible, to make the right response.

Standardised methods of analysis that are used across the sectors have great potential to rapidly identify acute humanitarian needs and to ensure that resources are directed accordingly. This section sets out agreed standards and indicators for collecting and analysing information to identify needs, to design interventions and to monitor and evaluate their effectiveness.

Analysis starts with an immediate initial assessment. This provides baseline data that measures the impact of the disaster and determines whether and how to respond. Analysis continues through the health information system with monitoring, which identifies how well interventions are meeting needs and whether changes are required. The health information system eventually provides data that can be used to evaluate the overall effectiveness of interventions and to identify lessons for the future.

The sharing of information and knowledge among all those involved, including the affected populations, is fundamental to achieving a full understanding of the problem and coordinated assistance. Documenting and disseminating information from the analysis process contributes to a broad understanding of the adverse public health and other consequences of disasters and also assists in the development of improved disaster prevention and mitigation strategies.

Analysis standard 1: initial assessment

The initial assessment determines as accurately as possible the health effects of a disaster, identifies the health needs and establishes priorities for health programming.

Key indicators

- An immediate initial assessment that follows internationally accepted procedures is carried out by appropriately experienced personnel including at least one epidemiologist. Data collection starts before the field assessment using available maps, country profiles etc.
- The initial assessment is conducted in cooperation with a multi-sectoral team (water and sanitation, nutrition, food, shelter, health), national health authorities, representatives of the affected population and humanitarian agencies intending to respond to the situation.
- The information is gathered and presented in a way that allows for transparent and consistent decision making. Appendix 2 provides a sample Checklist for Initial Health Assessment. Information gathered usually includes:

- Geographic extent of the impact of the disaster.
- Demographics of the disaster affected area:

The total disaster affected population (population denominator is estimated if census is impossible or not available).

Age breakdown of the affected population is collected for two age groups at least (<5 years age group) and (total population); if it is feasible to collect more detailed age data, the following breakdown is used: <1, 1-4, 5-14, 15-44, 45+.

Average family or household size including estimates of female heads of households and pregnant women.

- Incidence of communicable diseases.
- Injuries and deaths.

- Presence of continuing hazards.
 - Nutritional status of affected population.
 - Crude mortality rate (CMR) for total population expressed as deaths/10,000/population/day.
 - Under-5 mortality rate (U-5MR) (age specific mortality rate for under five year old age group) expressed as deaths/10,000/population/day.
 - Age and sex specific incidence rates of major problems and diseases.
 - Environmental conditions (access to potable water, current level of sanitation, availability and adequacy of shelter, disease vectors etc)
 - Availability of food.
 - Status and quality of local health infrastructure (services and staffing) and medical supplies.
 - Status of transportation system.
 - Level of communications network.
 - Estimates of external assistance based on preliminary findings.
- The crude mortality rate (CMR) for the total population and the U-5MR are computed daily during the early emergency to allow for detection of sudden changes. (See guidance note 2 on method for calculating the daily crude mortality rate.)
 - The initial assessment team's programming and recommendations aim from the start to prevent excess mortality and morbidity as well as anticipate future public health problems resulting from the ongoing emergency conditions. Recommendations are made on whether or not external assistance is needed to supplement in-country resources. If assistance is required, recommendations are made on priorities and a strategy is outlined for providing needed human and material resources. There is also consideration of:
 - The social and political structure of the population including the potential influx of refugees.

- The psycho-social dimension of the situation.
 - Special attention for groups at risk.
 - Access to the affected population.
 - Insecurity and violence.
 - Distribution systems.
 - The possible long term implications and environmental impact of the interventions proposed.
- An assessment report is produced that covers key areas and appropriate recommendations which are immediately shared with national and local authorities, representatives of the affected population and participating agencies.

Guidance notes and critical issues

1. During the acute phase of an emergency, the crude mortality rate (CMR) for the whole population and the under-5 mortality rate (U-5MR) for children under five years of age are very important indicators of the overall status of the affected population.
2. The following method is used to calculate crude mortality rates over short periods of time (<1 month).
 - a) Total the deaths for a given number of days.
 - b) Divide the total by the number of days over which data were gathered – this gives the average number of deaths per day.
 - c) Divide this number by the size of the affected population.
 - d) Multiply by 10,000 for a daily crude mortality rate.
3. Timeliness is of the essence for the initial assessment, which should be carried out as soon as possible after the disaster. If required there should be an immediate response to critical needs at the same time. A report should be generated as soon as possible after arrival at the site of the disaster, though this depends on the particular event and the wider situation.
4. People who are able to collect information from all groups in the

affected population in a culturally acceptable manner should be included, especially with regard to gender and language skills.

5. The logistics of conducting the assessment and the use of internationally recognised standards should be agreed upon by all participants before field work begins and specific tasks contributing to the assessment should be assigned accordingly.
6. While there are some emergencies where advanced knowledge will determine what actions are necessary, most humanitarian assistance must be based on some assessment data, even if incomplete. There are many different techniques for information gathering and these should be chosen carefully to match the situation and the type of information required. As a general rule, information should be gathered more frequently when the situation is changing more rapidly, and when there are critical developments such as new population movements or an epidemic outbreak of diarrhoea. Initial assessments may be quick and unrefined but analysis improves as more time and data are available through the health information system. As the emergency stabilises, better health information data on pregnant and lactating women, disabled people, elderly people and unaccompanied minors and other groups at risk should become available.
7. Further information for the assessment report can be compiled from other existing literature, relevant historical material, pre-emergency data and from discussions with appropriate, knowledgeable people including donors, agency staff, government personnel, community leaders, women, elders, participating health staff, teachers, traders and so on. National or regional level preparedness plans may also be an important source of information.
8. The initial assessment and subsequent health information analyses should demonstrate an awareness of underlying structural, political, economic and environmental issues operating in the area. It is imperative that prior experience and local understanding are taken into consideration when analysing the dynamics and impact of the new emergency. This requires inclusion of local expertise and

knowledge in data collection and analysis of resources, capacities, vulnerabilities and needs. The current and pre-emergency living conditions of displaced and non-displaced people in the area and local resources must also be considered.

9. The needs of groups that are at risk of additional harm such as women, children, elderly people, physically and mentally disabled people must be considered. Gender roles within the social system need to be identified and gender breakdown should be collected as part of the ongoing health information system.
10. Although each emergency generates particular health needs and problems, the following broad areas of activity are likely to be needed: surveillance of injuries and diseases, control of communicable diseases, measles immunisation, food and nutrition, water, sanitation and shelter. In addition, the initial assessment should indicate the extent of need for: prevention services, curative health care, the referral system, reproductive health, women's and children's health, community services, health education, medical supplies, personnel and the organisational resources required to establish and operate these services in an interrelated and coordinated manner.

Analysis standard 2: health information system – data collection

The health information system regularly collects relevant data on population, injuries, diseases, environmental conditions and health services in a standardised format in order to detect major health problems.

Key indicators

- Surveillance starts at the same time as the initial assessment and ideally uses the existing ongoing local health information system. In some emergencies, a new or parallel system may be necessary and this is determined by the initial assessment team.
- Responsibility for organising and supervising the surveillance system is clearly assigned to an individual agency to assure coordination between all partners if the local health authorities cannot serve in this function.
- The health information system in the initial stages of the emergency concentrates on demography, mortality and its causes, morbidity and priority programme activities (water, sanitation, food, nutrition, shelter) as specified by the initial assessment.
- Mortality data is collected from: health facilities and the community including cemetery staff, shroud distributors and other key informants to assess the daily CMR for the total population and U-5MR (age specific mortality rate for under five year olds). Cause-specific mortality data is also collected. (See Appendix 3 for sample mortality surveillance form.)
- Morbidity data on injuries, health conditions and diseases is collected from: health facilities providing outpatient services, nutrition centres, feeding programmes and community health workers, in order to calculate: incidence rates for primary causes of injury or illness; age and sex specific incidence rates; and to detect changes or new health problems. (See Appendix 3 for sample morbidity surveillance form.)

- Each health facility providing outpatient services completes the standard surveillance forms for mortality and morbidity providing age, sex, and cause specific data. (See Appendix 3 for sample mortality and morbidity surveillance forms.)
- Health service data is collected from participating agencies, local health facilities and community health workers in most emergency situations. Since the kind of data to be collected varies with each emergency, the initial assessment team determines the priority areas for which data is collected, eg feeding programme coverage, measles immunisation coverage etc. (See: Appendices 6 and 7 for sample nutrition, water, sanitation and environment forms; Water Supply and Sanitation, chapter 2; Nutrition, chapter 3.)
- The local health authority or agency designated with responsibility for the health information system regularly summarises data received from health facilities and the community using standard forms and standard data compilation, entry and analysis methods. (See Appendix 4 for example of presentation of mortality data.)
- Standard case definitions and standard reporting forms are available and used for every disease to be monitored. Definitions are simple, clear and adapted to available diagnostic means. (Examples of some standard case definitions are provided in the guidance notes below.)
- People working at reporting sites are trained in the use of standard reporting forms and case definitions. The frequency of reporting is specified and is adapted to the type and phase of the emergency situation.
- Communications and logistics systems for disseminating and receiving surveillance reports and feedback are in place or are created.
- The health information system is periodically assessed to determine its accuracy, completeness, simplicity, flexibility and timeliness.

Guidance notes and critical issues

1. The health information system serves to:
 - a) Rapidly detect and respond to health problems and epidemics.
 - b) Monitor trends in health status and continually address health care priorities.
 - c) Evaluate the effectiveness of interventions and service coverage.
 - d) Ensure that resources are correctly targeted to the areas and groups of greatest need.
 - e) Evaluate the quality of health interventions.
2. Examples of clinical case definitions for use in some emergency and post-emergency situations are provided below. More information on standard case definitions can be found in the bibliographic references (see Appendix 1, Select Bibliography, health information system).

Measles: generalised rash lasting >3 days and temperature >38°C and one of the following: cough, runny nose, red eyes.

Dysentery: 3 or more liquid stools per day and presence of visible blood in stools.

Common diarrhoea: 3 or more liquid watery stools per day.

Cholera: severe, profuse, watery diarrhoea with or without vomiting.

Acute Respiratory Infection (ARI): fever, cough and rapid breathing (>50 or more per minute).

Malnutrition: weight for height index <-2Z scores or kwashiorkor. (See Nutrition, chapter 3.)

Malaria: temperature >38.5°C and absence of other infection.

Meningitis: sudden onset of fever >38.9°C and neck stiffness or purpura.

Analysis standard 3: health information system – data review

Health information system data and changes in the disaster affected population are regularly reviewed and analysed for decision making and appropriate response.

Key indicators

- During the emergency phase, the crude mortality rate (CMR) and incidence rates of major health problems (injuries and diseases) are monitored and analysed daily for decision making. However, for some emergencies, the initial assessment team may recommend a less frequent cycle of analysis.
- Reports of health problems (injuries, malnutrition etc) are rapidly identified, further investigated and appropriate measures immediately instituted to prevent excess mortality from the identified problem(s).
- Individual cases and/or outbreaks of communicable diseases are investigated as soon as possible and confirmed. Outbreak control measures are instituted if indicated and cases receive appropriate treatment. (See Control of Communicable Diseases standards.)

Analysis standard 4: health information system – monitoring and evaluation

Data collected is used to evaluate the effectiveness of interventions in controlling disease and in preserving health.

Key indicators

- Measures of effectiveness used for evaluation include:
 - Decreasing death rate aiming towards less than 1/10,000/day.

- The under-5 mortality rate (U-5MR) is reduced to no more than 2/10,000/day.
- Epidemics/diseases are controlled.
- Measles vaccination coverage reaches more than 90%.
- There is delivery of adequate food (see Nutrition, chapter 3 and Food Aid, chapter 4).
- There is access to adequate water (see Water Supply and Sanitation, chapter 2).
- Adequate sanitation facilities are available (see Water Supply and Sanitation, chapter 2).

Guidance notes and critical issues

1. The objective of an emergency intervention should be to achieve a CMR of <1/10,000/day and an U-5MR of <2/10,000/day as soon as possible.
2. The health information system should be integrated into the host community system and include health facility and community health workers. Both the affected population and the host community participate in the health information system.
3. Emergencies are volatile and dynamic by definition. Regular and current information is therefore vital in ensuring that interventions remain relevant. Information derived from continual monitoring of interventions should be fed into reviews and evaluations. In some circumstances, a shift in strategy may be required to respond to major changes in the context or needs of the disaster affected population.
4. Evaluation is important because it measures effectiveness, identifies lessons for future preparedness, mitigation and humanitarian assistance, and promotes accountability. Evaluation refers here to two, linked processes:
 - a) Internal programme evaluation is normally carried out by staff as part of the regular analysis and review of monitoring

information. The agency must also evaluate the effectiveness of all its interventions in a given disaster situation or compare its interventions across different situations.

- b) External evaluation may by contrast be part of a wider evaluation exercise by agencies and donors, and may take place, for example, after the acute phase of the emergency. When evaluations are carried out it is important that the techniques and resources used are consistent with the scale and nature of the intervention or programme, and that the report describes the methodology employed and the processes followed in reaching conclusions.
5. Monitoring and evaluation activities require close cooperation with other sectors (see chapters on Water Supply and Sanitation, Nutrition, Food Aid, Shelter and Site Planning), host authorities and agencies.

