

What is the Sphere Project?

The Sphere Project

Basic Human rights of those affected by calamity and conflict is frequently not upheld. Born out of this concern, the Sphere project was launched in 1997 by a group of humanitarian NGOs and the Red Cross and Red Crescent movement.

The project began by developing a handbook with two significant parts, a **Humanitarian Charter** and a **set of universal minimum standards** in core areas of disaster response.

The cornerstone of the project is the **Humanitarian Charter**, which is based on international treaties and conventions emphasises the right of disaster- affected people to life with dignity.

The Charter is followed by **minimum standards** in five core sectors namely;

- △ Water supply and sanitation.
- △ Nutrition.
- △ Food aid
- △ Shelter and site planning.
- △ Health services.

The purpose of the standards is to improve the quality of assistance provided to people affected by disasters, and to enhance the accountability of humanitarian aid in disaster response. The standards define the general requirements for life with dignity and are accompanied by indicators that provide qualitative and quantitative measures to relevant standards. The minimum standards seek to describe the level of disaster assistance to which all people have a right – regardless of political or ethnic or geographical specificity.

The Humanitarian Charter and Minimum Standards will not solve all the problems of humanitarian response, nor can they prevent all human suffering. What they offer is a tool for humanitarian agencies to enhance the effectiveness and quality of their assistance and thus to make a significant difference to the lives of people affected by disaster.

How the Standards came about

The minimum standards represent the collective opinion of hundreds of experts in humanitarian practice from 228 organisations. In times of disaster, aid and assistance is mainly given to the displaced through Government Emergency Relief Programmes and by NGOs. The Government also conducts most relocation programmes. Together the standards and indicators may usefully inform many aspects of humanitarian action, from assessment, analysis, program planning, monitoring and evaluation to advocacy and coordination.

This version

This introduction to the Sphere Project contains.

Section 01

Tells you what the Sphere Project is about and how it originated.

Section 02

The Second section is the Humanitarian Charter, which expresses agencies commitment to fundamental humanitarian principals. This commitment is based on agencies appreciation of their own ethical obligations and reflects the rights and duties enshrined in international law including;

- Λ The right to life with dignity. (Universal declaration of Human Rights)
- Λ The distinction between combatants and non-combatants. (Geneva Conventions)
- Λ The principal of non-refoulement means that one cannot force a refugee to go back to a place where they have fear of persecution. (Refugee Law).

Section 03

The third section is a summary about the five technical chapters of the Sphere Handbook.

Section 04

The final section contains all of the Minimum standards.

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.

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.

Water quality

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.

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.

Solid Waste Management

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

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.

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.

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.

Nutrition

The importance of nutrition in emergencies

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

General Nutritional Support to the Population

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

Nutritional Support to Those Suffering from Malnutrition

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

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.

The purpose of food aid is to:

- Λ Sustain life by ensuring adequate availability and access to food by people affected by disaster.

- Λ 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.

- Λ 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.

Targeting

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

- Λ Saving lives.
- Λ Strengthening food security.
- Λ Protecting the nutritional and health status of vulnerable sub groups such as children, women and the elderly.
- Λ Preserving household assets, if these are being sold to cover food needs.
- Λ Providing food supplements to the displaced.

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.

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, for the right people, in the right condition, at the right time and for the right price.

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.

Shelter and Site Planning

The importance of shelter and site planning in emergencies

Along with water supply, sanitation, nutrition, food and health care, shelter is a critical determinant of survival in the initial stage of an emergency. Beyond survival, 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. Whether the affected people:

- △ stay at home.
- △ are displaced and stay in host communities.
- △ are displaced and stay in clusters.

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.

Clothing

The people affected by the disaster should be protected from the climate and their safety and well-being ensured. Providing clothes and other materials could do this.

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.

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.

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 (earthquakes, floods, volcanoes etc), warfare and conflicts, and technological disasters tend to result in excess mortality and morbidity¹. Diseases responsible for such increases have also been identified: measles, diarrhoeas (including dysentery and cholera), acute respiratory infections, malnutrition and malaria (where prevalent). The high incidence of diseases is due to the environmental factors to which populations are exposed, namely overcrowding, 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 key areas (water, sanitation, nutrition, food, shelter). The participation of local health authorities and that of qualified members of the affected population including community workers and home visitors is paramount in carrying out primary health care measures.

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. Women can contribute to an understanding of cultural factors and customs that impact on health, as well as the specific needs of vulnerable people within the affected population. 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.

Control of Communicable Diseases

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

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.

Analysis & Human Resource Capacity and Training

The standards for 'Analysis' and the standards for 'Human resource capacity and training' are common to all five technical sections and hence dealt with in this chapter.

Analysis

Programmes that meet the needs of disaster-affected populations must be based on a clear understanding of the current situation, including political and security factors, and anticipated developments.

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

The standards for analysis apply before any programme takes place and throughout the programme cycle. Analysis starts with an immediate initial assessment that identifies the impact of the disaster and whether and how to respond. It continues with monitoring, which identifies how well the programme is meeting needs and determines whether changes are required; and with evaluation, which determines the overall effectiveness of the programme and identifies lessons for the future. The sharing of information and knowledge among all those involved is fundamental to achieving a full understanding of the problem and coordinated assistance. Documenting and disseminating information from the analysis process contributes to a broad understanding of the adverse public health and other consequences of disasters, and can assist in the development of improved disaster prevention and mitigation strategies.

