

**The Practitioners**

**Reference Guide**

**In the Field**

**To**

**The Sphere Project**

## **Section 01**

**About the**

**'Practitioners Reference**

**Guide in the Field to the**

**Sphere Project'**

# 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 Non-Governmental Organizations in Disaster Relief (1994).

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

### **1.1 The right to life with dignity**

This right is reflected in the legal measures concerning the right to life, to an adequate standard of living and to 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.

### **1.2 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.

### **1.3 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.

## **2 Roles and Responsibilities**

2.1 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.

2.2 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.

- 2.3 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.
- 2.4 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.
- 2.5 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 in section 04, are based on 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 Section 04 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 must be to those we seek to assist.

# **The Minimum Standards for Water Supply and Sanitation**

## **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.

In most emergency situations the responsibility for procuring water falls to women and children. However, when using communal water and sanitation facilities, for example in refugee or displaced situations, women and adolescent girls are also more vulnerable to sexual violence or exploitation. It is important therefore to encourage women's participation in water supply and sanitation programmes wherever possible. Their involvement will help to ensure that the entire affected population has safe and easy access to water supply and sanitation services, and that services are equitable and appropriate.

## **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 of critical importance. 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 safe 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.

### **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.

### **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 for water supply**

- ◆ 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.
- ◆ There are no more than 10 faecal coliforms per 100 ml at the point of delivery for un-disinfected 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).
- ◆ Total dissolved solids are no more than 1,000 mg per litre (approximately 2,000  $\mu\text{s/cm}$  electrical conductivity for simple field measurement), 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.
- ◆ Each household 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 are 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; private laundering areas are available for women to wash and dry undergarments and sanitary cloths.

### **Guidance notes for water supply**

*Needs:* the exact quantities of water needed for domestic use may vary according to the climate, the sanitation facilities available, people's normal habits, their religious and cultural practices, the food they cook, the clothes they wear, 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. When providing water these additional quantities required should be taken in to account.

*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.

*Water disinfection:* 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. 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.

*Chemical and radiological contamination:* where hydro geological 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.

*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.

*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.

**Guidance notes for water supply continued**

*Quality / quantity:* during the emergency attention must be given to the quantity of water that is available as well as its quality. 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.

*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. If water is rationed or pumped at given times, this should be at times that are convenient to women and others who have responsibility for collecting water. Women and men from the affected population should be informed about their entitlements, and should also be involved in monitoring the equitable distribution of water.

*Water collection and storage:* 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.

*Communal washing and bathing facilities:* people may 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, especially women. Among the essential factors to consider are the safety, appropriateness and convenience of facilities for the users, especially women and girls, whose views on siting and design should be sought. As with latrines, facilities that are remote from the centre of a settlement are likely to pose additional risk of attack to female users.

## **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, safety, 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 acceptable access at all times of the day and night.

## **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 for excreta disposal**

- ◆ 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.
- ◆ Separate toilets for women and men are available in public places (markets, distribution centres, health centres etc).
- ◆ Technically sound design and construction specifications, approved by the intended users, are used for all forms of household and public toilets.

### **Key indicators for excreta disposal contd**

- ◆ 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 physically and mentally disabled people.
  - They are lit at night if necessary for security or convenience.
  - 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 for excreta disposal**

*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 all the intended users.

*Children's faeces:* particular attention should be given to children's faeces, which are commonly more dangerous than those of adults. Parents or caregivers need to be involved, and facilities should be designed and installed with children in mind. It may be necessary to provide parents or caregivers with information about safe disposal of infant faeces and nappy (diaper) laundering practices.

*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.

*Hygienic toilets:* if toilets are not kept clean they may be a focus for disease transmission and people will prefer not to use them. 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.

*Shared facilities:* it is not always 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.

*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.

*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.

*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.

*Security:* especially in crowded settlements, it is vital to consider the security of those using sanitation facilities, in particular women and girls. Latrines that are far from inhabited areas, or which are poorly lit, expose women and girls to additional risk of attack.

## **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.

### **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.

### **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 for vector control**

- ◆ 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 is a threat.
- ◆ 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.
- ◆ 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 informed about the potential risks of pesticides and about the schedule for application. They are protected during and after the application of pesticides according to internationally agreed procedures.
- ◆ The choice of pesticide and application method conforms to national and international protocols.
- ◆ The quality of pesticide and of treated bed nets conforms to international norms.

## **Guidance notes for vector control**

*Links with other sectors:* site selection is important in limiting the exposure of the population to vector-borne disease risk. 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.

*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.

*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
- Disposal of refuse for controlling flies
- Drainage of standing water for controlling mosquitoes
- Localised chemical control measures
- Individual protection measures.

*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.

*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.

*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, , 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.

## **Solid Waste Management**

If organic solid waste is not disposed of, the major risks posed are fly and rat breeding 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 management**

### **Standard 1: Solid waste collection and disposal**

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

### **Standard 2: Solid waste containers/pits**

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

#### **Key indicators for solid waste management**

- ◆ 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.

- ◆ 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 for solid waste management**

*Refuse type and quantity:* refuse in emergency settlements vary widely in composition and quantity, according to the amount and type of economic activity and the staple foods consumed. 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.

*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.

*Medical waste:* special provision is needed for medical waste. It should be disposed of within the perimeter of a medical facility. Responsibility for disposing of medical waste should be clearly defined.

*Market waste:* most market waste can be treated in the same way as domestic refuse. Slaughterhouse 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.

*The dead:* mortality rates are often high during the early stages of emergencies, or directly after a natural disaster. Graveyards must be located at least 30 metres from groundwater sources used for drinking water, with the bottom of any grave at least 1.5 metres above the groundwater table.

A common myth is that human remains are responsible for epidemics if not immediately buried or burned. However, in special cases such as during cholera or typhus epidemics, human remains may pose special health risks. 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. Depending on circumstances, the recovery and identification of the bodies of family members may be the primary concern of survivors. When those being buried are the victims of violence, forensic issues should be considered.

*Disposal of solid waste:* whatever means of final disposal is chosen, for instance burial or incineration, this should be done in such a way as to avoid creating health and environmental problems.

## **Drainage**

Surface water in and near emergency settlements may come from household and water point wastewater, leaking latrines and sewers, rainwater 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.

## **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.

### **Standard 2: installations and tools**

People have the means 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 for drainage**

- ◆ 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.
- ◆ 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 for drainage**

*Site selection and planning:* the most effective way to avoid drainage problems is in the choice and lay out of the emergency settlement. It may not be practicable to address the drainage problems of some sites, or have nearby water bodies.

*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.

*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.

## **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 a 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 behaviour 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.

### **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 for Hygiene Promotion**

#### **Water supply**

- ◆ People use the highest quality of readily available water.
- ◆ Public hygiene facilities are used appropriately and equitably.
- ◆ Parents and other caregivers demonstrate awareness of the need to dispose of children's faeces safely.

- ◆ Average water use for drinking, cooking and personal hygiene in any household is at least 15 litres per person per day.
- ◆ Covers are placed on water containers.
- ◆ Mean faecal contamination in potable water containers is indicated by less than 50 faecal coliforms per 100 ml.

**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.
- ◆ 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.

**Vector control**

- ◆ Bedding and clothing is aired and washed regularly.
- ◆ In malaria-endemic areas:
  - 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.

**Key indicators for Hygiene Promotion continued**

### **Solid waste management**

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

### **Drainage**

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

### **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.

### **Programme implementation**

- ♦ 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 for Hygiene Promotion**

#### *Agencies and the affected population share responsibility for hygiene practice:*

The ultimate responsibility for hygiene practice lies with all members of 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. As a part of this process, they should engage women from the affected population in developing hygiene messages and in distributing related materials and supplies to the community.

#### *Targeting priority hygiene risks and behaviour:*

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.

#### *Reaching all sections of the population:*

People who have access to all members of the population must deliver hygiene messages. For example, in some cultures it is not acceptable for women to speak to unknown men. Materials should be designed so that messages reach illiterate members of the population.