2 Measles Control

Measles vaccination campaigns should be assigned the highest priority at the earliest possible time in emergency situations. Measles vaccination programmes should begin as soon as the necessary personnel, vaccine, cold chain equipment and other supplies are available. Measles vaccination should not be delayed until other vaccines become available or until cases of measles have been reported. In some rare instances, the initial assessment team may assess that a measles vaccination campaign is not necessary. This decision should be based on epidemiological factors such as the conduct of a recent mass campaign in the population, level of measles vaccination coverage, and the estimated number of susceptible persons in the affected population. In some other instances, the initial assessment team may recommend that persons up to 15 years of age or higher be included if there is evidence of high susceptibility in this age group.

Measles control standard 1: vaccination

In disaster affected populations, all children 6 months to 12 years old receive a dose of measles vaccine and an appropriate dose of vitamin A as soon as possible.

Measles control standard 2: vaccination of newcomers

Newcomers (if this is a refugee situation) are systematically vaccinated. All children 6 months to 12 old years receive a dose of measles vaccine and an appropriate dose of vitamin A.

Key indicators

- Coordination with local health authorities (Expanded Programme on Immunisations – EPI) and involved agencies is established and ongoing.
- Up to 100% of all children in the target group (including newcomers) are vaccinated. (See Appendix 5 for sample measles vaccination form.)
- On-site supply of measles vaccine equals 140% of the target group including 15% for wastage and a 25% reserve stock; projections of vaccine needs for subsequent newcomers are made and vaccine is procured if not already available.
- Only vaccines and autodestruct syringes meeting WHO specifications are used.
- The cold chain is continuously maintained and monitored from vaccine manufacture to vaccination site.
- On-site supply of autodestruct syringes equals 125% of expected target groups including a 25% reserve stock. Sufficient 5ml syringes for diluting multiple dose vials are available. One syringe is required for each vial diluted.
- Sufficient WHO recommended ‘safety boxes’ are used to store autodestruct syringes before their disposal. Boxes are disposed of according to WHO recommendations.
- On-site supply of vitamin A equals 125% of the target group including a 25% reserve stock if vitamin A is to be provided as part of a mass vaccination campaign.
- e Previous experience indicates that staffing for vaccination activities (including administration of vitamin A) should consist of at least one supervisor and one logistics officer who can supervise one or more teams. The following team should be able to vaccinate up to 500-700 persons in approximately one hour. The number of vaccinators needed will depend on the target population to be immunised.
 - Four staff members to prepare the vaccines.

- Two staff members to administer the vaccines.
 - Six staff members to register and tally.
 - Six staff members to maintain order (crowd control).
- The date of measles vaccination is entered in each child's health record. Health records for recording vaccinations are provided if possible.
 - Infants vaccinated prior to 9 months require re-vaccination upon reaching that age.
 - Health facilities have the capacity to ensure routine ongoing measles vaccination of new arrivals if this is a refugee situation, and to identify children needing to be re-vaccinated at 9 months.
 - Relevant messages in the local language are provided to groups of waiting mothers or caregivers on the benefits of measles vaccination, possible side effects, when to return if re-vaccination is indicated and the importance of retaining the health record.
 - A public information campaign is conducted by community workers before conducting a mass vaccination campaign.

Guidance notes and critical issues

1. Vaccines must be maintained at the manufacturer's recommended temperature of $<8^{\circ}\text{C}$ to maintain vaccine potency.
2. Individual health records for recording measles vaccinations should be provided but may not always be available or issued in an emergency situation; the lack of records should not delay the implementation of measles vaccination activities.
3. It may be necessary to raise the measles target group from 12 to 15 years of age or higher in some areas if there is epidemiological evidence that this higher age group is susceptible. In other instances, the initial assessment may recommend a target group below 12 years of age.
4. See also Nutrition, General Nutritional Support standard 1, guidance notes on vitamin A.

Measles control standard 3: outbreak control

A systematic response is mounted for each outbreak of measles within the disaster affected population and the host community population.

Key indicators

- A single case (suspected or confirmed) warrants immediate on-site investigation which includes looking at the age and vaccination status of the suspect or confirmed case.
- Control measures include the vaccination of all children 6 months to 12 years of age (or higher if older ages are affected) and the provision of an appropriate dose of vitamin A.

Measles control standard 4: case management

All children who contract measles receive adequate care in order to avoid serious sequelae or death.

Key indicators

- A community-wide system for active case detection using the standard case definition and referral of suspected or confirmed measles cases is operational.
- Each measles case receives vitamin A and appropriate treatment for complications such as pneumonia, gastro-enteritis, severe malnutrition and meningoencephalitis which cause the most mortality.
- The nutritional status of children with measles is monitored, and if necessary children are enrolled in a supplementary feeding programme.

Guidance notes and critical issues

1. Because measles vaccination is so important in the early stages of an emergency in many countries, vaccination should not be delayed. Other EPI vaccines are introduced only when the immediate needs of the disaster affected population have been met.
2. When mass measles vaccination is indicated and individual records are not available, the immunisation of children who may have previously received vaccine is not harmful. It is more important to re-vaccinate than to leave a child unvaccinated and susceptible.
3. During a mass campaign, WHO recommends the following doses of vitamin A:
 - 6 months to 1 year of age: 100,000 International Units (IU)
 - 1 year of age and over: 200,000 IUs(See Nutrition, Appendix 1 for IU definition.)
4. For measles case management: administration of supplemental vitamin A to measles cases contributes to a decrease in mortality and measles sequelae. WHO recommends:
 - <6 months of age: 50,000 IU on day one; 50,000 IU on day two
 - 6-11 months of age: 100,000 IU on day one; 100,000 IU on day two
 - >12 months of age: 200,000 IU on day one; 200,000 IU on day two
5. If measles disease is in the affected population, it is possible that children who are vaccinated during their incubation period may still develop the disease.

3 Control of Communicable Diseases

The primary causes of morbidity and mortality in a disaster affected population are measles, diarrhoeal diseases, acute respiratory infections, malnutrition and, in areas where it is endemic, malaria. Other communicable diseases, such as meningococcal meningitis, hepatitis, typhoid fever, typhus and relapsing fever, may cause outbreaks in some settings.

Local health authorities including community health workers and home visitors are part of the control effort and work in conjunction with health facilities and participating agencies. The affected population plays an important part in disease prevention and control through the application of, and adherence to, good public health practices.

Prevention is a key priority in communicable disease control and therefore successful implementation of other sector activities such as water, sanitation, nutrition, food and shelter is of vital importance. Crowded populations, contamination of water supply, poor sanitation and low quality housing all contribute to the rapid spread of disease. Poor nutrition, particularly among young children, increases susceptibility to disease and contributes to high rates of mortality.

Control of communicable diseases standard 1: monitoring

The occurrence of communicable diseases is monitored.

Key indicators

- The responsible surveillance and disease control unit or agency is clearly identified and all participants in the emergency know where to send reports of suspect or confirmed communicable diseases.
- Staff experienced in epidemiology and disease control are part of the surveillance and disease control unit or agency.
- Surveillance is maintained at all times to rapidly detect communicable diseases and to trigger outbreak response.

Control of communicable diseases standard 2: investigation and control

Outbreaks of diseases of epidemic potential, such as measles, acute respiratory infections, diarrhoeal diseases including dysentery and cholera, and malaria are investigated and controlled according to internationally accepted norms and standards.

Key indicators

- Diseases of epidemic potential are identified by the initial assessment; standard protocols for prevention, diagnosis and treatment are in place and appropriately shared with health facilities and community health workers/home visitors.
- Case reports and rumours of disease occurrence are investigated by qualified staff.
- There is confirmation of the diagnosis.
- Outbreak control measures are instituted and include:

- **Attacking the source**, by reducing the sources of infection to prevent the disease spreading to other members of the community. Depending on the disease, this may involve the prompt diagnosis and treatment of cases (eg cholera), isolation of cases (eg viral haemorrhagic fevers) and controlling animal reservoirs (eg plague).
 - **Protecting susceptible groups** in order to reduce the risk of infection: immunisation (eg meningitis and measles), better nutrition and, in some situations, chemoprophylaxis for high risk groups (eg malaria prophylaxis may be suggested for pregnant women in outbreaks).
 - **Interrupting transmission** in order to minimise the spread of the disease by improvements in environmental and personal hygiene (for all faeco-orally transmitted diseases), health education, vector control (eg yellow fever and dengue) and disinfection and sterilisation (eg hepatitis B).
- Qualified outreach personnel (community health workers, home visitors) participate in the control measures at community level by providing both prevention messages and proper case management (provision of ORT and drugs, compliance with prescribed treatment, follow-up at home etc) following agreed guidelines.
 - Public information and health promotion messages on disease prevention are part of control activities.
 - Community leaders and community health workers/home visitors facilitate access to population groups and disseminate key prevention messages.
 - Only drugs from WHO's Essential Drugs List are used. (See WHO references in Appendix 1.)
 - In some instances, studies will need to be carried out to assess drug resistance.

Guidance notes and critical issues

1. Reports and rumours of outbreaks are common among disaster affected populations, including refugees, and should always be followed up.
2. An epidemic is defined as an excessive number of cases of a given disease in relation to prior experience according to place, time and population. It can sometimes be difficult to decide whether there is an epidemic or not, and criteria for epidemic thresholds should be established (by the surveillance unit) for the diseases for which this is possible. Since many diseases do not have a defined threshold for declaring an epidemic, any suspected or confirmed epidemic must be reported to the responsible surveillance and disease control unit.
3. Setting up a clinical laboratory is not a priority in most emergencies. Most cases will be diagnosed clinically and treatment will be presumptive or symptomatic. Some infectious agents will need to be identified and sample material will need to be collected for testing and sent to a reference lab. This can be determined by the responsible surveillance and disease control unit.
4. Information on the control of the most common communicable diseases – diarrhoeal diseases (including dysentery and cholera), acute respiratory diseases, measles and malaria – is briefly provided below. The control of rarer or less severe diseases is described in the references provided in the bibliography in Appendix 1. See in particular Médecins Sans Frontières, (1997).

The following is adapted and modified from *Control of Infectious Diseases in Refugee and Displaced Populations in Developing Countries* by C Paquet and G Hanquet, published in the Bulletin Institut Pasteur, 1998, 96, 3-14.

Diarrhoeal Diseases

Diarrhoeal diseases represent an important cause of death among disaster affected populations, mainly because overcrowding, lack of water and poor hygiene and sanitation favour the transmission of this group of diseases. As treatment of common diarrhoea relies on the prevention of dehydration through oral rehydration therapy (ORT), the basic health services in a disaster affected setting should include a

network of ORT points. Since poor nutritional status further increases the case fatality rate of the disease, all children with diarrhoea must be checked for malnutrition and be managed accordingly. The provision of safe water in sufficient quantity, building of latrines, distribution of soap, and appropriate site planning to avoid overcrowding are the most effective ways of controlling diarrhoea-related morbidity and mortality.

Dysentery Outbreaks

S dysenteriae type 1 (Sd1) infection has been a major public health problem in Latin America, south Asia and central Africa. Unfortunately, Sd1 has proven its extraordinary ability to develop resistance to antibiotics. In some areas today, the only effective antimicrobial agent against Sd1 is ciprofloxacin (5 day regimen), further complicating patient management and increasing the cost of the treatment to a level which may prevent its use on a large scale.

Cholera Outbreaks

Cholera outbreaks are frequently observed in settings in Asia and Africa. When properly managed, cholera case fatality rates can be kept below 1% during outbreaks occurring in refugee settings. Outbreak control is based on active case-finding and appropriate case-management. Severely dehydrated patients receive intravenous (IV) treatment. Mild cholera cases are treated with ORT. A short course of antibiotic therapy can reduce the duration of the disease and is still recommended by the WHO for severely dehydrated patients. Cholera transmission is reduced by appropriate waste management and water treatment (chlorination). Mass vaccination has never been used for controlling cholera outbreaks, and it is agreed that vaccination would have very little or no impact once the outbreak has started (reactive strategy) and would divert resources from other essential control activities.

Control of Acute Respiratory Infections (ARI)

In developing countries, 25-30% of deaths among children under five are caused by ARI, and 90% of them are attributable to pneumonia alone. Proper case management is the cornerstone of the prevention of deaths from pneumonia. Clinical diagnosis, based on observation of the child's breathing, has been developed by

WHO and UNICEF, and can be used for early recognition of cases in a refugee population. Cotrimoxazole remains the drug of choice because it is easy to administer and cost-effective in the ambulatory treatment of pneumonia.

Measles Control

Measles remains a major cause of childhood mortality throughout the world. While the Expanded Programme on Immunisation (EPI) has achieved satisfactory overall vaccine coverage levels in some countries, coverage levels vary widely among regions of the world. Outbreaks can occur in camp settings and other crowded environments where a concentration of susceptible individuals is an important risk factor for transmission of the virus. High mortality rates occur because of poor nutritional status, vitamin A deficiency and intensive exposure to virus due to overcrowding. High mortality due to measles is preventable and mass immunisation coupled with vitamin A distribution is a top priority in an emergency.