Human resource capacity and training

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

Summary of the Minimum Standards

This section provides an overview of the minimum standards for each of the five sectors described in Section 03: water supply and sanitation, nutrition, food aid, shelter and site planning, and health services.

Minimum Standards in Water Supply and Sanitation

1 Analysis

Analysis standard 1: initial assessment

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

Analysis standard 2: monitoring and evaluation

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

Analysis standard 3: participation

The disaster-affected population has the opportunity to participate in the design and implementation of the assistance programme.

2 Water Supply

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.

Water supply standard 2: water quality

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

Water supply standard 3: water use facilities and goods

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

3 Excreta Disposal

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.

Excreta disposal standard 2: design and construction

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

4 Vector Control

Vector control standard 1: individual and family protection

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

Vector Control Std 2: physical, environmental & chemical Protection measures

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

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

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

5 Solid Waste Management

Solid waste management std 1: solid waste collection and disposal

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

Solid waste management std 2: solid waste containers/pits

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

6 Drainage

Drainage standard 1: drainage works

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

Drainage standard 2: installations and tools

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

7 Hygiene Promotion

Hygiene promotion std 1: hygiene behaviour and use of facilities

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

Hygiene promotion standard 2: programme implementation

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

8 Human Resource Capacity and Training

Capacity standard 1: competence

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

Minimum Standards in Nutrition

1 Analysis

Analysis standard 1: initial assessment

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

Analysis standard 2: response

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

Analysis standard 3: monitoring and evaluation

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

Analysis standard 4: participation

The disaster-affected population has the opportunity to participate in the design and implementation of the assistance programme.

2 General Nutritional Support to the Population

General nutritional support standard 1: nutrient supply

The nutritional needs of the population are met.

General nutritional support std 2: food quality and safety

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

General nutritional support standard 3: food acceptability

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

General nutritional support std 4: food handling and safety

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

3 Nutritional Support to Those Suffering From Malnutrition

Targeted nutritional support standard 1: moderate malnutrition

The public health risks associated with moderate malnutrition are reduced.

Targeted nutritional support standard 2: severe malnutrition

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

Targeted nutritional support standard 3: micronutrient deficiencies

Micronutrient deficiencies are corrected.

4 Human Resource Capacity and Training

Capacity standard 1: competence

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

Capacity standard 2: support

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

Capacity standard 3: local capacity

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

Minimum Standards in Food Aid

1 Analysis

Analysis standard 1: initial assessment

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

Analysis standard 2: monitoring and evaluation

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

Analysis standard 3: participation

The disaster-affected population has the opportunity to participate in the design and implementation of the assistance programme

2 Requirements - Requirements standard

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

3 Targeting Targeting standard

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

4 Resource Management - Resource mngmnt standard Food aid commodities and programme funds are managed, tracked, and accounted for using a transparent and auditable system.

5 Logistics Logistics Standard

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

6 Distribution - Distribution Standard

The method of food distribution is equitable, and appropriate to local conditions. Recipients are informed of their ration entitlement its rationale.

7 Human Resource Capacity and Training - Std 1

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

Capacity standard 2: local capacity

Local capacity and skills are used and enhanced by food aid programme

Minimum Standards in Shelter and Site Planning

1 Analysis

Analysis standard 1: initial assessment

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

Analysis standard 2: monitoring and evaluation

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

Analysis standard 3: participation

The disaster-affected population has the opportunity to participate in the design and implementation of the assistance programme.

2 Housing (shelter)

Housing standard 1: living quarters

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 wellbeing.

3 Clothing

Clothing standard

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.

4 Household Items

Household items standard 1: items for households and livelihood support

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

Household items standard 2: environmental concerns

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

5 Site Selection

Site standard 1: site selection

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

Site standard 2: site planning

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

Site standard 3: security

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

Site standard 4: environmental concerns

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

6 Human Resource Capacity and Training

Capacity standard 1: competence

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

Capacity standard 2: local capacity

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

Minimum Standards in Health Services

1 Analysis

Analysis standard 1: initial assessment

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

Analysis standard 2: health information system - data collection

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

Analysis std 3: health information system - data review

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

Analysis std 4: health info - monitoring and evaluation

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

Analysis standard 5: participation

The disaster-affected population has the opportunity to participate in the design and implementation of the assistance programme.

2 Measles Control

Measles control standard 1: vaccination

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

Measles control standard 2: vaccination of newcomers

Newcomers 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.

Measles control standard 3: outbreak control

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

Measles control standard 4: case management

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

Control of Communicable Diseases

Control of communicable diseases standard 1: monitoring

The occurrence of communicable diseases is monitored.

Control of communicable diseases standard 2: investigation and control

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

4 Health Care Services

Health care services standard 1: appropriate medical care

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

Health care srv std 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.

5 Human Resource Capacity and Training

Capacity standard 1: competence

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

Capacity standard 2: support

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

Capacity standard 3: local capacity

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

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1. An Introduction to the Sphere Project’.
2. The Sri Lankan video of the Sphere Project.

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The CHA —Sphere Working Group

The Consortium of Humanitarian Agencies is a Pilot agency for the Sphere Project and plans to systematically introduce Sphere into policies for disaster response.

The members of the CHA- Sphere Working group are:

- **Caritas Sedec**
- **Cordaid**
- **UN-Resident Coordinators Office**
- **Oxfam**
- **SC-UK**
- **UNHCR**
- **Sarvodaya**