# **Minimum Standards in Shelter and Site Planning**

## **The importance of shelter and site planning in emergencies**

Beyond survival, shelter is necessary to enhance resistance to disease and provide 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 purpose of shelter, site selection and physical planning interventions is to meet the physical and primary social needs of individuals, families and communities for safe, secure and comfortable living space, incorporating as much self-sufficiency and self-management into the process as possible.

Interventions should 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**

It is not always the case that people are displaced from their homes in a disaster. People in communities directly affected by a natural disaster almost always want to stay in or near their homes if possible. In such situations, 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.

### **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 such situations, displaced people may stay with the local host community, other family members or people who share historical, religious or other ties. Assistance in such situations includes responding to the rights and needs of the disaster-affected population as well as of those who are secondarily affected by the disaster.

### **Scenario C: people are displaced and stay in clusters**

Temporary settlement for refugees or displaced populations becomes necessary when circumstances of natural disaster or conflict make it necessary for people to leave their homes and local regions, and settle elsewhere. In these situations populations live as groups, often very large, for undetermined lengths of time. Assistance requires response to the needs of people in both self-settled and selected sites.

Involving women in shelter and site programmes can help ensure that they and all members of the population affected by the disaster have equitable and safe access to shelter, clothing, construction materials, food production equipment and other essential supplies. Women should be consulted about a range of issues such as security and privacy, sources and means of collecting fuel for cooking and heating, and how to make sure that there is equitable access to housing and supplies. Particular attention will be needed to prevent and respond to gender-based violence and sexual exploitation. For example, improved lighting and security patrols can help make the site safe and accessible for all the population, but particularly groups who are likely to be at risk of violence. It is therefore important to encourage women's participation in the design and implementation of shelter and site programmes wherever possible.

### **Housing (Shelter)**

The purpose of shelter interventions is to help the repair of homes, the construction of temporary shelters or the settlement of displaced people within existing communities depending on the situation.

## **Housing**

### **Standard 1:**

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 for Housing**

- ◆ The covered area available per person averages 3.5-4.5m<sup>2</sup>.
- ◆ 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 UNHCR.

### **Guidance notes for housing**

*Shelter standards depend on the climate and the size of the household:* 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.

*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; neighbouring shelters should not obstruct it, for example. 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.

*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.

*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 airflow 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. However, 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.

## Guidance notes for housing continued

*Supply of sheeting and other materials:* 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 household of five people should receive at least one 4 metres x 6 metres sheet of plastic. This is best imported in rolls for easy transportation, storage and distribution (4 metres x 60 metres for 10 families). However, sheets of 4 metres x 7 metres per family would give more head clearance.

*Plastic sheeting:* plastic sheeting provided for shelter should meet specifications defined by UNHCR. Plastic sheeting for weatherproofing damaged buildings should follow different performance specifications.

*Shared accommodation:* shared accommodation is not a desirable solution to shelter problems. Where it has to be used, particular attention needs to be paid to maximising people's privacy.

*Damaged homes:* displaced people returning to homes damaged by war or natural disasters must be adequately supported. In cold climates it is preferable to help people to make one room habitable, rather than providing collective accommodation. Victims of earthquakes should be discouraged from inhabiting damaged buildings if there is a significant risk of aftershocks or further earthquakes.

*Vector control:* control measures may be required in shelters in both hot and cold climates to prevent infestation by vectors such as mosquitoes, rats and flies, and pests such as snakes and scorpions. An understanding of local building practices, the patterns of shelter use by displaced people, and material selection should inform shelter programmes and subsequent control measures.

*Environmental impact:* appropriate measures need to be taken to minimise the environmental impact of shelter programmes. These include:

- Provision of construction material to avoid depletion of local environmental resources.
- Protection of vegetation essential for control of erosion and/or flooding.
- Safeguarding agricultural and productive forest.

## Clothing

### Clothing

#### Standard 1:

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

#### Key indicators for clothing

- ◆ People have access to sufficient blankets.
- ◆ Children up to 2 years old have at least one full set of clothing and hygiene materials appropriate to the culture, season and climate.
- ◆ Women, girls, men and boys have at least one full set of clothing in roughly the correct size, appropriate to the culture, season and climate. In addition, women and girls have a regular supply of sanitary protection.
- ◆ Culturally appropriate burial cloth is available as required.

#### Guidance notes for clothing

*Appropriateness:* 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.

*Women's needs:* 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.

*Insulation:* the insulation capacity of blankets and clothes decreases significantly when they are wet (10 to 15 times) and bodies lose more thermal energy. 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.

## **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.

### **Household items**

#### **Standard 1: items for households and livelihood support**

Families have access to household utensils, soap for personal hygiene and tools for their dignity and well-being.

#### **Standard 2: environmental concerns**

Fuel-economic cooking implements and stoves are made available, and their use is promoted.

### **Key indicators for house hold items**

- ♦ People have appropriate household items: 1 cooking pot with well-fitting

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 and each person has: 1 eating plate, 1 metal spoon and 1 mug and has access to 250g of soap per month.

- ◆ There is planning for durable items to be replaced when necessary.
- ◆ As soon as possible, each household has access to appropriate tools and materials to support livelihood activity.
- ◆ 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.
- ◆ Those affected are aware of their entitlements under assistance programmes.
- ◆ 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 well-fitting lids and are aware of the benefits of using fuel-economic devices.
  
- ◆ The use and benefit of fuel-economic devices is promoted through community education programmes, if needed, and their production is planned as early as possible.
  
- ◆ Women are consulted about the location and means of collecting fuel for cooking and heating.

### **Guidance notes for house hold items**

*Opportunities for self-reliance:* as soon as feasible, women and men should 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 household space requirements.

*Supply and procurement:* technical items can be paid for in cash, 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 household-to-household basis. It is important to ensure that female- and adolescent-headed households, single women and widows enjoy fair access to supplies, allowances, cash-for-work programmes and training. More durable items supplied to the population should be technologically simple, and be maintained by the people themselves or locally. .

### **Site Selection and Planning**

This section applies to the situation, 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 (reception or transit centres, self-settled camps, planned temporary settlements, extensions to temporary settlements). 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 selection**

##### **Standard 1: site selection**

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

**Standard 2: site planning**

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

**Standard 3: security**

Site selection and planning ensure sufficient personal liberty and security for the entire affected population.

**Standard 4: environmental concerns**

The site is planned and managed in such a way as to minimise damage to the environment.

**Key indicators for site selection**

*These indicators combine to describe a process, which is expanded upon in the guidance notes.*

- ♦ The appropriate population size of a temporary settlement is defined following socio-economic assessments of both displaced and host populations, and assessments of the carrying capacity of the region and site.
  
- ♦ 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.
  
- ♦ Requirements for the form the settlement is to take are determined with reference to:
  - Information generated by the physical assessment.
  
  - Actual or potential threats to the security of the affected population. This is particularly important for refugee populations and is always critical for single women, widows and unaccompanied adolescent girls.
  
  - 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.

- ♦ The site provides 45m<sup>2</sup> 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 adequate firebreaks of at least: 2 metres between dwellings, 6 metres between clusters of dwellings, and 15 metres between blocks of clusters.

**Key indicators for site selection continued**

- ♦ The requirements for the form of the settlement are tested against the physical constraints of each potential site. The site meets the following requirements, regardless of seasonal variations:
  - It is located at a safe distance from possible external threats to physical security, usually not less than 50km.
  - It is accessible by heavy trucks from an all-weather road. If it is necessary to construct a road, the soil type and terrain should support this activity. Communal facilities are accessible by light vehicles..
  - 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 are established prior to occupation and permitted use is negotiated as necessary.
  - The soil type is suitable for digging and water infiltration.
  - There are sufficient grasses, shrubs and trees for shade and

to avoid soil erosion.

– Sufficient sustainable resources of fuel wood and construction materials are available. - Sufficient and appropriate land is available for the required levels of agriculture and animal husbandry. The impacts of these are understood, and land use is negotiated as necessary.

– The site is not prone to endemic diseases that might affect inhabitants or their livestock, to standing water, or to flooding; it is not situated on land at risk from landslides and is not close to an active volcano.

- ◆ 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.
  
- ◆ The site gradient is not more than 7% unless extensive drainage and erosion control measures are taken.
  
- ◆ The site is located at a safe distance from possible external threats to physical security.
  