Malaria Control

Malaria caused by *plasmodium falciparum* remains the main health hazard in tropical areas all over the world. Even for populations displaced from a highly endemic area, prevention of malaria is based on individual protection with impregnated bednets and community protection through vector control. Mass distribution of mosquito nets impregnated with insecticide can have a significant impact on malaria transmission by reducing the mosquito population and creating a shield effect, thus benefiting even people who do not themselves use nets. Mass chemoprophylaxis has not been recommended because it is extremely difficult to implement and to monitor on a large scale and because it can accelerate the development of drug resistance. The ideal strategy in principle is to treat cases with confirmed parasitaemia, but this is rarely possible in practice. In the absence of laboratory facilities and in highly endemic areas, treatment is often administered on a purely clinical basis. Therapy should be in line with the national malaria programme of the host country but adapted to the epidemiological patterns in the affected population. This is best defined in the post-emergency phase, when epidemiological trends can be better assessed.

4 Health Care Services

Health care services standard 1: appropriate medical care

Emergency health care for disaster affected populations is based on an initial assessment and data from an ongoing health information system, and serves to reduce excess mortality and morbidity through appropriate medical care.

Key indicators

- Interventions are designed to be responsive to the identified major causes of excess death and disease.
- If possible, the local health authorities lead the health care effort and local health facilities are used and strengthened by participating humanitarian agencies. If this is not possible, an external agency leads the effort, works with existing facilities which may require substantial support and coordinates efforts of participating agencies.
- All participating humanitarian agencies agree to coordinate with the lead health care authority which is designated at the time of the initial assessment.
- The health care system is able to cope with a high level of demand.
- e The health care system is flexible enough to adapt to changes identified by the health information system.

Health care services standard 2: mortality reduction

Health care in emergencies follows primary health care (PHC) guidelines and targets health problems that cause excess mortality.

Key indicators

- Emergency health care interventions are implemented through the existing PHC system if available. The PHC system includes the following levels of care:
 - Family level.
 - Community level including community health workers and home visitors.
 - Peripheral health facilities (dispensary, health post or health clinic).
 - Central health facilities (health centre).
 - Referral hospital.
- Health care interventions are implemented at the appropriate level of the PHC system. Not every emergency will need all levels of care and the initial assessment can make this determination. If a local health care system does not exist, only those levels needed to prevent excess mortality and morbidity are introduced.
- Emergency health care, including treatment of injuries and disease, is provided to the population largely at community level. Some treatment occurs at health facilities and a smaller number of serious cases is sent to referral centres.
- Staffing at each level of the PHC system is appropriate to meet the needs of the population and only those levels required to reduce excess mortality and morbidity are used or introduced. Suggestions for staffing at each PHC level is provided in the guidance notes below.

- Health professionals from the disaster affected population are integrated into the health services as much as possible. Outreach workers are selected from the community and reflect the gender and cultural profile of the population as determined during the initial assessment.
- All health care providers agree on the common use of standardised procedures for diagnostic techniques and the treatment of the major priority diseases causing excess mortality and morbidity.
- The new Emergency Health Kits (1/10,000 population) are used to start the intervention but subsequent drug needs are ordered and follow the WHO recommended Essential Drug List.
- Unsolicited donations of drugs that do not follow guidelines for drug donations are not used and are disposed of safely.
- Universal precautions to prevent and limit spread of infections are taught and practised.
- Suitable transportation is organised for patients to reach the referral facilities.

Guidance notes and critical issues

1. Emergency health care is available to the disaster affected population and, if displaced persons are involved, to the host population. The geography, ethnicity, language and gender characteristics of the affected area need to be considered when implementing interventions.
2. Services provided at the different levels of the PHC system usually include the following:

Family level: some preventive and curative care is provided by the family itself, nearby relatives or by community health workers such as taking medications, administration of oral rehydration therapy (ORT).

Community level: data collection; ORT, compliance with treatments, home visits and case detection; referral of patients to facilities; health promotion/education, information.

Peripheral level: first level outpatient services; ORT; dressing; referral of patients to higher level; data collection; vaccinations.

Central health facility level: diagnoses; outpatient department (first level and referral); dressing and injections; ORT; emergency service; uncomplicated deliveries, minimum reproductive health activities; minor surgery; pharmacy; health surveillance; basic hospitalisation; referral to hospital; possibly: laboratory, transfusions; ongoing measles immunisations.

Referral hospital level: surgery; major obstetric emergencies; referral laboratory.

3. Staffing at each level of a PHC system can vary but the following are general guidelines taken from *Médecins Sans Frontières, Refugee Health, An Approach to Emergency Situations*:

Community level:

1 home visitor for 500-1,000 population.

1 supervisor for 10 home visitors.

1 senior supervisor.

Peripheral health facility level: (for approximately 10,000 population)

Total of 2 to 5 workers with a minimum of 1 qualified health worker based on 1 person for 50 consultations per day.

Locally trained person for ORT, dressing, registering etc.

Central health facility level: (for approximately 50,000 population)

1 doctor for diagnoses, 1 health worker for 50 consultations per day; 1 health worker for 20-30 beds (8 hour shifts); 1 ORT; 1 to 2 for pharmacy; 1 to 2 for dressing/injection/sterilisation.

Non-medical staff: 1 to 2 clerks; 1 to 3 guards (8 hour shifts); cleaners.

Referral hospital level:

Variable: at least 1 doctor; 1 nurse for 20-30 beds (8 hour shifts).

4. Throughout the emergency and thereafter, humanitarian agencies should aim to strengthen local health services rather than to create separate services.

5 Human Resource Capacity and Training

All aspects of humanitarian assistance rely on the skills, knowledge and commitment of staff and volunteers working in difficult and often insecure conditions. The demands placed on them can be considerable, and if they are to conduct their work to a level where minimum standards are assured it is essential that they are suitably experienced and trained and that they are adequately managed and supported by their agency.

Capacity standard 1: competence

Health interventions are implemented by staff who have appropriate qualifications and experience for the duties involved, and who are adequately managed and supported.

Key indicators

- All staff working on a health intervention are informed of the purpose and method of the activities they are asked to carry out.
- Staff with technical and management responsibilities have access to support for informing and verifying key decisions.
- The initial assessment, the design of interventions and key technical decision making are carried out by staff with relevant technical qualifications (epidemiology, water, sanitation, food, nutrition, shelter, health care expertise) and previous emergency experience.

- Staff and volunteers involved in surveillance (as part of assessment, monitoring or review processes) are thoroughly briefed and quickly checked by an experienced person before starting the work.
- Staff responsible for communicable disease control and for health care interventions in the affected population have previous experience or training and are regularly supervised in the use of recommended treatment protocols, guidelines and procedures.
- Introduction of any new medical supplies or equipment is accompanied by thorough explanation and supervision.
- Vaccination programme staff have the demonstrated ability to implement the programme including advising people about the vaccine, side effects and other relevant messages.
- Targeted health care procedures have clear written guidelines and protocols.
- The treatment of severe disease or injury is supervised by a medically qualified, experienced practitioner with specific training in this area.
- Health, nutrition and/or outreach workers who have contact with moderately malnourished individuals or their carers (at home, in feeding centres, in clinics etc) have the demonstrated ability to provide appropriate advice and support.
- Health staff have the demonstrated ability to advise mothers and carers on appropriate infant and young child feeding and other priority practices.

Capacity standard 2: support

Members of the disaster affected population receive support to enable them to adjust to their new environment and to make optimal use of the assistance provided to them.

Key indicators

- Carers are informed about priority prevention activities such as need for vaccination, use of soap, bednets, latrines and good health seeking behaviours.
- All members of the emergency affected population are informed about the availability of community health workers, home visitors and the location of health facilities and services.

Capacity standard 3: local capacity

Local capacity and skills are used and enhanced by emergency health interventions.

Key indicators

- Local health professionals, health workers, leaders and other members of the disaster affected population are included in the implementation of health interventions.
- Selection criteria for international staff recruitment includes a commitment to strengthen the capacities of local health systems for long term benefit.
- The skills base within existing local partners and institutions is tapped and strengthened during the course of the humanitarian assistance programme.

Guidance notes

1. See the *People in Aid Code of Best Practice in the Management and Support of Aid Personnel* which is appended in this binder.
2. See also Nutrition, Human Resource Capacity and Training standard 1, in chapter 3.
3. When programmes are designed, human resource capacity issues must be addressed. Volunteers and staff should demonstrate capabilities equal to their respective assignments; specific training in the relevant areas of expertise must be a prerequisite for engagement of staff. The provision of training and support as a part of emergency preparedness is important to ensure that skilled personnel are available to deliver quality services. Given that emergency preparedness cannot be assured in many countries, humanitarian agencies should ensure that qualified and competent staff are identified and properly prepared before eventual assignment to an emergency situation.

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Appendix 7: Sample Water, Sanitation and Environment Forms

Appendix 1

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Appendix 2

Sample Checklist for Initial Health Assessment

(Adapted from CDC (1992), *Famine-Affected, Refugee, and Displaced Populations: Recommendations for Public Health Issues*. MMWR (RR-13), July.)

Preparation

- Obtain available information on the disaster affected population and resources from host country ministries and organisations.
- Obtain available maps or aerial photographs.
- Obtain demographic and health data from international organisations.

Field Assessment

- Determine the total disaster affected population and proportion of children <5 years old.
- Determine the age and sex breakdown of population.
- Identify groups at increased risk.
- Determine the average household size and estimates of female heads of households.

Health Information

- Identify primary health problems in country of origin if refugees are involved.
- Identify primary health problems in the disaster affected area if no refugees are involved.
- Identify previous sources of health care.
- Ascertain important health beliefs and traditions.

- Determine the existing social structure and the psycho-social dimensions of the situation.
- Determine the strengths and coverage of local public health programmes in people's country of origin.

Nutritional Status

- Determine the prevalence of protein-energy malnutrition (PEM) in population <5 years of age.
- Ascertain prior nutritional status.
- Determine the prevalence of micronutrient deficiencies in the population <5 years of age.

Mortality Rates

- Calculate the overall mortality rate (crude mortality rate – CRM).
- Calculate the under-5 mortality rate (age specific mortality rate for children under five years old).
- Calculate cause specific mortality rates.

Morbidity

- Determine age and sex specific incidence rates of major health problems and diseases that have public health importance.

Environmental conditions

- Determine climatic conditions; identify geographic features; ascertain local disease epidemiology; assess access to affected population; assess the level of insecurity and violence.
- Assess local, regional and national food supplies (quantity, quality, types), distribution systems, coordination and services of existing organisations, logistics of food transport and storage, feeding programmes and access to local supplies.
- Assess existing shelters and availability of local materials for shelter, access, amount of land and building sites, topography and

Appendix 3

Sample Weekly Surveillance Reporting Forms

(Actual forms should be established and based on findings and recommendations of the initial assessment)

Site: _____ Date: from _____ to _____

1. Disaster affected population

- A. Total population at the beginning of week: _____
- B. Births this week: _____ Deaths this week: _____
- C. Arrivals this week (if applicable): _____ Departures this week: _____
- D. Total population at the end of the week: _____
- E. Total population < 5 years of age: _____

2. Mortality

Number of deaths	0-4 years		5+ years		Total
	Males	Females	Males	Females	
Diarrhoeal disease					
Respiratory disease					
Malnutrition					
Measles					
Malaria					
Maternal factors					
Other/Unknown					
Total by Age and Sex					
Total < 5 years					

Average total mortality rate: M_____ F_____ Total _____
 (Deaths/10,000 total population day averaged for week) by age + sex

Average under-five mortality rate: M_____ F_____ Total _____
 (Deaths/10,000 under-fives/day averaged for week)

3. Morbidity

Primary symptoms/ diagnosis	0-4 years		5+ years		Total
	Males	Females	Males	Females	
Diarrhoea/dehydration					
Fever with cough					
Fever and chills/malaria					
Measles					
Trauma/accident					
Suspected meningitis					
Suspected cholera					
Other/Unknown					
Total					

4. Comments

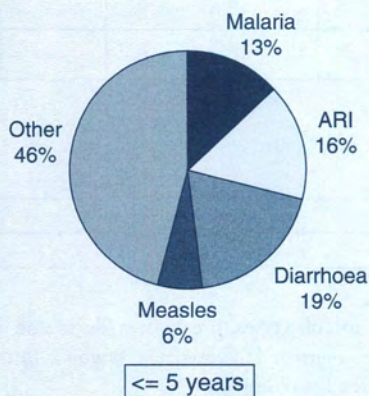
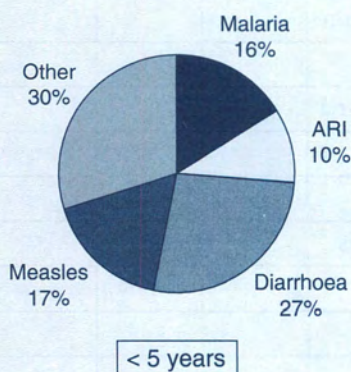
(It may not be possible to collect sex breakdown during an initial assessment. The columns for sex may be omitted. However, the ongoing health information system should be able to collect sex breakdown).