- ◆ Site planning ensures that safe integrated living areas are provided for groups at risk.
  
- ◆ Social, health, sanitation and other essential facilities are safely accessible for everyone, 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.
  
- ◆ The host authorities and/or the relevant UN agency carry out internal and external security and protection activities.
  
- ◆ The agency assigned responsibility for overall coordination assists with internal security for groups at risk.
  
- ◆ Systems to prevent and manage the

consequences of sexual and gender-based violence are in place.

- ◆ Women and adolescents know about the availability of health services for victims of sexual violence.
  
- ◆ Reasonable steps are taken to ensure that staff is not at risk. In insecure areas an evacuation plan is agreed between agencies.
  
- ◆ Planning of temporary settlements takes into consideration density and dispersal of the displaced population:
  - 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 small settlements since these are less likely to cause environmental damage than large settlements.
  
- ◆ During site planning, trees and other vegetation are spared as far as possible. Roads and drainage patterns are planned in such a way as to make use of natural contours in order to avoid erosion and flooding.

## Guidance notes for site selection

These notes combine to describe a process by which the requirements of a settlement are identified, and explore the critical characteristics of a site.

*Identifying the type of settlement:* the assessments provide information that guide selection of the type of settlement and the form it takes. There are four basic types of temporary settlement:

- a.** Reception or transit centres: where displaced people or refugees stay for short periods. A reception and transit centre should be treated in the same way as a planned settlement if it is:
  1. large, having a population over 2,000, or
  2. expected to last a long time.

Environmental resources will have to be carefully managed to make sure that both displaced and local populations have enough water, fuel, and construction material, and that the local economy and environment are not adversely affected. If a transit camp receives many groups for short periods over a long period of time, this will have similar social and economic impacts on the local population as for a planned settlement.

- 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).

*Deciding the form of settlement:* 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.

- c. Interaction with the local population, economy and environment.

*Assessing the physical site:* 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) Site conditions

- Topography and site gradients should be sufficient for drainage while being habitable for the expected density of occupation. The appropriate maximum site gradient depends on soil conditions, vegetation and possible drainage and erosion control measures, which need to be taken into consideration in order to prevent flooding and mudslides. The ideal gradient is between 2% & 4%.
- 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.
- Micro-climatic conditions.

### c) Water

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

### Guidance notes for site selection contd

### 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.
- Type and quantity of ground cover in terms of their influence on micro-climatic conditions, wind speeds and soil erosion.
- Endemic diseases, pests, risk of disease.

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.

*Minimising negative impacts:* when a displaced population settles close to a larger host community it can benefit from access to locally available infrastructure services and livelihood opportunities. The displaced population may outnumber the host communities. This can place demands on the local infrastructure, economy and environment, which may create animosity between the two communities. Careful site selection and planning are thus critical in determining the effectiveness of the wider humanitarian assistance programme and the security of women, men and children from the

affected populations.

*Social factors:* wherever possible, the social structure and gender roles of the displaced population should be reflected in the planning of the 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, particularly women, and their involvement in humanitarian interventions.

*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, is of particular importance when providing for refugee populations or internally displaced populations who feel similarly threatened. Identifying the security needs of particular groups, especially women, will help reinforce security measures taken by host authorities and UN agencies. It is important that women and other groups considered at risk of harm are not housed in isolated areas where they can be easily targeted for physical attack or rape.

*Security measures:* the coordinating agency should ensure that there is lighting in strategic areas at night and that female- and adolescent-headed households and single women are housed in secure areas near facilities, but not in such a way that 'ghettos' are created. It is important to work with the affected population to establish security measures including, for example, safe haven facilities and neighbourhood watch groups. Measures to prevent sexual violence may include: site planning in consultation with women and men from the affected population; ensuring the presence of female protection and health staff and interpreters; reviewing issues of sexual violence in coordination meetings.

*Space requirement:* UNHCR guidelines recommend a total space requirement of 45m<sup>2</sup> per person, which includes a small space for kitchen gardening. The ideal is for the displaced population to live at the same density as in their home region/country, or at the same density as the host population, whichever is most appropriate for the situation. 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.

*Firebreaks:* care should be taken to prevent firebreaks acting as 'wind tunnels'. Fire control teams should be trained, equipped and regularly tested.

*Graveyards:* graveyards and mass graves must be located at least 30 metres from groundwater sources used for drinking water (in soil and more in fractured rock formations), with the bottom of any grave 1.5 metres above the groundwater table. Surface water from graveyards must not enter the settlement. Customs of the local and displaced population should be considered.

*Fuel wood consumption:* 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 1km<sup>2</sup> of undisturbed forest to cater for their annual fuel wood consumption need of 600-900 kg per person. Assuming however that only 20% of forest is undisturbed, only 100 people would be able to access the land.

## **The Minimum Standards for Human Resource Capacity and Training**

**The standards for 'Human Resource Capacity and Training' are common to all five technical sections and hence dealt with in this chapter.**

All aspects of humanitarian assistance rely on the skills, knowledge and commitment of staff and volunteers working in difficult and sometimes 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**

Staff who have appropriate qualifications and experience for the

duties involved, and who are adequately managed and supported implements programmes pertaining to all 05-core areas.

**Key indicators for competence in all five core areas**

- ◆ All staff working in any one of the 05 core areas is informed of the purpose and method of the activities they are asked to carry out.
- ◆ Staff with relevant technical qualifications and previous emergency experience carry out assessments, programme design and key technical decision-making.
- ◆ Staff and volunteers are aware of gender issues relating to the affected population. They know how to report incidents of sexual violence.
- ◆ Staff with technical and management responsibilities has access to support for informing and verifying key decisions.
- ◆ Staff or volunteers involved in information gathering are thoroughly briefed and regularly supervised.
- ◆ Training and supervision mechanisms are in place.
- ◆ Staff or volunteers involved in either of the 05 core areas 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.
- ◆ Introduction of new equipment is accompanied by training and testing in their use.
- ◆ Targeted interventions & procedures have clear written guidelines and protocols.

**Additional key indicators for competence in Nutrition**

- ◆ 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.
- ◆ Staff responsible for assessing the nutritional status of individuals are trained and regularly supervised in the necessary techniques for children, adolescents and/or adults.
- ◆ 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.
- ◆ All staff involved in targeted feeding have been thoroughly trained and tested on application of the protocols.
- ◆ Health staff has the demonstrated ability to identify key micronutrient deficiencies correctly - through clinical examination and/or biochemical analysis if available.
- ◆ A medically qualified, experienced practitioner supervises the treatment of severely malnourished people with specific training in this area.
- ◆ Health, nutrition and/or outreach workers who have contact with moderately malnourished individuals or their carers, have the demonstrated ability to provide appropriate advice and support as appropriate.

### **Additional key indicators for competence in Food Aid**

- ◆ 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.
- ◆ Female food monitors and distributors are equally represented on staff teams.

### **Additional key indicators for competence in Health**

- ◆ The introduction of any new medical supplies and the training and testing of new equipment is done in the presence of staff accompanied by thorough supervision and explanation. Equipment for the assessment of nutritional status, preparation of foods, testing of food quality etc.
- ◆ A medically qualified, experienced practitioner supervises the treatment of severe disease or injury with specific training in this area.
- ◆ 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.
- ◆ Vaccination programme staff have the demonstrated ability to implement the programme including advising people about the vaccine, side effects and other relevant messages.

### **Guidance notes for competence in all 05 core areas**

*Staffing:* staff and volunteers should demonstrate capabilities equal to their respective assignments. They should also be aware of key aspects of human rights conventions, international humanitarian law and the Guiding Principles on Internal Displacement.

Providing 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.

When deploying staff and volunteers, agencies should seek to ensure that there is a balance in the number of women and men on emergency teams.

## **Capacity**

### **Standard 2: local capacity**

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

### **Key indicators for local capacity**

- ◆ Women and men from the disaster-affected population are included in the planning, implementation, monitoring and evaluation of nutrition programmes.
- ◆ Staff understands the importance of strengthening local capacities for long-term benefit.
- ◆ The skills base within existing local partners and institutions and in the affected population is tapped and strengthened during the course of the humanitarian assistance programme.
- ◆ The skills base within existing local partners and institutions and in the

affected population is tapped and strengthened during the course of the humanitarian assistance programme.

- ◆ Training is provided to community outreach workers.

**Capacity**

### **Standard 3: support in Nutrition**

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.

### **Additional key indicators for support in Nutrition and Health**

- ◆ Carers are trained in how to care for severely malnourished individuals after recovery and discharge to the home environment.
- ◆ Households are advised on preparation methods for blended foods, and their contribution to the family diet, particularly for young children.
- ◆ Mothers and caregivers identified for re-lactation receive support, advice and encouragement on a regular basis by experienced and trained women.
- ◆ Pregnant women and mothers of newborn infants 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.
- ◆ Carers are informed about priority prevention activities such as need for vaccination, use of soap, bed nets, 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.

## **Minimum Standards in Food Aid**

### **The importance of food in emergencies**

All people need to consume 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 gain access to 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 assistance 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.

Women usually assume overall responsibility for food in the household and because they and their children are the major recipients of food aid, they have an important role to play in helping to ensure that food aid programmes are equitable, appropriate and accessible. Gender roles and the cultural practices that are likely to affect how women and men access food aid will need to be taken into consideration; and measures to monitor, prevent and respond to gender-based violence or sexual exploitation at food distribution points will be needed. It is important therefore that women's participation in the design and implementation of food aid programmes is encouraged wherever possible.

**The purpose of food aid is to:**

- △ Sustain life by ensuring adequate availability and access to food by people affected by disaster.
- △ 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 for recovery.

**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.

*Food aid requirements may be established for:*

**A general ration:** to provide a complete basket of food commodities in quantities sufficient to meet requirements.

**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 1:**

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

### **Key indicators for requirements**

- ◆ Requirements are based on the following WHO initial planning estimates:
  - 2,100 kcals 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.

### **Guidance notes for requirements**

*Initial reference value:* 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 kcal allows the needs of specific groups under the care of supplementary feeding programmes to be met.

*Adjusting the ration level:* 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.

*Other cases of food deficit:* periodic food security assessments should target female- and adolescent-headed households to identify cases of food deficit, which do not fall into normal assessment categories.

*Coordination:* all organisations involved in providing food aid should be committed to coordinated assistance. Improperly coordinated food aid programmes can exacerbate existing problems or create new ones. Some groups may be over-served, while others are unfairly deprived. Different ration scales, food baskets and/or selection criteria may result in people moving to where they think they can receive the most benefit. It is also important 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. Working together to agree on food aid policies and activities helps ensure that interventions are effective and may also serve to stabilise a volatile situation.

*Early use of food aid:* using food aid early on 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.

*Fuel assessment:* 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. Agencies should provide appropriate fuel or establish a wood harvesting programme that is supervised for the safety of women and children who collect firewood. Grain mills should be provided to reduce cooking time and the amount of fuel required.

*Unfamiliar foods:* where the food basket contains unfamiliar food, cooking instructions should be provided to women and other food preparers to maximise acceptance and minimise nutrient loss.

*Essential non-food items:* 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.

*Additional food commodities:* 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.

## **Targeting**

### **Targeting**

#### **Standard 1:**

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

### **Key indicators for targeting**

- ◆ Targeting objectives are agreed between the coordinating authorities, female and male 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 for targeting**

*The objectives of targeting food aid 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, adolescents, breastfeeding mothers, pregnant women,

elderly people and people with disabilities).

- Preserving households' assets (if these are being sold to cover food needs).
- Providing food supplements to those whose food need is caused by social/political vulnerability (for example, separated minors, refugees or displaced persons, female-headed households, people with disabilities and ethnic or religious minority groups).
- Effectively using limited available resources (whether this is available food, logistical infrastructure, experienced personnel, transportation and so forth).

*Cost:* 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 cost of the targeting should be weighed against potential savings.

*Responding to change:* 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.

## **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 1:**

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

### **Key indicators for resource management**

- ◆ 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 for resource management**

*Reporting requirements:* 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.

*Accounting system:* Generally Accepted Commodity Accountability Principles, published by Food Aid Management (1993), provides guidance in establishing a food aid accounting system.

*Certification:* where possible, commodities purchased for phytosanitary

certificates should accompany distribution or other inspection certificates that confirm fitness for human consumption.

*Disposal of commodities unfit for human consumption:* 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.

*Transparency:* 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.

*Expertise:* 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.

*Documentation:* 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.

*Providing information:* 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. Women's groups in the affected population may be enlisted to help provide information to the community about food aid programmes.

## **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 fail. 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

tonnes. The physical movement of food commodities to point of distribution may involve an extensive network of purchasers, forwarding agents, transporters and receivers, and 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 1:**

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

### **Key indicators for logistics**

- ◆ 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 for logistics**

*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.

*Agency roles:* 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.

*Theft:* at all stages of the supply chain, there is the potential for loss of goods through theft. Stock control and storage systems must be designed and run in such a way as to minimise the risk of theft. This is particularly an issue in situations of armed conflict, where food may be

at risk from banditry or could be commandeered by armed forces. Where large quantities are involved, this can be a significant factor in the war economy.

*Using local services:* 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.

*Stock levels:* 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.

*Measuring performance:* 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 and 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.

*Links with other sectors:* 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.

## **Distribution**

An appropriate distribution method is central to the effectiveness of food aid. 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. 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 1:**

The method of food distribution is equitable, and appropriate to local

conditions. Recipients are informed of their ration entitlement and its rationale.

#### **Key indicators for distribution**

- ◆ 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 readily accessible and scheduled at convenient times to minimise disruption to everyday activity.
- ◆ Recipients are involved in deciding the most efficient and equitable method of distribution; women are consulted and have an equal input into decision-making.
- ◆ 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 for distribution**

*Participation:* 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. The participation of women should be actively sought.

*Registration:* 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. Women have the right to be registered in their own names if requested. Lists developed by local authorities and community-generated family lists may also be used. Corruption and/or control by powerful individuals may mean that female- and adolescent-headed households and people with exceptional vulnerabilities are omitted from distribution lists. The involvement of women from various segments of the population should improve representation of the community. 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.

*Random weighing:* 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.

*Distribution of food aid should be equitable:* variation of 20% between distribution targets (households or communities) is within the acceptable range.

*Distribution methods:* 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.

*Recipients should be informed about changes:* 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 female and male community leaders, 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.

*Substitution ratios:* 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 and oil	3:1

*Minimising security risks:* as with the distribution of any valuable commodity, food distribution can create security risks, including both the risk of diversion and the potential for violence. When delivery of desperately needed food is made, tensions can run high. Women, children, elderly people and people with disabilities may be especially vulnerable, and may be unable to obtain their entitlement, or have it taken from them by force. The risks must be assessed in advance and steps taken to minimise them. Steps should include adequate supervision of distributions and appropriate guarding of distribution points. One essential safeguard is to communicate clearly what people should expect to receive. For example, ration quantities should be displayed prominently at distribution sites, written in the local language and/or drawn pictorially so that people can know their entitlements.

**Section 08**

**Minimum Standards in**

**Shelter & Site Planning**

## **Minimum Standards in Shelter and Site**

### **Planning**

#### **The importance of shelter and site planning in emergencies**

Beyond survival, shelter is necessary to enhance resistance to disease and provide 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 purpose of shelter, site selection and physical planning interventions is to meet the physical and primary social needs of individuals, families and communities for safe, secure and comfortable living space, incorporating as much self-sufficiency and self-management into the process as possible.

Interventions should be designed and delivered in such a way as to minimise any negative impact on the host population 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**

It is not always the case that people are displaced from their homes in a disaster. People in communities directly affected by a natural disaster almost always want to stay in or near their homes if possible. In such situations, 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.

### **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 such situations, displaced people may stay with the local host community, other family members or people who share historical, religious or other ties. Assistance in such situations includes responding to the rights and needs of the disaster-affected population as well as of those who are secondarily affected by the disaster.

### **Scenario C: people are displaced and stay in clusters**

Temporary settlement for refugees or displaced populations becomes necessary when circumstances of natural disaster or conflict make it necessary for people to leave their homes and local regions, and settle elsewhere. In these situations populations live as groups, often very large, for undetermined lengths of time. Assistance requires response to the needs of people in both self-settled and selected sites.