(Please note that these forms may include age specific morbidity and mortality for use by the health information system. The following age groups should be used: <1, 1-4, 5-14, 15-44, 45+).

Appendix 4

Example of Mortality Dataset Presentation

Proportional mortality among Mozambican refugees in Malawi, 1987-89



Source: MSF (1997), *Refugee Health, An Approach to Emergency Situations*. Macmillan. London.

Appendix 5

Sample Measles Vaccination Form

Place:

Reported by:

From:/...../.....
day/month/year

To:/...../.....
day/month/year

• Mass measles vaccination campaign

Yes ☐

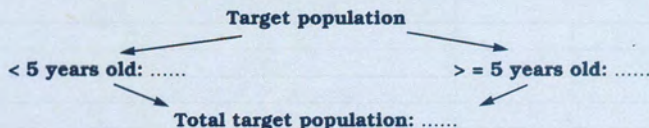
No ☐

• Routine measles vaccination in health facilities

Yes ☐

No ☐

• Measles vaccination coverage



No. vaccinated	Mass campaign A		Routine vaccination B		Cumulative measles vaccination coverage*
	No. this week	Cumulative No.	No. this week	Cumulative No.	
< 5 years old					
> = 5 years old					
TOTAL					

* Calculation of the cumulative coverage: A + B/target population

Comments:

N.B.: This form can also be used for another mass vaccination campaign; just change the name.

Source: MSF (1997), *Refugee Health, An Approach to Emergency Situations*. Macmillan. London.

Appendix 6a

Sample Nutrition Forms

(Please note: these forms should be adapted to the particular situation and follow the initial assessment recommendations.)

Place: **Reported by:**

From:/...../..... **To:**/...../.....
day/month /year day/month /year

• General food distribution

Any food distribution during the week: Yes ☐ No ☐

Amount in Kcal /person /day that the organization in charge of the distribution is said to have distributed:

If a food basket monitoring has been carried out, fill the table below.

Food	Quantity/pers.	Number of days between previous and actual distribution	Quantity/pers./day	Kcal/pers./day
Total				

Comments:
.....
.....

• Feeding centre structures and characteristics

Structures	No. of centers	No. of child. end of week	No. of meals/day	Kcal/p/d
TFC				
SFC wet				
SFC dry				
Blanket				

Comments:
.....
.....

Source: MSF (1997), *Refugee Health, An Approach to Emergency Situations*. Macmillan. London.

Appendix 6b

Nutrition Forms

(Please note: these forms should be adapted to the particular situation and follow the initial assessment recommendations.)

Place:

Reported by:

From:/...../.....
day/month/year

To:/...../.....
day/month/year

1. Therapeutic feeding

	< 70% W/H or < 110mm MUAC	Oedema	> 70% W/H	> 110cm or > 5 years	TOTAL
TOTAL END OF PREVIOUS WEEK					
New admissions					
Readmissions					
TOTAL ADMISSIONS					
Cured					
Dead					
Defaulters					
Transferred					
TOTAL EXITS					
TOTAL END OF THIS WEEK					

2. Supplementary feeding

	< 80% W/H or < 110mm MUAC	Oedema	> 80% W/H	> 110cm or > 5 years	TOTAL
TOTAL END OF PREVIOUS WEEK					
New admissions					
Readmissions					
TOTAL ADMISSIONS					
Cured					
Dead					
Defaulters					
Transferred					
TOTAL EXITS					
TOTAL END OF THIS WEEK					

Comments:
.....

Source: MSF (1997), *Refugee Health, An Approach to Emergency Situations*. Macmillan. London.

Appendix 6c

Nutrition Forms

(Please note: these forms should be adapted to the particular situation and follow the initial assessment recommendations.)

Place:

Reported by:

From:/...../.....
day/month/year

To:/...../.....
day/month/year

EXITS	THERAPEUTIC		SUPPLEMENTARY	
	Number	%	Number	%
Cured				
Defaulters				
Dead				
Transferred				
Total exits		100%		100%
* Average length of stay (in days)				
* Weight gain in g/kg/day				

* These indicators are calculated on the cured exits only

Comments:
.....
.....
.....
.....
.....

Source: MSF (1997), *Refugee Health, An Approach to Emergency Situations*. Macmillan. London.

Appendix 7

Sample Water, Sanitation and Environment Forms

(Please note: these forms should be adapted to the particular situation and follow the initial assessment recommendations.)

Place: ,.....

Reported by:

From:/...../.....
day/month/year

To:/...../.....
day/month/year

• Water

	No. of litres/day	Population	No. of litres/pers/day	Objective
Water supply				15 litres/p/day

	No. of water points	Population	No. of pers./water point	Objective
Water supply				200 pers./water point

• Sanitation

	No. of latrines	Population	No. of persons /latrine	Objective
Latrines				20 persons/latrine

• Crowding (space/person)

	Surface area in m ²	Population	M ² per person	Objective
Crowding				30m ² /person

Comments:

Source: MSF (1997), *Refugee Health, An Approach to Emergency Situations*. Macmillan. London.





The Sphere Project

Humanitarian Charter
and Minimum Standards
in Disaster Response



Acknowledgements

Chapter 7



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 Helen Awan, Overseas Development Institute, UK ♦ Tom Baker,
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 Bayarmaa, IFRC ♦ Dana Beegun, InterAction, USA ♦ Claude Belleau,
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 Women and Children, USA ♦ Jon Bennet, Norwegian Refugee Council
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Norway ◇ SMSF, Zaire ◇ Water and Sewage Corporation, Ghana

Sphere Participating Agencies

Steering Committee for Humanitarian Response members:

CARE International (CARE Australia, CARE Austria, CARE Canada, CARE Denmark, CARE France, CARE Germany, CARE Italy, CARE Japan, CARE Norway, CARE UK, CARE USA) ◇ Caritas Internationalis ◇ International Federation of Red Cross and Red Crescent Societies ◇ International Save the Children Alliance ◇ Médecins Sans Frontières International (MSF Belgium, MSF France, MSF Holland, MSF Spain, MSF UK, MSF USA) ◇ Oxfam ◇ The Lutheran World Federation (ACT) ◇ Save the Children Alliance ◇ World Council of Churches (ACT)

InterAction members:

Action Against Hunger ◇ Adventist Development and Relief Agency International ◇ African Medical and Research Foundation ◇ Africare ◇ Aga Khan Foundation USA ◇ American Friends Service Committee ◇ American Jewish Joint Distribution Committee, Inc ◇ American Jewish World Service ◇ American Near East Refugee Aid ◇ American Red Cross, International Services Department ◇ American Refugee Committee ◇ Ananda Marga Universal Relief Team ◇ Baptist World Alliance ◇ CARE ◇ Catholic Medical Mission Board, Inc ◇ Catholic Relief Services - USCC ◇ Child Health Foundation ◇ Children's Survival Fund, Inc ◇ Christian Children's Fund ◇ Christian Reformed World Relief Committee ◇ Church World Service, Inc (ACT) ◇ Council of Jewish Federations ◇ Counterpart International, Inc ◇ Direct Relief International ◇ Doctors of the World ◇ Doctors Without Borders USA/MSF-USA ◇ Episcopal Church of the USA, Presiding Bishop's Fund for World Relief ◇ Food for the Hungry International ◇ Friends of Liberia ◇ Grassroots International ◇ Interchurch Medical Assistance, Inc ◇ International Aid, Inc ◇ International Executive Service Corps ◇ International Medical Corps ◇ International Orthodox Christian Charities (ACT) ◇ International Rescue Committee ◇ Islamic African Relief Agency USA ◇ Latter-day Saint Charities ◇ Lutheran World Relief (ACT) ◇ MAP International ◇ Mercy Corps International ◇

National Peace Corps Association ◇ OIC International ◇ Operation USA ◇ Oxfam America ◇ Planning Assistance ◇ Points of Light Foundation ◇ Refugees International ◇ Relief International ◇ Salvation Army World Service Office ◇ Save the Children ◇ Service and Development Agency, Inc ◇ SHARE Foundation: Building a New El Salvador Today ◇ Solar Cookers International ◇ Unitarian Universalist Service Committee ◇ United Israel Appeal ◇ United Methodist Committee on Relief (ACT) ◇ US Committee for Refugees ◇ US Committee for UNICEF ◇ Volunteers in Technical Assistance ◇ World Relief Corporation ◇ World Vision Relief and Development

International Committee of the Red Cross

VOICE members:

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Mundi ♦ Zoa Refugee Care ♦ Norwegian People's Aid ♦ Assistencia Medica Internacional ♦ Caritas Spain ♦ Medicus Mundi Navarra ♦ Movimiento por la Paz el Desarme y La Libertad ♦ Caritas Sweden ♦ Lutherhjälpen Church Of Sweden Aid (ACT) ♦ PMU Interlife ♦ Star of Hope International ♦ The Lutheran World Federation (ACT) ♦ ActionAid ♦ Catholic Fund for Overseas Development ♦ Christian Aid UK (ACT) ♦ Concern Universal ♦ Health Unlimited ♦ HelpAge International UK ♦ Merlin ♦ Oxfam GB ♦ Save the Children Fund UK ♦ Tear Fund UK ♦ World Vision UK

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Refugee Council ♦ Diakonia (ACT) ♦ EMO-BARAKA, Union Pour la Promotion du Paysan ♦ Encuentro de Entidades no Gubernamentales para el Desarrollo ♦ Episcopal Church Center of the USA ♦ Equilibre Suisse ♦ European Association of Non Governmental Organisations for Food Aid and Emergency Aid ♦ Federacion de Organismos no Gubernamentales de Nicaragua ♦ Feed the Children International ♦ Forum of African Voluntary Development Organizations ♦ Fundacion Augusto Cesar Sandino ♦ General Union of Voluntary Societies ♦ Gonoshahajjo Sangstha ♦ Handicap International ♦ Human Appeal International ♦ Indian Institute of Youth and Development ♦ Individuell Manniskohjelp ♦ InterAction ♦ Inter-Africa Group ♦ InterAid International ♦ International Catholic Migration Commission ♦ International Islamic Relief Organisation ♦ International Rescue Committee ♦ International Social Service ♦ Islamic Relief Agency ♦ Jesuit Refugee Service ♦ Lebanese NGO Forum ♦ LINK-NGO Forum ♦ Lutheran Immigration and Refugee Service ♦ The Lutheran World Federation (ACT) ♦ Mauritius Council of Social Service ♦ National NGO Council of Sri Lanka ♦ Netherlands Organisation for International Development Cooperation ♦ Non-Governmental Organisation Coordinating Committee ♦ Norwegian Refugee Council ♦ Organisation for Industrial Spiritual and Cultural Advancement-International ♦ PACS/PRIES/Instituto Politicas Alternativas para o Cone Sul ♦ Philippine Development NGOs for International Concerns ♦ Queen Alia Fund for Social Development ♦ Réseau Africain Pour le Developpement Intègre ♦ Rural Development Foundation of Pakistan ♦ Lanka Jathika Sarvodaya Shramadana Sangamaya Inc ♦ Secours Populaire Français ♦ Sudanese Women General Union ♦ Voluntary Health Association of India ♦ World Council of Churches (ACT) ♦ World University Service/Servicio Universitario Mundial ♦ World Vision International ♦ Yayasan Indonesia Sejahtera

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Code of Conduct

for

the International Red Cross and

Red Crescent Movement

and

Non-Governmental Organizations (NGOs)

in Disaster Relief

CODE OF CONDUCT

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**THE INTERNATIONAL RED CROSS AND
RED CRESCENT MOVEMENT**

and

NON-GOVERNMENTAL ORGANIZATIONS (NGOs)

in Disaster Relief

Sponsored by Caritas Internationalis, Catholic Relief Services, the International Federation of Red Cross and Red Crescent Societies, the International Save the Children Alliance, the Lutheran World Federation, Oxfam, and the World Council of Churches (members of the Steering Committee for Humanitarian Response), together with the International Committee of the Red Cross (ICRC).

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Purpose

This Code of Conduct seeks to guard our standards of behaviour. It is not about operational details, such as how one should calculate food rations or set up a refugee camp. Rather, it seeks to maintain the high standards of independence, effectiveness and impact to which disaster response NGOs and the International Red Cross and Red Crescent Movement aspires. It is a voluntary code, enforced by the will of organisations accepting it to maintain the standards laid down in the Code.

In the event of armed conflict, the present Code of Conduct will be interpreted and applied in conformity with international humanitarian law.

The Code of Conduct is presented first. Attached to it are three annexes, describing the working environment that we would like to see created by Host Governments, Donor Governments and Intergovernmental Organisations in order to facilitate the effective delivery of humanitarian assistance.

Definitions

NGOs: NGOs (Non-Governmental Organisations) refers here to organisations, both national and international, which are constituted separate from the government of the country in which they are founded.