Involving women in shelter and site programmes can help ensure that they and all members of the population affected by the disaster have equitable and safe access to shelter, clothing, construction materials, food production equipment and other essential supplies. Women should be consulted about a range of issues such as security and privacy, sources and means of collecting fuel for cooking and heating, and how to make sure that there is equitable access to housing and supplies. Particular attention will be needed to prevent and respond to gender-based violence and sexual exploitation. For example, improved lighting and security patrols can help make the site safe and accessible for all the population, but particularly groups who are likely to be at risk of violence. It is therefore important to encourage women's participation in the design and implementation of shelter and site programmes wherever possible.

## Housing (Shelter)

The purpose of shelter interventions is to help the repair of homes, the construction of temporary shelters or the settlement of displaced people within existing communities depending on the situation.

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### Housing

#### Standard 1:

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.

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#### Key indicators for Housing

- \* The covered area available per person 3.5-4.5m(2).
- \* 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 UNHCR.

### **Guidance notes for housing**

*Shelter standards depend on the climate and the size of the household:* 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.

*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 overhands. The construction of the shelter should be light, as low thermal capacity is required. Appropriate orientation is important to maximise airflow; neighbouring shelters should not obstruct it, for example. Shades 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.

*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. Alternately, 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.

*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 airflow 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. However, 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.

*Supply of sheeting and other materials:* reinforced sheets of polyethylene are generally supplied in the early stage of the emergency, occasionally with rope and support materials such as 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 household of five people should receive at least one 4 metre x 6 metres sheet of plastic. This is best imported in rolls for easy transportation, storage and distribution (4 metres x 60 metres for 10 families). However, sheets of 4 metres x 7 metres per family would give more head clearance.

*Plastic sheeting:* plastic sheeting provided for shelter should meet specifications defined by UNHCR. Plastic sheeting for weatherproofing damaged buildings should follow different performance specifications.

*Shared accommodation:* shared accommodation is not a desirable solution to shelter problems. Where it has to be used, particular attention needs to be paid to maximising people's privacy.

*Damaged homes:* displaced people returning to homes damaged by war or natural disasters must be adequately supported. In cold climates it is preferable to help people to make one room habitable, rather than providing collective accommodation. Victims of earthquakes should be discouraged from inhabiting damaged buildings if there is a significant risk of aftershocks or further earthquakes.

*Vector control:* control measures may be required in shelters in both hot and cold climates to prevent infestation by vectors such as mosquitoes, rats and flies, and pests such as snakes and scorpions. An understanding of local building practices, the patterns of shelter use by displaced people, and material selection should inform shelter programmes and subsequent control measures.

*Environmental impact:* appropriate measures need to be taken to minimise the environmental impact of shelter programmes. These include:

- Provision of construction material to avoid depletion of local environmental resources.
- Protection of vegetation essential for control of erosion and/or flooding.
- Safeguarding agricultural and productive forest.

## Clothing

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### **Clothing**

#### **Standard 1:**

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

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#### **Key indicators for clothing**

- \* People have access to sufficient blankets.
- \* Children up to 2 years old have at least one full set of clothing and hygiene materials appropriate to the culture, season and climate.
- \* Women, girls, men and boys have at least one full set of clothing in roughly the correct size, appropriate to

the culture, season and climate. In addition, women and girls have a regular supply of sanitary protection.

- \* Culturally appropriate burial cloth is available as required.

### **Guidance notes for clothing**

*Appropriateness:* 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.

*Women's needs:* 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.

*Insulation:* the insulation capacity of blankets and clothes decreases significantly when they are wet (10 to 15 times) and bodies lose more thermal energy. 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.

## **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.

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### **Household items**

#### **Standard 1: items for households and livelihood support**

Families have access to household utensils, soap for personal hygiene and tools for their dignity and well-being.

#### **Standard 2: environmental concerns**

Fuel-economic cooking implements and stoves are made available and their use is promoted.

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### **Key indicators for house hold items**

- \* People have appropriate household items: 1 cooking pot with well-fitting 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 and each person has: 1 eating plate, 1 metal spoon and 1 mug and has access to 250g of soap per month.
- \* There is planning for durable items to be replaced when necessary.
- \* As soon as possible, each household has access to appropriate tools and materials to support livelihood activity.

- \* 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.
- \* Those affected are aware of their entitlements under assistance programmes.
- \* 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 well-fitting lids and are aware of the benefits of using fuel-economic devices.
- \* The use and benefit of fuel-economic devices is promoted through community education programmes, if needed, and their production is planned as early as possible.
- \* Women are consulted about the location and means of collecting fuel for cooking and heating.

### **Guidance notes for house hold items**

*Opportunities for self-reliance:* as soon as feasible, women and men should 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 household space requirements.

*Supply and procurement:* technical items can be paid for in cash, 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 household-to-household basis. It is important to ensure that female-and adolescent-headed households, single women and widows enjoy fair access to supplies, allowances, cash-for-work programmes and training. More durable items supplied to the population should be technologically simple, and be maintained by the people themselves or locally.

## **Site Selection and Planning**

This section applies to the situation, 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 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 (reception or transit centres, self-settled camps, planned temporary settlements, extensions to temporary settlements). 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.

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### **Site selection**

#### **Standard 1: site selection**

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

#### **Standard 2: site planning**

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

#### **Standard 3: security**

Site selection and planning ensure sufficient personal liberty and security for the entire affected population.

#### **Standard 4: environmental concerns**

The site is planned and managed in such a way as to minimise damage to the environment.

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#### **Key indicators for site selection**

*These indicators combine to describe a process, which is expanded upon in the guidance notes.*

- \* The appropriate population size of a temporary settlement is defined following socio-economic assessments of both displaced and host populations, and assessments of the carrying capacity of the region and site.
- \* 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.
- \* Requirements for the form the settlement is to take are determined with reference to:
  - Information generated by the physical assessment.
  - Actual or potential threats to the security of the affected population. This is particularly important for refugee populations and is always critical for single women, widows and unaccompanied adolescent girls.
  - 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.

- \* The site provides 45m<sup>2</sup> 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 adequate firebreaks of at least: 2 metres between dwellings, 6 metres between clusters of dwellings, and 15 metres between blocks of clusters.
- \* The requirements for the form of the settlement are tested against the physical constraints of each potential site. The site meets the following requirements, regardless of seasonal variations:
  - It is located at a safe distance from possible external threats to physical security, usually not less than 50km.
  - It is accessible by heavy trucks from an all-weather road. If it is necessary to construct a road, the soil type and terrain should support this activity. Communal facilities are accessible by light vehicles.
  - 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 are established prior to occupation and permitted use is negotiated as necessary.

- The soil type is suitable for digging and water infiltration.

- There are sufficient grasses, shrubs and trees for shade and to avoid soil erosion.

- Sufficient sustainable resources of fuel wood and construction materials are available. Sufficient and appropriate land is available for the required levels of agriculture and animal husbandry. The impacts of these are understood, and land use is negotiated as necessary.

- The site is not prone to endemic diseases that might affect inhabitants or their livestock, to standing water, or to flooding; it is not situated on land at risk from landslides and is not close to an active volcano.

\* 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.

\* The site gradient is not more than 7% unless extensive drainage and erosion control measures are taken.

\* The site is located at a safe distance from possible external threats to physical security.

\* Site planning ensures that safe integrated living areas are provided for groups at risk.

\* Social, health, sanitation and other essential facilities are safely accessible for everyone, 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.

- \* The host authorities and/or the relevant UN agency carry out internal and external security and protection activities.
- \* The agency assigned responsibility for overall coordination assists with internal security for groups at risk.
- \* Systems to prevent and manage the consequences of sexual and gender-based violence are in place.
- \* Women and adolescents know about the availability of health services for victims of sexual violence.
- \* Reasonable steps are taken to ensure that staff is not at risk. In insecure areas an evacuation plan is agreed between agencies.
- \* Planning of temporary settlements takes into consideration density and dispersal of the displaced population:
  - 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 small settlements since these are less likely to cause environmental damage than large settlements.
- \* During site planning, trees and other vegetation are spared as far as possible. Roads and drainage patterns are planned in such a way as to make use of natural contours in order to avoid erosion and flooding.