NGHAs: For the purposes of this text, the term Non-Governmental Humanitarian Agencies (NGHAs) has been coined to encompass the components of the International Red Cross and Red Crescent Movement – the International Committee of the Red Cross, The International Federation of Red Cross and Red Crescent Societies and its member National Societies – and the NGOs as defined above. This code refers specifically to those NGHAs which are involved in disaster response.

IGOs: IGOs (Intergovernmental Organisations) refers to organisations constituted by two or more governments. It thus includes all United Nations agencies and regional organisations.

Disasters: A disaster is a calamitous event resulting in loss of life, great human suffering and distress, and large-scale material damage.

The Code of Conduct

Principles of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Response Programmes

1: *The humanitarian imperative comes first*

The right to receive humanitarian assistance, and to offer it, is a fundamental humanitarian principle which should be enjoyed by all citizens of all countries. As members of the international community, we recognise our obligation to provide humanitarian assistance wherever it is needed. Hence the need for unimpeded access to affected populations, which is of fundamental importance in exercising that responsibility.

The prime motivation of our response to disaster is to alleviate human suffering amongst those least able to withstand the stress caused by disaster.

When we give humanitarian aid it is not a partisan or political act and should not be viewed as such.

2: *Aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind. Aid priorities are calculated on the basis of need alone*

Wherever possible, we will base the provision of relief aid upon a thorough assessment of the needs of the disaster victims and the local capacities already in place to meet those needs.

Within the entirety of our programmes, we will reflect considerations of proportionality. Human suffering must be alleviated whenever it is found; life is as precious in one part of a country as another. Thus, our provision of aid will reflect the degree of suffering it seeks to alleviate.

In implementing this approach, we recognise the crucial role played by women in disaster-prone communities and will ensure that this role is supported, not diminished, by our aid programmes.

The implementation of such a universal, impartial and independent policy can only be effective if we and our partners have access to the necessary resources

to provide for such equitable relief, and have equal access to all disaster victims.

3: Aid will not be used to further a particular political or religious standpoint

Humanitarian aid will be given according to the need of individuals, families and communities. Notwithstanding the right of NGHAs to espouse particular political or religious opinions, we affirm that assistance will not be dependent on the adherence of the recipients to those opinions.

We will not tie the promise, delivery or distribution of assistance to the embracing or acceptance of a particular political or religious creed.

4: We shall endeavour not to act as instruments of government foreign policy

NGHAs are agencies which act independently from governments. We therefore formulate our own policies and implementation strategies and do not seek to implement the policy of any government, except in so far as it coincides with our own independent policy.

We will never knowingly – or through negligence – allow ourselves, or our employees, to be used to gather information of a political, military or economically sensitive nature for governments or other bodies that may serve purposes other than those which are strictly humanitarian, nor will we act as instruments of foreign policy of donor governments.

We will use the assistance we receive to respond to needs and this assistance should not be driven by the need to dispose of donor commodity surpluses, nor by the political interest of any particular donor.

We value and promote the voluntary giving of labour and finances by concerned individuals to support our work and recognise the independence of action promoted by such voluntary motivation. In order to protect our independence we will seek to avoid dependence upon a single funding source.

5: We shall respect culture and custom

We will endeavour to respect the culture, structures and customs of the communities and countries we are working in.

6: *We shall attempt to build disaster response on local capacities*

All people and communities – even in disaster – possess capacities as well as vulnerabilities. Where possible, we will strengthen these capacities by employing local staff, purchasing local materials and trading with local companies. Where possible, we will work through local NGHAs as partners in planning and implementation, and co-operate with local government structures where appropriate.

We will place a high priority on the proper co-ordination of our emergency responses. This is best done within the countries concerned by those most directly involved in the relief operations, and should include representatives of the relevant UN bodies.

7: *Ways shall be found to involve programme beneficiaries in the management of relief aid*

Disaster response assistance should never be imposed upon the beneficiaries. Effective relief and lasting rehabilitation can best be achieved where the intended beneficiaries are involved in the design, management and implementation of the assistance programme. We will strive to achieve full community participation in our relief and rehabilitation programmes.

8: *Relief aid must strive to reduce future vulnerabilities to disaster as well as meeting basic needs*

All relief actions affect the prospects for long-term development, either in a positive or a negative fashion. Recognising this, we will strive to implement relief programmes which actively reduce the beneficiaries' vulnerability to future disasters and help create sustainable lifestyles. We will pay particular attention to environmental concerns in the design and management of relief programmes. We will also endeavour to minimise the negative impact of humanitarian assistance, seeking to avoid long-term beneficiary dependence upon external aid.

9: We hold ourselves accountable to both those we seek to assist and those from whom we accept resources

We often act as an institutional link in the partnership between those who wish to assist and those who need assistance during disasters. We therefore hold ourselves accountable to both constituencies.

All our dealings with donors and beneficiaries shall reflect an attitude of openness and transparency.

We recognise the need to report on our activities, from both a financial perspective and the perspective of effectiveness.

We recognise the obligation to ensure appropriate monitoring of aid distributions and to carry out regular assessments of the impact of disaster assistance.

We will also seek to report, in an open fashion, upon the impact of our work, and the factors limiting or enhancing that impact.

Our programmes will be based upon high standards of professionalism and expertise in order to minimise the wasting of valuable resources.

10: In our information, publicity and advertising activities, we shall recognise disaster victims as dignified human beings, not objects of pity

Respect for the disaster victim as an equal partner in action should never be lost. In our public information we shall portray an objective image of the disaster situation where the capacities and aspirations of disaster victims are highlighted, and not just their vulnerabilities and fears.

While we will co-operate with the media in order to enhance public response, we will not allow external or internal demands for publicity to take precedence over the principle of maximising overall relief assistance.

We will avoid competing with other disaster response agencies for media coverage in situations where such coverage may be to the detriment of the service provided to the beneficiaries or to the security of our staff or the beneficiaries.

The Working Environment

Having agreed unilaterally to strive to abide by the Code laid out above, we present below some indicative guidelines which describe the working environment we would like to see created by donor governments, host governments and the intergovernmental organisations – principally the agencies of the United Nations – in order to facilitate the effective participation of NGHAs in disaster response.

These guidelines are presented for guidance. They are not legally binding, nor do we expect governments and IGOs to indicate their acceptance of the guidelines through the signature of any document, although this may be a goal to work towards in the future. They are presented in a spirit of openness and co-operation so that our partners will become aware of the ideal relationship we would seek with them.

Annex I: Recommendations to the governments of disaster-affected countries

1: Governments should recognise and respect the independent, humanitarian and impartial actions of NGHAs

NGHAs are independent bodies. This independence and impartiality should be respected by host governments.

2: Host governments should facilitate rapid access to disaster victims for NGHAs

If NGHAs are to act in full compliance with their humanitarian principles, they should be granted rapid and impartial access to disaster victims, for the purpose of delivering humanitarian assistance. It is the duty of the host government, as part of the exercising of sovereign responsibility, not to block such assistance, and to accept the impartial and apolitical action of NGHAs.

Host governments should facilitate the rapid entry of relief staff, particularly by waiving requirements for transit, entry and exit visas, or arranging for these to be rapidly granted.

Governments should grant over-flight permission and landing rights for aircraft transporting international relief supplies and personnel, for the duration of the emergency relief phase.

3: Governments should facilitate the timely flow of relief goods and information during disasters

Relief supplies and equipment are brought into a country solely for the purpose of alleviating human suffering, not for commercial benefit or gain. Such supplies should normally be allowed free and unrestricted passage and should not be subject to requirements for consular certificates of origin or invoices, import and/or export licences or other restrictions, or to import taxes, landing fees or port charges.

The temporary importation of necessary relief equipment, including vehicles, light aircraft and telecommunications equipment, should be facilitated by the receiving host government through the temporary waiving of licensing or

registration requirements. Equally, governments should not restrict the re-exportation of relief equipment at the end of a relief operation.

To facilitate disaster communications, host governments are encouraged to designate certain radio frequencies, which relief organisations may use in-country and for international communications for the purpose of disaster communications, and to make such frequencies known to the disaster response community prior to the disaster. They should authorise relief personnel to utilise all means of communication required for their relief operations.

4: Governments should seek to provide a co-ordinated disaster information and planning service

The overall planning and co-ordination of relief efforts is ultimately the responsibility of the host government. Planning and co-ordination can be greatly enhanced if NGHAs are provided with information on relief needs and government systems for planning and implementing relief efforts as well as information on potential security risks they may encounter. Governments are urged to provide such information to NGHAs.

To facilitate effective co-ordination and the efficient utilisation of relief efforts, host governments are urged to designate, prior to disaster, a single point of contact for incoming NGHAs to liaise with the national authorities.

5: Disaster relief in the event of armed conflict

In the event of armed conflict, relief actions are governed by the relevant provisions of international humanitarian law.

Annex II: Recommendations to donor governments

1: Donor governments should recognise and respect the independent, humanitarian and impartial actions of NGHAs

NGHAs are independent bodies whose independence and impartiality should be respected by donor governments. Donor governments should not use NGHAs to further any political or ideological aim.

2: Donor governments should provide funding with a guarantee of operational independence

NGHAs accept funding and material assistance from donor governments in the same spirit as they render it to disaster victims: a spirit of humanity and independence of action. The implementation of relief actions is ultimately the responsibility of the NGHAs and will be carried out according to the policies of that NGHAs.

3: Donor governments should use their good offices to assist NGHAs in obtaining access to disaster victims

Donor governments should recognise the importance of accepting a degree of responsibility for the security and freedom of access of NGHAs staff to disaster sites. They should be prepared to exercise diplomacy with host governments on such issues if necessary.

Annex III: Recommendations to intergovernmental organisations

1: IGOs should recognise NGHAs, local and foreign, as valuable partners

NGHAs are willing to work with UN and other intergovernmental agencies to effect better disaster response. They do so in a spirit of partnership which respects the integrity and independence of all partners. Intergovernmental agencies must respect the independence and impartiality of the NGHAs. NGHAs should be consulted by UN agencies in the preparation of relief plans.

2: IGOs should assist host governments in providing an overall co-ordinating framework for international and local disaster relief

NGHAs do not usually have the mandate to provide the overall co-ordinating framework for disasters which require an international response. This responsibility falls to the host government and the relevant United Nations authorities. They are urged to provide this service in a timely and effective manner to serve the affected State and the national and international disaster response community. In any case, NGHAs should make every effort to ensure the effective co-ordination of their own services.

3: IGOs should extend security protection provided for UN agencies to NGHAs

Where security services are provided for intergovernmental organisations, this service should be extended to their operational NGHAs partners on request.

4: IGOs should provide NGHAs with the same access to relevant information as is granted to UN agencies

IGOs are urged to share all information pertinent to the implementation of effective disaster response with their operational NGHAs partners.

Analysis of the Role of the State in the Development of the Environment

The role of the state in the development of the environment is a complex and multifaceted issue. It involves the interaction of various factors, including economic, social, and political, which shape the state's policies and actions in this domain.

One of the primary roles of the state is to establish a legal framework that governs environmental protection. This includes the enactment of laws and regulations that define the standards for environmental quality and the responsibilities of individuals and organizations. The state also plays a crucial role in monitoring and enforcing these standards, ensuring that they are effectively implemented.

In addition to establishing a legal framework, the state is also responsible for providing financial support for environmental protection. This can be done through various means, such as direct funding, subsidies, and the creation of environmental funds. The state's financial support is essential for the implementation of large-scale environmental projects and the maintenance of environmental infrastructure.

Furthermore, the state plays a significant role in promoting public awareness and participation in environmental protection. This involves the dissemination of information about environmental issues and the promotion of sustainable development. The state can also encourage the private sector to adopt environmentally friendly practices and technologies, thereby contributing to the overall goal of environmental protection.

In conclusion, the role of the state in the development of the environment is a multifaceted and complex one. It involves the establishment of a legal framework, the provision of financial support, and the promotion of public awareness and participation. The state's actions in this domain are crucial for the achievement of sustainable development and the protection of the environment for future generations.

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Registration form

Non-governmental organisations which would like to register their support for this Code and their willingness to incorporate its principles into their work should fill in the form below and return it to

**Disaster Policy Department,
International Federation of Red Cross
and Red Crescent Societies,
PO Box 372,
1211 Geneva 19
Switzerland.
Tel +41 (022) 7304222
Fax +41 (022) 7330395**

We would like to register our support for the Code of Conduct and will endeavour to incorporate its principles into our work.

Agency name	
Address	
Telephone	
Fax	
Signature	
Position in organisation	
Date	

1. The first of these is the fact that the system is not a simple one, but a complex one, involving many different factors and many different people.

2. The second is the fact that the system is not a static one, but a dynamic one, which is constantly changing and evolving.

3. The third is the fact that the system is not a closed one, but an open one, which is constantly interacting with the outside world.

4. The fourth is the fact that the system is not a perfect one, but an imperfect one, which is constantly subject to error and failure.

5. The fifth is the fact that the system is not a simple one, but a complex one, involving many different factors and many different people.

6. The sixth is the fact that the system is not a static one, but a dynamic one, which is constantly changing and evolving.

7. The seventh is the fact that the system is not a closed one, but an open one, which is constantly interacting with the outside world.

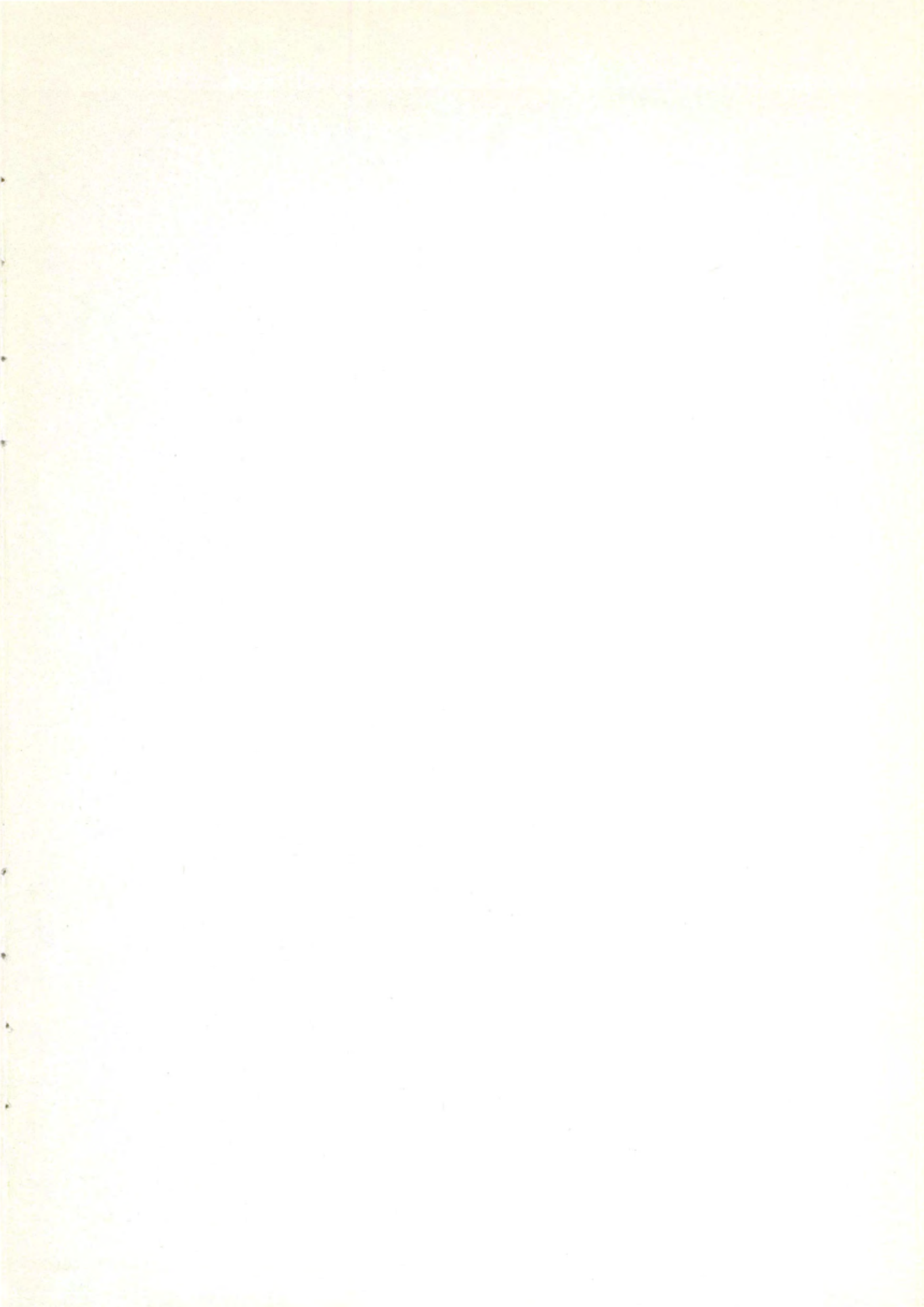
8. The eighth is the fact that the system is not a perfect one, but an imperfect one, which is constantly subject to error and failure.

9. The ninth is the fact that the system is not a simple one, but a complex one, involving many different factors and many different people.

10. The tenth is the fact that the system is not a static one, but a dynamic one, which is constantly changing and evolving.

11. The eleventh is the fact that the system is not a closed one, but an open one, which is constantly interacting with the outside world.

12. The twelfth is the fact that the system is not a perfect one, but an imperfect one, which is constantly subject to error and failure.





*Code of best practice
in the management and
support of aid personnel*



Sara Davidson
with

Action Health
British Red Cross
International Health Exchange
Medical Foundation
Overseas Development Administration (DFID)
Oxfam
RedR
Relief and Rehabilitation Network, ODI
Returned Volunteer Action
Save the Children
Tear Fund

ACKNOWLEDGEMENTS

I wish to thank all members of the People in Aid project steering group for their contribution and commitment to the Code of Best Practice, including the Overseas Development Administration, which provided funding, and the British Red Cross, which found us office space.

I would also like to thank the many people working in the international aid community and in the fields of management, education and industrial relations who have so generously lent information, knowledge, wisdom and encouragement to the People in Aid initiative.

Finally, my thanks must go to Isobel McConnan and her colleagues at International Health Exchange for many kindnesses, and an attention to management and support which sometimes made me wonder if our project was really necessary.

Sara Davidson
Inter-Agency Co-ordinator

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DEFINITIONS

Aid agency	An 'aid agency' or 'agency', as used throughout this document, is an entity in the public or voluntary sectors whose primary activity is the transfer of expertise or human, financial or material resources for charitable or humanitarian purposes to middle- and low-income countries, and to countries affected by war, civil strife or disaster.
Field staff	'Field staff' are staff who normally work in a location to which aid agency resources are directed. Unless otherwise indicated, the term is used without distinction to refer to host country and expatriate staff, volunteer, salaried and contract staff, and to managers and other groups of workers.
Expatriate	'Expatriate field staff' or 'expatriate' here refers to staff who work in field projects located outside the country in which they have nationality or in which they are normally resident. Unless otherwise indicated, the term is used without distinction to refer both to nationals of the country where the agency has its headquarters and to nationals of third countries.
Host country	'Host country' refers to staff who are nationals of, or normally resident in, the country to which aid agency resources are directed. Unless otherwise indicated, the text makes no distinction between volunteer and salaried staff, nor between managers and other groups of workers.

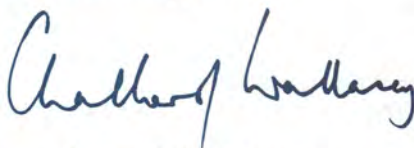
Preface

The People in Aid Code is an important contribution by British aid agencies to the international debate on standards in humanitarian assistance and long-term development.

The organisations that undertook this task include relief and development agencies large and small. In compiling the Code, People in Aid have drawn on the experience and expertise of agencies that are household names, as well as those whose profile is lower but whose contribution to the British development programme is no less important.

Development agency field staff confront unique challenges in their day to day work. Recognising this, the People in Aid Code represents a three-fold commitment: to the quality and effectiveness of aid, to the effective management of aid personnel, and to the protection and well being of those who work under circumstances that are frequently difficult, dangerous and sometimes life-threatening.

By addressing these issues, the Code also represents a unique challenge to the aid community. It is a challenge we at the Overseas Development Administration take seriously. We are glad to be involved in this initiative: we welcome the Code and give it our support.



Baroness Chalker of Wallasey

(Minister of State for Foreign and Commonwealth Affairs
and Minister for Overseas Development 1989-1997)

Introduction

If all the articles, essays and books ever written about international humanitarian relief and development were a library of a thousand volumes, it is doubtful that the people who work for aid agencies would take up much more than one chapter of one volume.

This is surprising because the objectives and values of aid are, after all, to do with people. These values focus on human welfare and development: on ways to prevent and alleviate suffering, discrimination, and the infringement of human rights. And, whatever else it is, aid is a labour-intensive occupation.

Like other organisations, aid agencies have seen many changes in recent years. Like other employers, they have had to adapt to a world of financial uncertainty, technological transformation and political - and historical - change.

But aid agencies are also unlike other organisations. They have a mandate to send their staff, national or international, salaried staff or volunteers, to work in parts of the world where global and regional change have threatened security and development; where the boundary between war and peace has grown harder to distinguish; and where the scale and complexity of emergencies have drastically increased.

First and foremost, this change means greater vulnerability for the people of those regions. Secondly, it puts increasing demands on their resourcefulness and that of the staff of local

agencies and institutions. Though they are less often in the front line, aid agency field staff are not immune to these risks and pressures.

Global and regional change have also altered the balance between relief and development in aid budgets and changed the way international aid agencies and donors view the way they work, individually and collectively. Whether or not they are working effectively has been the question underpinning recent international evaluations of relief work in Rwanda and Sudan.

The Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief, drawn up by the Geneva-based Steering Committee for Humanitarian Response (SCHR), was one of the first attempts by relief agencies to agree a common frame of policy reference. The InterAction NGO Field Cooperation Protocol, drawn up by aid agencies in the USA, formalised the sharing of operational information by NGOs working in the same country or region. At the time of writing, SCHR and InterAction are planning a 'Beneficiaries' Charter' which will set minimum entitlements to shelter, food, health care and other necessities for those affected by disaster.

The People in Aid project began in 1994, when four British aid organisations, with funding from the Overseas Development Administration, commissioned a survey into the working experience of expatriate field staff and managers working for British- and Irish-based agen-

cies. Rebecca Macnair's findings, backed by anecdotal evidence from agency managers and staff, put the case for a professional standard on field staff management to match their employers' commitment to common policies in other areas.

Room For Improvement (Macnair R. 1995, Network Paper 10, Relief and Rehabilitation Network) concluded that for many expatriate field staff, occupational stress was not only a product of the danger and emotional impact of their work but that, in common with those working in other spheres, it was also caused by workload, management problems and the insecurity of short-term contracts. The report underlined the need for agencies to ensure that their philosophy of humane action and human welfare embraces the employees to whom they owe a duty of care, as well as the project beneficiaries they are mandated to serve.

In response to the recommendations of Room For Improvement, a group of eleven organisations began work in 1996 on the Code Of Best Practice In The Management And Support Of Aid Personnel.

The group reviewed human resource management practice both inside and outside the aid sector and presented a draft Statement of Principles at People in Aid's Workshop, Putting People First, held in July 1996. Representatives of over 50 international aid agencies gave the

Statement of Principles broad support. They were adamant that the Code should clearly refer to all staff, including volunteer and contract staff, who work in relief and development field programmes, whatever their country of origin.

The People in Aid Code complements those of SCHR and InterAction but is different in three ways. Firstly, it is intended for use by development as well as relief agencies. Secondly, it includes indicators against which achievement in implementing the Code can be measured by internal and external evaluators. Thirdly, the Code will undergo testing by a number of agencies over a period of up to three years and its effectiveness will be evaluated.

The discussion that follows each of the seven Principles includes a brief case study drawn from current practice by British- and Irish-based agencies. The case studies are used to exemplify indicators and share experience rather than to prescribe a specific course of action for other agencies. Nevertheless, each case demonstrates that best practice in the management and support of aid personnel is achievable: that the process has, in fact, already begun.

We hope the Code will focus fresh attention on human resource issues, and that the question of people who work in aid programmes will now occupy a position deservedly high on the agenda of future debates.

Sara Davidson

PEOPLE IN AID

Statement of Principles

Principle 1:

The people who work for us are integral to our effectiveness and success

Our approach to the people in our organisation is a fundamental part of our work. We recognise that the effectiveness and success of our organisation depend on all the people who work for us. Human resource issues are integral to our strategic plans.

Principle 2:

Our human resource policies aim for best practice

We recognise that our human resource policies should aim constantly for best practice. We do not aim to respond solely to minimum legal, professional or donor requirements.

Principle 3:

Our human resource policies aim to be effective, efficient, fair and transparent

We recognise that our policies must enable us to achieve both effectiveness in our work and good quality of working life for our staff. Our human resource policies therefore aim to be effective, efficient, fair and transparent and to promote equality of opportunity.

Principle 4:

We consult our field staff when we develop human resource policy

We recognise that we must implement, monitor and continuously develop our human resource policies in consultation with the people who work for us. We aim to include field personnel in this process, whether they are full-time, part-time, temporary, short-term or long-term members of our staff.

Principle 5:

Plans and budgets reflect our responsibilities towards our field staff

We recognise that the effectiveness and success of our field operations depend on the contribution of all the salaried, contract or volunteer staff involved in them. Operational plans and budgets aim to reflect fully our responsibilities for staff management, support, development, security and well-being.

Principle 6:

We provide appropriate training and support

We recognise that we must provide relevant training and support to help staff work effectively and professionally. We aim to give them appropriate personal and professional support and development before, during and after their field assignments.

Principle 7:

We take all reasonable steps to ensure staff security and well-being

We recognise that the work of relief and development agencies often places great demands on staff in conditions of complexity and risk. We take all reasonable steps to ensure the security and well-being of staff and their families.

Principle 1:

The people who work for us are integral to our effectiveness and success

Our approach to the people in our organisation is a fundamental part of our work. We recognise that the effectiveness and success of our organisation depend on all the people who work for us.