### **Guidance notes for site selection**

These notes combine to describe a process by which the requirements of a settlement are identified, and explore the critical characteristics of a site.

*Identifying the type of settlement:* the assessments provide information that guide selection of the type of settlement and the form it takes. There are four basic types of temporary settlement:

- b.** Reception or transit centres: where displaced people or refugees stay for short periods. A reception and transit centre should be treated in the same way as a planned settlement if it is:

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1. large, having a population over 2,000, or
2. expected to last a long time.

Environmental resources will have to be carefully managed to make sure that both displaced and local populations have enough water, fuel, and construction material, and that the local economy and environment are not adversely affected. If a transit camp receives many groups for short periods over a long period of time, this will have similar social and economic impacts on the local population as for a planned settlement.

- 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).

*Deciding the form of settlement:* 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.
- c.** Interaction with the local population, economy and environment.

*Assessing the physical site* 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) Site Conditions

- Topography and site gradients should be sufficient for drainage while being habitable for the expected density of occupation. The appropriate maximum site gradient depends on soil conditions, vegetation and possible drainage and erosion control measures, which need to be taken into consideration in order to prevent flooding and mudslides. The ideal gradient is between 2% & 4%.
- 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.

c) Water

- Availability of sufficient water within a suitable distance throughout the year for displaced people, the host community, agriculture and livestock.
- Separation of animal and water points.
- Whether there is more than once source of water, in order to reduce vulnerability of the water supply.

d) Space

- Whether there is sufficient space for the desired density of the population and dispersal of that population into the number of settlement 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.
- Type and quantity of ground cover in terms of their influence on micro-climatic conditions, wind speeds and soil erosion.
- Endemic diseases, pests, risk of disease.

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.

*Minimising negative impacts:* when a displaced population settles close to a larger host community it can benefit from access to locally available infrastructure services and livelihood opportunities. The displaced population may outnumber the host communities. This can place demands on the local infrastructure, economy and environment, which may create animosity between the two communities. Careful site selection and planning are thus critical in determining the effectiveness of the wider humanitarian assistance programme and the security of women, men and children from the affected populations.

*Social factors:* wherever possible, the social structure and gender roles of the displaced population should be reflected in the planning of the 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, particularly women, and their involvement in humanitarian interventions.

*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, is of particular importance when providing for refugee populations or internally displaced populations who feel similarly threatened. Identifying the security needs of particular groups, especially women, will help reinforce security measures taken by host authorities and UN agencies. It is important that women and other groups considered at risk of harm are not housed in isolated areas where they can be easily targeted for physical attack or rape.

*Security measures:* the coordinating agency should ensure that there is lighting in strategic areas at night and that female- and adolescent-headed households and single women are housed in secure areas near facilities, but not in such a way that 'ghettos' are created. It is important to work with the affected population to establish security measures including, for example, safe haven facilities and neighbourhood watch groups. Measures to prevent sexual violence may include: site planning in consultation with women and men from the affected population; ensuring the presence of female protection and health staff and interpreters; reviewing issues of sexual violence in coordination meetings.

*Space requirement:* UNHCR guidelines recommend a total space requirement of 45m<sup>2</sup> per person, which includes a small space for kitchen gardening. The ideal is for the displaced population to live at the same density as in their home region/country, or at the same

density as the host population, whichever is most appropriate for the situation. 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.

*Firebreaks:* care should be taken to prevent firebreaks acting as 'wind tunnels'. Fire control teams should be trained, equipped and regularly tested.

*Graveyards:* graveyards and mass graves must be located at least 30 metres from groundwater sources used for drinking water (in soil and more in fractured rock formations), with the bottom of any grave 1.5 metres above the groundwater table. Surface water from graveyards must not enter the settlement. Customs of the local and displaced population should be considered.

*Fuel wood consumption:* 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 1km<sup>2</sup> of undisturbed forest to cater for their annual fuel wood consumption need of 600-900 kg per person. Assuming however that only 20% of forest is undisturbed, only 100 people would be able to access the land.



## **Section 09**

### **Minimum Standards ;in**

#### **Health Services**

##### **Minimum Standards in Health Services**

###### **The importance of Health Services in emergencies**

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

The main purpose of providing health services to a disaster-affected population is to prevent excess mortality and morbidity. Essential to this is the identification of priorities through rapid assessment, ongoing monitoring and surveillance; interventions must respond to priorities identified by the initial assessment and must be technically sound. Planning, implementation and monitoring should be coordinated among the agencies involved.

Priority should be given to primary health care (PHC) measures including multi-sectoral assistance in the 05 key areas. 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.

In most emergency situations, women and children are the main users of health care services, and it is important to seek women's views as a means of ensuring that services are equitable, appropriate and accessible for the affected population as a whole. They should therefore participate in the planning and implementation of health care services wherever possible.

## **Measles Control**

Measles is one of the most contagious and lethal viruses known. Crowded emergency settings and unexpected population movements provide an ideal environment for the rapid and intense transmission of this virus, which can result in high levels of morbidity and mortality especially among children.

Measles vaccination campaigns should be assigned the highest priority at the earliest possible time in emergency situations. The necessary personnel, vaccine, cold chain equipment and other supplies to conduct a mass campaign should be assembled at the site of the emergency as quickly as possible. The decision of when to begin the vaccination campaign should be based on epidemiological factors such as whether a mass campaign in the population has taken place recently, level of measles vaccination coverage, and the estimated number of susceptible persons in the affected population. In some 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.

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### **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.

#### **Standard 2: vaccination of newcomers**

Newcomers to displaced settlements are vaccinated systematically. All children 6 months to 12 years old receive a dose of measles vaccine and an appropriate dose of Vitamin A.

#### **Standard 3: outbreak control**

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

#### **Standard 4: case management**

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

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### **Key indicators for Measles Control**

- \* Coordination with local health authorities and involved agencies is established and ongoing.
- \* More than 95% of all children in the target group (including newcomers) are vaccinated.
- \* 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 and dilution 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.
- \* 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 displaced situation, and to identify infants needs 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. Community workers conduct a public information campaign before conducting a mass vaccination campaign.
- \* 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.
- \* 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, diarrhoea, 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 for Measles Control**

*Temperature:* vaccines must be maintained at the manufacturer's recommended temperature of <8 C to maintain vaccine potency.

*Records:* 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.

*Target group:* 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.

*During a mass campaign:* WHO recommends the integration of vitamin A supplementation as follows:

#	Infants 6-12 months:	100,000 International Units (IU) (repeat every 4-6 months)
#	children > 12 months:	200,000 IUs  (repeat every 4-6 months)

*Staffing:* 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, though 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).

*Expanded programme on immunisation (EPI) vaccines:* because measles vaccination is so important in the early stages of an emergency in many countries, vaccination should not be delayed. In some emergencies other EPI vaccines may be introduced along with measles vaccination, provided measles vaccination is not delayed until other EPI vaccines are available. If only measles vaccination is provided, other EPI vaccines are introduced only when the immediate needs of the disaster-affected population have been met.

*In conflict situations:* UNICEF and others have sometimes been successful in getting agreement from the warring parties to a temporary cease-fire, in order to allow a vaccination campaign to be safely conducted.

*Re-vaccination:* 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.

*For measles case management or for treatment of Vitamin A deficiency:* administration of Vitamin A contributes to a decrease in mortality and measles sequelae.

WHO recommends:

#	Infants <6 months:	50,000 IU on day one; 50,000 IU on day two
#	Infants 6-12 months:	100,000 IU on day one; 100,000 IU on day two
#	Children >12 months	200,000 IU on day one; 200,000 IU on day two

*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.

## **Control of Communicable Disease**

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. Diarrhoeal diseases and communicable diseases such as tuberculosis commonly appear at the onset of an emergency and may also be the first manifest symptoms of HIV/AIDS.

Local health authorities, including community health workers and home visitors, are likely to be in the front line of the control effort, where resources allow, 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.

It is also important to consider what measures may be needed for the control and prevention of STDs and HIV. Any measures taken will depend on available epidemiological information concerning the affected population and the nature of the disaster.

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## **Control of communicable diseases**

### **Standard 1: monitoring**

The occurrence of communicable diseases is monitored.

### **Standard 2: investigation and control**

Diseases of epidemic potential are investigated and controlled according to internationally accepted norms and standards.

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## **Key indicators for the control of communicable diseases**

- \* 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.

- \* 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.
- \* Qualified staff investigates case reports and rumours of disease occurrence.
- \* 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, ebola) 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); safe blood supply and condoms for prevention of sexually transmitted infections and HIV.
  - 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, ebola).
- \* 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.

## Guidance notes for the control of communicable diseases

*Internationally accepted norms and standards are:* See

1. WHO (1997), *Communicable Disease Surveillance Kit*. World Health Organisation, Geneva.
2. Medecins Sans Frontieres (1997). *Refugee Health, An Approach to Emergency Situations*. Macmillan, London.

*Rumours:* reports and rumours of outbreaks are common among disaster-affected populations, including refugees, and should always be followed up.

*Determining if there is an epidemic:* 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.

*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.

*Drug resistance:* in some instances, studies will need to be carried out to assess drug resistance.

*Control of 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 dehydration 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.

*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.

*HIV prevention:* action must be taken in the acute stage following the disaster to minimise risk of infection. The nature of the disaster and the epidemiological situation of the people affected will dictate what HIV/AIDS interventions are called for and what is feasible. A basic response to any emergency must aim to maintain respect for the individual rights of people with HIV infection or AIDS, and to prevent nosocomial transmission of HIV (transmission that takes place in the health facility). The intervention must ensure: safe blood transfusion; access to condoms; availability of materials and equipment needed for universal precautions; and relevant information, education and communication.(2)

*Control of dysentery: 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.

*Control of Cholera:* 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.

*Measles control:* measles remain a major cause of childhood mortality throughout the world. While the Expanded Programme on Immunisation (EPI) has achieved satisfactory overall vaccine coverage level 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 Vitamina 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.

## **Health care services**

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### **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 services to reduce excess mortality and morbidity through appropriate medical care.

## **Standard 2: reduction of morbidity and mortality**

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

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### **Key indicators for Health care**

- \* Interventions are designed to be responsive to the identified major causes of excess death, disease and injuries.
- \* 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.
- \* The health care system is flexible enough to adapt to changes identified by the health information system.
- \* 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 interventions are implemented through the existing PHC system if available. The PHC system includes the following levels of care:
  - Household level.
  - Community level including community health workers and home visitors.
  - Peripheral health facilities (dispensary, health clinic).
  - Central health facilities (health centre).
  - Referral hospital.
- \* Emergency health care, including treatment of diseases and injuries, 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.
- \* 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.
- \* The Minimum Initial Service Packages is used from the start of the intervention to respond to the reproductive health needs of the population.
- \* 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 the spread of infections are taught and practised.
- \* Suitable transportation is organised for patients to reach the referral facilities.

### **Guidance notes for Health Care**

*Availability of health care services:* emergency health care should be 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 populations need to be considered when implementing interventions.

*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, reproductive health activities (including family planning, maternal and infant care, safe motherhood services, and treatment and counselling related to sexual and gender-based violence, sexually transmitted infections and HIV/AIDS); 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.

*Neo-natal and maternal morbidity and mortality should be prevented by:* establishing ante-natal services for preparing to handle obstetric

emergencies; making available and distributing clean delivery kits; Health care providers should plan for the provision of comprehensive reproductive health services by identifying sites for the future delivery of those services.

*The Minimum Initial Service Package (MISP):* the MISP is designed to prevent and manage the consequences of sexual violence, reduce HIV transmission, prevent excess neonatal and maternal morbidity and mortality and plan for the provision of comprehensive reproductive health services. Appropriately trained staff from the start of the emergency intervention should implement the MISP. Implementation should be coordinated with other agencies and sectors and should include: reporting of cases of sexual violence to health services, supplies for universal precautions (gloves, protective clothing and disposal of sharp objects), sufficient quantities of condoms for the af\_\_\_\_\_

*Staffing:* staffing of each level of a PHC system can vary, but the following are based on general guidelines taken from *Medecins Sans Frontieres, Refugee Health, an Approach to Emergency Situations*:

*Community level:* 1 home visitor for 500-1,000 population; 1 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 diagnosis, 1 health worker for 50 consultations/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).

*Universal precautions:* universal precautions to prevent and limit spread of infections should include measures to reduce transmission of HIV.

*Strengthening local health services:* throughout the emergency and thereafter, humanitarian agencies should aim to strengthen local health services rather than to create separate services.

*Use of medical facilities:* consideration should be given to factors affecting the use of, and attendance at, medical facilities. These may include cultural factors, and in conflict situations may also relate to security concerns. Although the impartial provision of health care should be seen as a neutral act, it is not always perceived as such by warring factions, and health facilities may become the target of attacks. The siting and staffing of facilities should take such concerns into account as far as possible.

*Note*

*It should be noted that Caritas Internationalis members cannot endorse: guidance note 7 of the control of communicable diseases section, dealing with condoms; and guidance note 5 of the health care services section, dealing with the Minimum Initial Service Package (MISP).*

## **Section 10**

### **Appendices**

#### **Appendix 01**

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#### **Initial Needs Assessment Questions, Water Supply and Sanitation**

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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.

##### **General**

- > How many people are affected and where are they?
- > What are people's likely movements? What are the security factors for the people affected and for potential relief interventions?
- > 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? What special security risks exist for women and girls?

## **Water Supply**

- > What is the current water source?
- > How much water is available per person per day?
- > What is the daily/weekly frequency of the water supply?
- > 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? Are they safe?
- > 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 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?

## **Excreta Disposal**

- > What is the current defecation practice? If it is open defecation, is there a designated area? Is the area safe?

- > 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 the current beliefs and practices, including gender-specific 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 manage issues related to menstruation? Are there appropriate materials or facilities available for this?

### **Vector-borne disease**

- > What are the vector-borne disease risks and how serious are those risks? (See Vector Control section 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?
- > What information and safety precautions need to be provided to households?

### **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?

### **Drainage**

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

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## **Sample Check List for Initial Health Assessment**

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(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- and child-headed 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, traditions and practices.
- > Determine the existing social structure and the psychosocial 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 hierarchical food allocation practices as they affect the nutritional status of women and different social and age groups.
- > 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, including sexual violence/rape.

### **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 drainage, blankets, clothing, domestic utensils, fuel, livestock, money.
- > Identify and assess water sources, quantity, quality, transport and storage.
- > Assess sanitation including excreta practices, soap, vectors and rats, burial sites.

### **Resources available**

- > Identify and assess local health services including: access to facilities, health personnel, interpreters, types of facilities/structures, water, refrigeration, generators at facilities, drug and vaccine supplies.

## Logistics

- > Assess transport, fuel, storage of food, vaccines and other supplies, communication.

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### Appendix 02

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

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Public toilets	* 1-2 litres/user/day for hand washing * 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/day * Additional quantities may be needed for some laundry

	equipment, flushing toilets etc.
Cholera centres	* 60 litres/patient/day * 15 litres/carer/day
Therapeutic feeding centres	* 15-30 litres/person/day * 15 litres/carer/day
Livestock	20-30 litres/large or medium animal/day 5 litres/small animal/day

### Appendix 03

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#### Nutritional Requirements

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<b>Nutrient</b>	<b>Mean Population Requirements</b>
Energy	* 2100 kcals
Protein	* 10-12% total energy (52-63g), but, 15%
Fat	* 17% of total energy (40 g)
Vitamin A	* 1,666 IU (or 0.5 mg retinal equivalents)
Thiamine (B1)	* 0.9mg (Or 0.4mg per 1,000 kcal intake)
Riboflavin (B2)	* 1.4mg (Or 0.6mg per 1,000 kcal intake)
Niacin (B3)	* 12.0mg (Or 6.6mg per 1,000 kcal intake)
Vitamin C	* 28.0mg

Vitamin D	* 3.2 – 3.8 mg calciferol
Iron	* 22 mg {low bio availability (ie 5-9%)}
Iodine	* 150 mg

Adapted from: WHO (1997, draft) and WFP/UNHCR (December 1997)

### Appendix 03

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#### Provisional Nutrient Densities

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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)	ug	95	28
SELENIUM (Se)	ug	3.6	1.85
CHROMIUM (Cr)	nmol	2	
MANGANESE (Mo)	umol	0.3	
MOLYBDENUM (Mo)	nmol	5	
FLOURINE (FI)	umol	<1	

Source: Golden M.H.N. Briend A. Grellety Y (1995). Report of meeting on supplementary feeding programmes with particular reference to refugee populations. European Journal of Clinical Nutrition. No.49, pp137-145.