Human resource issues are integral to our strategic plans.

KEY INDICATORS

- The Chief Executive or Chair has made a written and public commitment to the People in Aid Code of Best Practice.
- The agency's corporate strategy or business plan explicitly values field staff for their contribution to corporate as well as project objectives.
- The agency allocates resources to enable its managers to meet staff support, training and development needs.
- The agency assigns responsibility and appropriate authority for implementing the People in Aid Code to a named project manager.
- The agency informs field staff and their line managers that the agency is committed to the People in Aid Code and supports this initiative.

WHY IS THIS IMPORTANT?

Field staff need to know that the agencies employing them value people for more than their immediate usefulness to projects. Host governments, partner organisations and the wider aid community need to know that the agencies they work with demonstrate professionalism in all their activities. Donors need to know that their funds are committed to agencies that know how to manage all their resources, including human ones, effectively.

The People in Aid Code is about more than making field staff better at their jobs or happier about their role. It is also about corporate effectiveness and ensuring the key contribution field staff make is valued. An agency may need to re-examine corporate thinking about field staff when it implements the Code. That is why real support and commitment at the highest level in the agency are crucial.

Most agencies have a written corporate strategy or business plan. The Code should be a part of that strategy and of agency budgets, plans and discussions. The decision to endorse the Code should be in writing if it is to become part of institutional thinking and corporate memory. Once endorsed, the Code needs to be common knowledge and a shared commitment by decision makers and managers within the agency. Without this commitment, it will be difficult to carry through the implementation process.

Commitment to the Code and its implementation must be sustainable: this will call for allocation of people, time and money - probably in that order. If responsibility for implementing the Code is delegated to a member of staff, some or all of his or her current work may have to be reassigned. The project manager must have the time and status needed to put principles into practice. He or she should in turn report to a senior manager within the organisation.

People, programmes and strategic change at PLAN International

The development agency, PLAN International, began to change its approach to field staff management in 1996. It started to look at competencies - the attributes as well as the technical skills - that help make field staff successful.

PLAN had recognised that many of its senior field staff needed additional support when the agency moved from supporting solely micro-projects to a nationally focused programme for each of the countries in which it worked. This meant major structural change, establishment of higher-profile field offices in capital cities, and local as well as international fundraising. PLAN saw attention to its people and the competency approach as key factors in helping manage transition to the new structure.

Introducing this new approach took careful planning and allocation of resources, staff and budget. With the backing of its Senior Management Group, PLAN appointed a dedicated project manager, a respected country programme director with several years' field experience, to work with its human resource management (HRM) team.

The team interviewed and involved senior managers and country directors in deciding what attributes were key for effective field staff and programmes. In this way, valuable experience was shared and the process of change involved the people who would implement and be affected by it.

Though it is early days, PLAN expects competencies to become an important element of field staff recruitment and career development. The process of developing and introducing core competencies has, at times, proved frustrating. Nevertheless, the agency hopes that this approach, together with other support to staff through a period of change, will result in better prepared and committed senior field staff and more effective programmes that support children in Asia, Africa and Latin America.

Principle 2:

Our human resource policies aim for best practice

We recognise that our human resource policies should aim constantly for best practice. We do not aim to respond solely to minimum legal, professional or donor requirements.

KEY INDICATORS

- The agency sets out in writing the policies that relate to field staff employment.
- Policies comply with best practice if field staff are, in practical terms, outside the scope of legal provision.
- Policies respond to best practice initiatives in the aid sector and to changes in working and legal environments.
- The agency familiarises field staff with policies that affect them at the start of assignments and when significant changes take place.

WHY IS THIS IMPORTANT?

Documenting policies on field staff management and support helps ensure staff and agency know what to expect from each other. This is important if staff are appointed in one country or region yet normally work elsewhere. It is also important if groups of staff within the same agency have different rights and expectations.

That may be the case where expatriate, host and third country nationals work together.

Agencies and their field staff need to know which national law applies and what that means in practice. For example, UK health & safety laws do not normally protect agency staff who work in hazardous conditions outside the UK. So what action should be taken, reports made or records

kept if field staff are injured at work? Can staff on temporary or volunteer contracts expect local employment laws to protect them? Is it possible or desirable to rely on local law in regions at war?

If, for all practical purposes, some field staff are left outside the scope of legislation relating to employment, agencies should aim to comply with best practice by similar agencies and inform their staff accordingly.

Policies relating to field staff might include health and safety, including malaria protection, immunisation and first aid; security; smoking; alcohol and drug abuse; HIV/AIDS; maternity leave; family care; equal pay and opportuni-

ties; insurance; pensions; training; harassment; personal use of project vehicles.

The list may look lengthy but most agencies will have related policies in use at head office. Consultation with field staff or their representatives may enable the agency to formulate policies appropriate to field needs.

Finally, donor expectations may make it difficult for aid agencies to spend time and money on themselves and their staff. But endorsing best practice initiatives means making a commitment to effectiveness and quality in aid. Investing in people is part of that commitment. People who do things well save time and money too.

International employment issues: aiming for best practice at CARE

CARE International is a confederation of nine northern NGOs with offices in Europe, North America and Australia. It has field programmes in 65 countries. Its workforce includes salaried staff, volunteers recruited on its behalf by other agencies, interns or *stagiaires* gaining work experience, and consultants.

Most of its 10,000 field staff are recruited locally in Africa, Asia, Latin America and Central and Eastern Europe. As a signatory to the InterAction NGO Field Cooperation Protocol, CARE ensures host country staff terms and conditions are compatible with those of other humanitarian organisations. Terms, conditions and human resource policy are normally contained in a staff handbook.

CARE's International Personnel Policy governs terms and conditions for staff working outside their own country. For expatriate salaried staff working in field programmes, the starting point is the employment contract used by CARE USA. This is adapted to comply with employment law in the country of recruitment while aiming to ensure CARE benefits for this group are similar.

These include insurance for disability, loss of life, work in war zones, medical and dental treatment, travel and personal effects. The agency calculates employer's national insurance at statutory US rates, and CARE USA also contributes towards a pension plan. At the end of their contracts, non-US citizens can either claim a cheque for these savings or continue to maintain contributions in the US.

As CARE grows, expatriates may increasingly be offered contracts based on UK, Canadian or Australian law. The agency's International Staff Working Group keeps personnel policy, terms and conditions under review, and acts as an appeals tribunal if there is disagreement on international personnel matters. Expatriate field staff participate in this forum through membership of the Care Overseas Association. The Association is financed by members' subscriptions, and elects its own representatives to negotiate with management.

Principle 3:

Our human resource policies aim to be effective, efficient, fair and transparent

We recognise that our policies must enable us to achieve both effectiveness in our work and good quality of working life for our staff. Our human resource policies therefore aim to be effective, efficient, fair and transparent, and to promote equality of opportunity.

KEY INDICATORS

- New programme and field managers are recruited in part for their people management skills. New and existing managers receive training in recruitment, staff appraisal and equal opportunities.
- Field staff have clear work objectives and performance standards, know whom they report to and what management support the agency will give them.
- The agency monitors how well recruitment and people management meet:
 - corporate and programme aims
 - field staff expectations of fairness and transparency
 - equal opportunities targets.

WHY IS THIS IMPORTANT?

It is said that projects in any sphere often fail to reach their optimum level of performance not because of any lack of money, equipment or systems but because human factors have not been adequately addressed.

People management skills are not always a priority when programme managers are recruited. However, programme managers, not personnel managers, often decide field appointments and develop, support and manage teams. If field staff are to be effective, they need to know what their job is, what performance standards are expected, to whom they report, and what support, guidance and feedback they can expect. Recruitment and management should be transparent and fair.

They should offer equality of opportunity and respect the human rights and dignity of field staff.

Existing agency systems do not necessarily need mending but whatever procedures are in use, they need to demonstrate how well they get the right people to the right place at the right time. They also need to make sure those people are content to stay with the agency. Failure to complete a contract can be damaging for all parties concerned, resulting in extra costs and loss of effectiveness and reputation for the agency, and in distress, loss of income and reduced job prospects for the former employee. Monitoring progress against objectives will demonstrate what really works and where changes need to be made.

Volunteers and salaried staff: recruiting international personnel at Concern

Whether field staff are recruited on volunteer or salaried terms, their calibre and the quality of management and technical skills directly determine programme effectiveness, efficiency and service to beneficiary communities, according to Concern Worldwide.

Concern employs 5,000 host country staff and up to 200 international volunteers and salaried staff in 13 countries. In each country, local field staff responsible for programme work are supported by international personnel recruited for their particular professional or managerial skills. Host country field staff work on salaried terms and are recruited directly by the relevant country office.

International staff normally work on volunteer terms for the first two years of service. If a country director needs to recruit international field staff, salaried or volunteer, he or she completes a staff requisition form. This details the job to be done, plus programme information such as project location, degree of isolation and whether an assignee can be accompanied by partner and children. The staff requisition also details the education, experience, personal qualities and technical skills needed to do the job, and explains why an expatriate is necessary.

It also outlines pre-departure and post-arrival training recommendations. The staff requisition is forwarded to the Personnel Division at headquarters in Dublin. There the Recruitment Officer prepares a person specification and a job description. The job description includes the main purpose of the job, specific work targets and reporting lines. It also provides background information and briefing notes for potential assignees.

For shorter-term emergency relief programmes, the process is speeded up. Generic job descriptions and person specifications are adapted to local circumstances and emphasis is placed on recruitment of volunteers and staff with previous experience.

Concern Worldwide plans to build further on the requisition system, linking it to performance appraisal and monitoring systems which the agency hopes to develop in the near future.

Principle 4:

We consult our field staff when we develop human resource policy

We recognise that we must implement, monitor and continuously develop our human resource policies in consultation with the people who work for us. We aim to include field personnel in this process, whether they are full-time, part-time, temporary, short-term or long-term members of our staff.

KEY INDICATORS

- The agency consults field staff when it develops or reviews human resource policies that affect them.
- Field managers and staff understand the scope of consultation and how to participate.
- Field managers and staff may be represented in consultations by recognised trade unions or staff associations.
- Results of policy reviews are recorded in writing and communicated to field managers, field staff and their representatives.

WHY IS THIS IMPORTANT?

It is accepted in any employment sphere, that whatever the size of an organisation and whether it is unionised or non-unionised, staff can only perform well if they know their duties, obligations and rights and have an opportunity of making their views known to management on issues that affect them.

Communication is the interchange of ideas, consultation the process by which managers and staff or their representatives jointly examine issues before decisions are made. The two are closely related. Poor communication has been found to be one of the major causes of workplace stress among expatriate aid staff.

Communication and consultation are often made harder by physical distance, the time-frame of contracts and the priorities of short-term projects. Yet both are central to effective people and project management and consistent with the emphasis most

agencies place on participation and accountability. However long or short their contracts, field staff views, information and experience are valuable.

Policies that are well-informed and widely understood are more likely to go into effective practice. If field staff themselves cannot participate directly in meetings about issues that affect them, consultation should involve their elected representatives in recognised trade unions or staff associations. It is important to involve field staff or their representatives in consultations: head office programme staff usually work under different terms and conditions, so they and their representatives may have a different perspective and different priorities.

If major decisions are usually made without the participation of those they affect, staff may be unwilling to participate in joint meetings on other matters that urgently require their attention.

Ask the family: policy making at Tear Fund

Tear Fund has no field offices. It recruits specialist staff from the UK who share the agency's Christian ethic, then second them to partner organisations in approximately 20 countries. Here they may work in areas as diverse as environmental health or handicrafts marketing, or in emergency relief projects.

Tear Fund seeks field staff ideas on a range of issues. These can be one-off personnel problems, such as how to simplify a cumbersome system of overseas expenses claims. At a policy level, all 70 field staff were consulted in 1996 on proposed long-term changes to field strategy. Their ideas had major implications for existing recruitment policy and, in particular, the length and type of field staff assignment.

The agency subsequently decided it should also include their children in this process. It asked the children of field staff who were now back in the UK how they had felt about being apart from their parents during school terms. This helped the agency gauge the longer-term effects of separation on them and their families. As a result, Tear Fund is now also considering how to provide briefing and debriefing sessions for children as well as for their parents.

Field staff were also asked to comment as Tear Fund changed to a flatter, less hierarchical organisational structure. Written information was sent to the field, comments were invited and face-to-face discussions were held during head office and field visits.

Human resources staff acknowledge that communication by letter or fax meant field staff were not always in the thick of discussions held by UK management and staff at this time. Nevertheless, some field staff and local partner agency staff joined in a series of agency-wide group discussions that contributed to the new 10-year strategy.

It can be difficult to involve people working overseas, says a senior personnel manager at Tear Fund, but you cannot just send people a *fait accompli*. Implementing new policies is not easy either, he adds, but in the long run the process will become easier if you have sought the opinions of field workers at an early stage.

Principle 5:

Plans and budgets reflect our responsibilities towards our field staff

We recognise that the effectiveness and success of our field operations depend on the contribution of all the salaried, contract or volunteer staff involved in them. Operational plans and budgets aim to reflect fully our responsibilities for staff management, support, development, security and well-being.

KEY INDICATORS

- All staff and their families moving country or region have a health check and specific health advice before their field assignment starts.
- Briefing before an assignment includes training in any areas essential for the safe, effective accomplishment of key tasks by field staff.
- Field staff and their families moving country or region receive information and advice about the location in which they will live and work.
- Work plans are based on an average maximum 48-hour working week. Time off and leave periods during assignments are mandatory.
- Staff who move country or region have paid leave after or between assignments.
- All staff have a debriefing or exit interview at the end of their assignment. Staff who move country or region receive a standard offer of a health check, personal counselling and career advice. Families are offered a health check and personal counselling.

WHY IS THIS IMPORTANT?

Agencies rightly feel they must respond as quickly as possible to fill field staff vacancies. However, good briefing and preparation particularly of personnel who work abroad, is seen as essential by employers whose staff work in situations less complex than those faced by relief and development personnel.

A briefing package that introduces staff to the organisation and provides essential training, health checks and health advice is cheap compared to the total cost of employing an individual. For UK employers of expatriates, contract costs can average two to three times those of equivalent posts at home. Staff and their families, particularly those working abroad for the first time or in a new region, need information and an opportunity to discuss implications and provision. Good preparation and briefing mean more realistic expectations of agency and project, less culture shock, less risk of illness, injury or early termination of contract.

An end-of-assignment or debriefing interview is the opportunity for agency and individual to

learn from field experience. These interviews should assess change in job profile or support needs and offer personal counselling and career advice to staff who have moved country or region. Making these offers standard increases the likelihood that staff will take up the offer, and do so without fear or embarrassment.

Relief work, in particular, takes place against a background of unforeseen circumstance and abnormal schedule. Yet *Room For Improvement* found that half of all expatriate relief and development field workers questioned *routinely* worked more than 60 hours a week. More than a quarter worked over 70 hours a week.

Field staff are also part of family or social networks essential for their well-being. Excessive working hours contribute to job-related illness, stress, accidents and problems in reconciling work and personal life. Agencies in which people regularly work long hours display altruism and dedication. They do not always demonstrate realistic expectations, good people management, or concern for the well-being and rights of staff and their families.

Investing in field people: briefing new staff at Voluntary Service Overseas

The development agency Voluntary Service Overseas holds induction courses for new field staff three times a year. Each course is designed for 16 expatriate and host country programme management staff who travel to Britain from Africa, Asia, the Pacific and Caribbean. The course is up to four weeks long, most of it conducted in-house by VSO staff.

VSO introduces new field staff to the agency and their job through a three-week core programme that mixes formal briefing sessions, hands-on exercises, social gatherings, and one-to-one meetings. It ensures field staff are familiar with the agency's in-house systems, including volunteer recruitment and support, and financial and database management. Staff moving country receive travel and payroll information and those coming to Britain for the first time receive an introduction to London. The core programme is followed by skills training as necessary in, for example, use of computers or four-wheel drive vehicles.

The agency sees this intensive briefing as a key investment in its field programmes - one that helps ensure new staff are 'up and running' almost from the day they start their new job in the field. It enables field staff to establish links with their new colleagues in London, and helps faces become as familiar as names early in the working relationship.

Responsibilities do not end when an emergency does: the British Red Cross

The British Red Cross has recently changed its approach to stress counselling for the expatriate field staff it recruits on behalf of the International Federation of Red Cross and Red Crescent Societies. It contracts another British charity, InterHealth, which specialises in health care for people who work abroad, to conduct pre- and post-assignment medical checks and counselling sessions.

Confidential counselling sessions are now offered as standard procedure. Field workers in the aid sector can suffer from a 'tough-guy' culture and a fear of being thought inadequate or unemployable if they ask for help. Delegates are free to decline the offer of counselling and about one percent do. Nevertheless, the agency feels the refusal rate for counselling would be far higher if the offer were not routine.

Debriefing at the end of an assignment has also been restructured. It now includes interviews with a personnel officer to cover human resource issues and their implications, as well as meetings with UK-based managers and technical officers on programme issues. Of common concern to field staff, human resource and programme managers have been the repeated short-term contracts on which nearly all field staff work, and the British Red Cross is now considering ways of retaining experienced delegates between assignments.

Principle 6:

We provide appropriate training and support

We recognise that we must provide relevant training and support to help staff work effectively and professionally. We aim to give them appropriate personal and professional support and development before, during and after their field assignments.

KEY INDICATORS

- Project plans and budgets are explicit about training provision. Field staff and managers understand agency and individual responsibility for meeting training needs.
- Line managers know how to assess the training and development needs of field staff before, during and at the end of assignments.
- The agency monitors the effectiveness of its training and development support in meeting:
 - corporate and programme aims
 - field staff expectations of fairness and transparency
 - equal opportunities targets.
- Where possible, the agency links training and development to external qualifications.

WHY IS THIS IMPORTANT?

For some agencies, training and staff development are low priorities: they see the need to maximise resources to project beneficiaries as one that outweighs the need to train or develop project staff.

The expertise of field staff is itself a valuable resource. The majority of staff recruited in Britain for field programmes are people with professional qualifications in health, education, engineering and other areas of expertise. Yet, however well-qualified they may be in their chosen specialisation, field staff are expected to

undertake a wider range of tasks, in project settings that are unfamiliar or complex. They frequently assume increased responsibility and work with teams of colleagues who may be specialists in other areas.

The purpose of training is to enable staff to carry out the job in hand. Training can mean informal or formal learning. It can focus on information essential for specific programmes, such as refugee health or adult literacy, or cover generic management topics: team building, negotiating skills, and project management. Ultimately, whatever its focus and however it is conducted, the aim of assessing individuals and providing them with appropriate training is consistent with the need to make maximum use of the expertise and resources they bring to field programmes.

Staff development helps them and the agencies that employ them realise potential. It supports staff who want to take on new tasks or responsibilities gain new skills or build on existing experience. It also helps agencies adapt to new

circumstances, change the focus of programmes or the profile and opportunity of their workforce. Linking staff development and training to vocational or professional qualifications helps to ensure that achievement is recognised both inside and outside the aid sector. This is particularly important when career paths are not always clear.

But if some agencies under-estimate its contribution, others risk viewing training as the only solution when field programmes are not as effective as they might be. Effectiveness, like quality, is a chain that needs to link all activities as an organisation strives to achieve its goals. If the chain becomes broken at any point, by a system, a person or a piece of equipment that fails to work well, this failure will eventually find its way to the interface where the organisation meets its clients - or, in the case of aid programmes - project beneficiaries. Training field staff may not be the right answer if problems that become evident in the field are caused by failings elsewhere in the 'chain'.

Staff development and equal opportunity at Oxfam

In addition to locally-held budgets, Oxfam's International Division holds a central staff development fund. This was set up in 1994 to provide money for staff development when no other sources of funding are available. It focuses on support to women and to field staff from non-OECD countries, particularly those who want to compete for management positions. This is because equal opportunities monitoring shows that these groups are currently under-represented at management level in the agency.

Though total funding available is modest, Oxfam feels it important to monitor its take-up, purpose and impact in order to ensure the Fund's objectives are met and to make recommendations for the future. During 1995-6 the Fund provided allocations to 18 staff members, the majority women, from Africa, Asia, Latin America and the UK. Applicants have to demonstrate that their proposal has clear learning objectives, is cost-effective and has the support of their line manager.

Staff development activities during 1995-96 included short and full-time courses, distance learning, including an Open University course, and visiting other Oxfam offices to learn from the experience and perspective of colleagues. The agency firmly believes that learning and development do not automatically mean taking formal courses, but stresses that alternatives, such as visits, secondments or 'shadowing' a colleague, must be carefully planned and structured.

In a brief annual report, international human resources staff sum up the experience of Fund recipients in both quantitative and qualitative terms. They note promotions, enhanced responsibility and self-confidence or even, in the case of one recipient subsequently made redundant, the ability to find a new job.

Principle 7:

We take all reasonable steps to ensure staff security and well-being

We recognise that the work of relief and development agencies often places great demands on staff in conditions of complexity and risk. We take all reasonable steps to ensure the security and well-being of staff and their families.

KEY INDICATORS

- Programme plans include written assessment of security and health risks specific to country or region.
- Before the assignment begins, field staff and families accompanying them receive oral and written briefing on country or regional security, emergency evacuation procedures and insurance arrangements.
- Briefing before an assignment includes training in the use and maintenance of any vehicle, equipment or procedure essential to personal, family and team safety and security. Briefings are updated in the field when new vehicles or equipment are purchased or procedures amended.
- The agency maintains records of work-related injuries, accidents and fatalities, and uses these records to help assess and reduce future risk to field staff.
- Security, health, insurance provision and emergency evacuation procedures are regularly reviewed. Briefings and information to staff are updated when procedures are amended.
- Field staff and families accompanying them know how to identify health risks in the country or region, how to protect against illness, injury and stress, and how to obtain support or medical treatment including support following incidents that cause distress.

WHY IS THIS IMPORTANT?

A measure of risk and stress may be unavoidable in field programmes. Nevertheless, agencies have a duty of care to field staff, and there is much that can be done to minimise risks to them and their families from the consequences of illness, injury, stress or burn-out, while ensuring that field programmes are sustainable.

All field programme plans, whether they emphasise emergency relief or development, must weigh up whether the benefits to the local population of an agency presence outweigh the risks to which field staff are exposed.

Security and health risk assessment should cover availability of health facilities and the need for appropriate levels of insurance. Assessment should also cover the availability of counselling, pastoral or peer group support. This support can help staff and managers who witness events that are profoundly disturbing by normal standards, or who work in environments where danger, distress and sudden death are the norm.

Two of the main sources of risk and stress among expatriate field staff - security issues and bearing witness to suffering - are usually associated with emergency relief programmes. However, they are also a feature of development programmes in unstable or unpredictable regions. In any aid programme, security and health risk assessment and the use of injury, accident and fatality records should inform field staff recruitment processes, health briefings and pre-assignment training.

As well as keeping security and emergency evacuation procedures under active review, attention is required to more routine health & safety measures: ensuring car seat-belts or motorcycle crash helmets are used, for example, or aiming to ensure that accommodation is functional and affords acceptable levels of privacy.

International relief and development agencies share an ethic that stresses universal health, welfare and humanitarian values. Endorsing the People in Aid Code means including field staff in those institutional values too.

Two-way communications: security briefing at the Save the Children Fund

The Save the Children Fund takes a comprehensive and practical approach to field staff health, safety and security in its manual *Safety First*, published in 1995. All the same, the agency emphasises that every situation is different. So whatever agency policies are set, the onus is always on the country programme director to review security needs, develop guidelines and brief field staff accordingly.

At one end of the scale, guidelines must cover local and individual safety, e.g. the time, equipment and care a staff member should expect to take when travelling from A to B. At the other end of the scale, they must set out how to evacuate all or part of a country team, in line with agency policy, if a political or military situation threatens their lives.

New field staff are advised about local security during one-to-one briefings with their country director and line manager. In an insecure situation or during the build-up to an emergency, team briefings may need to be held every day or even more often. As one Save the Children senior programme manager stresses, "You cannot spend enough time sharing information. And you must ensure that guidelines, like policy, are clear and transparent."

But briefing a new team member or updating field staff on a changing situation is not just about talking to them, he says. It is about listening too: giving people the opportunity to ask about the issues that are important to them, and understanding why. "It's normal to be frightened," says the same manager, "but one thing people mustn't be frightened of is asking you questions. You must never forget that people are individuals and they will be affected differently by the same situation. Managing people during, say, the evacuation of a field team, means you have to be as much aware of those differences as of the mechanics of getting them into a car or onto a 'plane'."

Appendix 1

The People in Aid Steering Group 1996-97

Action Health	Ian Harper
British Red Cross	Paul Emes, Anna Salma
International Health Exchange	Isobel McConnan
Medical Foundation for the Care of Victims of Torture	Jane Shackman
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Relief and Rehabilitation Network, ODI	Laura Gibbons
Returned Volunteer Action	Tammy Walker
Save the Children Fund	Maggie Reid
Tear Fund	David Talbot
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Appendix 2

Special Thanks

Bert Griffin, ACAS • Jo Barnett, British Quality Foundation • Lizzie Bell and James Fennell, CARE • Liz Joyce, Concern • Bill Shaw, Cranfield Trust • James Davidson, HelpAge International • Philippe Dind, International Committee of the Red Cross • Willy McCourt, Institute of Development Policy and Management, University of Manchester • Dr Ted Lankester and Dr Rob Morris, InterHealth • Professor Jon Rhodes, Liverpool University • Dr Michael Peel, Medical Foundation for the Care of Victims of Torture • Rhian Cadvan-Jones, Janet Sly and Alison Crowder, Oxfam • Craig Stein, PLAN International • Koenraad van Brabant, Relief and Rehabilitation Network, ODI • Peter Hawkins, Save the Children Fund • Gary Colvin, Tear Fund • Kathy Moore, Voluntary Service Overseas • Nick Cater, Words and Pictures

Appendix 3

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