### Appendix 03

#### **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)

<b>Indicator</b>	<b>Minimum prevalence</b>
Night blindness (present at 24-71 months)	>1%
Conjunctival xerosis with Bitot spots	>0.5%
Corneal xerosis/ulceration/keratomalacia	>0.01%
Corneal scars	>0.05%

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 to all children under five years of age, according to the following schedule:

Infants 6-12 months: 100,000 IU orally (repeat every 4-6 months)

Children >12 months: 200,000 IU orally (repeat every 4-6 months)

For clinical treatment of vitamin A deficiency, or in the case management of measles, WHO recommends:

Infants < 6 months: 50,000 IU orally on day one;  
50,000 IU orally on day two.

Infants 6-12 months: 100,000 IU orally on day one;  
100,000 IU orally on day two.

Children >12 months: 200,000 IU orally on day one;  
200,000 IU orally on day two.

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. (See: WHO (1997), and Health Services standards for measles control, in chapter 5).

### Appendix 03

#### **Indicators of iodine deficiency – goitre**

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

<b>Indicator</b>	<b>Target population</b>	<b>Severity of public health problem (prevalence)</b>		
		<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Goitre grade >0	School age children*	5.0-19.9%	20.0-19.9%	>=30.0%
Thyroid volume >97 <sup>th</sup> centile by ultra sound	School age children	5.0-19.9%	20.0-19.9%	>=30.0%
Median urinary iodine level(ag/1)	School age children	50-99	20-49	<20

Thyroid Stimulating Hormone >5mU/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

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.

## Appendix 04

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### **Sample Weekly Surveillance Reporting Forms**

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(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					
Maternal Factors					
Other-unknown					

<b>Total by age and sex</b>					
<b>Total &lt; 5 years</b>					

### Appendix 04

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#### **Sample Weekly Surveillance Reporting Forms**

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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-diagnoses	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:**

(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 04**

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**Sample Measles Vaccination Forms**

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Place \_\_\_\_\_ Reported by \_\_\_\_\_

From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

**Mass measles vaccination campaign** Yes \_\_\_\_ No \_\_\_\_

**Routine measles vaccination in health facilities** Yes\_\_No\_\_

**Measles vaccination coverage** Yes \_\_\_\_\_ No \_\_\_\_\_

**Target population:**

**< 5 years old** \_\_\_\_\_ **> 5 years old** \_\_\_\_\_ **Total**

**target population:** \_\_\_\_\_

No. vaccinated	Mass campaign A	Routine vaccination B	Cumulative measles vaccination coverage*
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No. Cumulative No Cumulative

This no. this no.

Week week

< 5 years			
> 5 years			
TOTAL			

**\* Calculation of the cumulative coverage:  $A+B/\text{target population}$**

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 04

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### Sample Water, Sanitation and environment Forms

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(Please note: these forms should be adapted to the particular situation and follow the initial assessment recommendations).

Place \_\_\_\_\_ Reported by \_\_\_\_\_

From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Water**

Water Supply	No. of liters-day	Population	No. of lt/per/day	Objective

Water Supply	No. of water points	Population	No. of pers./water point	Objective

**Sanitation**

Latrines	No. of Latrines	Population	No. of persons/latrine	Objective

**Crowding (space-person)**

Crowding	Surface area in m2	Population	M2 per person	Objective

**Comments:**

Source: MSF (1997), Refugee Health, An Approach to Emergency Situations, Macmillan, London.

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## Sample Sexual Violence Report Form

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(Please note: this form should be adapted to the particular situation).

### CONFIDENTIAL

### Sexual Violence Incident Report Form

Camp: \_\_\_\_\_ Reporting Officer: \_\_\_\_\_ Date: \_\_\_\_\_

#### 1. Affected Person

Code\*: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Civil Status: \_\_\_\_\_

If a Minor: Code/Name of Parents/Guardian: \_\_\_\_\_

#### 2. Report of Incident:

Place: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Description of incident (specify type of sexual violence): \_\_\_\_\_

Persons involved: \_\_\_\_\_

#### 3. Actions Taken

Medical examination done    yes                      no    By whom: \_\_\_\_\_

Major findings and treatment given: \_\_\_\_\_

Protection Staff Notified:    yes                      no

If no, reasons given: \_\_\_\_\_

If yes, actions taken: \_\_\_\_\_

Psycho-social counselling given:    yes    no

By whom and actions taken: \_\_\_\_\_

#### 4. Proposed Next Steps

#### 5. Follow-up Plan

Medical follow-up: \_\_\_\_\_

Psycho-social counselling: \_\_\_\_\_

Legal proceedings: \_\_\_\_\_

\* Code numbers should be used rather than names to ensure confidentiality.

## Appendix 05

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### Code of Conduct

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For the

**International Red Cross and Red Crescent Movement**

And

**NGOs in Disaster Relief**

***Prepared jointly by the International Federation of Red Cross and Red Crescent Societies and the ICRC***

#### **Purpose**

This Code of Conduct seeks to guard our standards of behaviour. It is not about operational detail, 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 aspired. It is a voluntary code, enforced by the will of the organisation 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 Inter-

governmental 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 separately 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 Crescent Societies and its member National Societies – and the NGOs as defined above. This code refers specifically to those NGHAs who are involved in disaster response.

**IGOs:** IGOs (Inter-Governmental 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.

## Appendix 05

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### Code of Conduct

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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 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 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.

## **Appendix 05**

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### **Code of Conduct**

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**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 depended 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.

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#### **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, which actively reduce 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.

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**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, both from 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 humans, not hopeless objects**

Respect for the disaster victims 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 cooperate 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.

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#### **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 inter-governmental 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 to in the future. They are presented in a spirit of openness and cooperation so that our partners will become aware of the ideal relationship we would seek with them.

## **Recommendations to inter-governmental organisations**

### **1 IGOs should recognise NGHAs, as valuable partners**

NGHAs are willing to work with UN and other inter-governmental agencies to effect better disaster response. They do so in a spirit of partnership which respects the integrity and independence of all partners. Inter-governmental 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 coordinating framework for intern. and local disaster relief**

NGHAs do not usually have the mandate to provide the overall coordinating 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 all efforts to ensure the effective coordination of their own services. In the event of armed conflict, relief actions are governed by the relevant provisions of international humanitarian law.

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### **3 IGOs should extend security protection provided for UN organisations**

Where security services are provided for inter-governmental organisations, this service should be extended to their operational NGHAs partners where it is so requested.

#### **4 IGOs should provide NGHAs with the same access to relevant information as is granted to UN organisations**

IGOs are urged to share all information, pertinent to the implementation of effective disaster response, with their operational NGHAs partners.

#### **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; one 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 level 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.

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##### **1 Governments should recognise and respect the independent, humanitarian and impartial actions of NGHAs**

NGHAs are independent bodies. Host governments should respect this independence and impartiality.

## **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 that these are 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 licenses or other restrictions, or to importation taxation, landing fees or port charges.

The temporary importation of necessary relief equipment, including vehicles, light aircraft and telecommunications equipment should be facilitated by the received host government through temporary waiving of license or registration restrictions. 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 communications required for their relief operations.

## **4 Governments should seek to provide a coordinated disaster information and planning service**

The overall planning and coordination of relief efforts is ultimately the responsibility of the host government. Planning and coordination 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 coordination 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, the relevant provisions of international humanitarian law govern relief actions.

## **Appendix 06**

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I think it opportunity to reiterate at this juncture that this book serves mainly as a teaching and an easy reference guide. I also hope and believe that it will assist and make easy, translation of the Sphere Project.

***Niloufer Lebbe***

***Editor***