

A photograph of three women sitting outdoors under a large tree with green leaves. The woman on the left is older, wearing a dark blue headscarf with yellow and orange geometric patterns and a matching patterned top. The woman in the center is younger, wearing a white headscarf with a red and gold pattern and a white long-sleeved shirt. The woman on the right is also younger, wearing a light blue headscarf with yellow and green patterns and a light blue top. They are all looking towards the camera. The background shows a brick wall and more greenery.

AUSTRALIAN MEDICAL ASSISTANCE TEAM TRAINING

**AusMAT**



NATIONAL CRITICAL CARE  
AND TRAUMA RESPONSE CENTRE

# AusMAT



NATIONAL CRITICAL CARE  
AND TRAUMA RESPONSE CENTRE

Version 3

# Preface

---

This AusMAT text is a compilation of original material and material originating from widely available free publications by leading NGO's and publications from the United Nations and World Health Organisation. This compilation document is available without charge in digital format, and in printed copy at cost. Its purpose is to be a ready resource for Australian Medical Assistance Team (AusMAT) members for humanitarian responses. Reproduced extracts from internationally available on-line texts are done so with full acknowledgement of the original source material, and links to these sources for further reading.

The choice of text has been guided by the following documents:

- OCHA Disaster Response Preparedness toolkit 2008.
- The European Commission Generic Security Guide for Humanitarian organisations 2004.
- Australia's Final Report, Workforce Planning Models for Disaster Medical Response Teams, James Cook University and WA Health. 4th July 2007 and
- Disaster Medical Assistance Teams: A Literature Review, Health Protection Group, April 2006.
- The Sphere Project: Humanitarian Charter and Minimum Standards in Humanitarian Response, 3rd Edition, April 2011.

The information contained in this document has been carefully compiled from sources believed to be reliable, but no warranty, guarantee or representation is made by NCCTRC as to the accuracy of the information or its sufficiency or suitability for the application to which any individual user may wish to put it, and not responsibility is accepted for events or damages resulting from its use.

Every effort has been made to trace and acknowledge copyright. However should any infringement have occurred, the publishers tender their apologies and invite copyright holders to contact them.

The National Critical Care and Trauma Response Centre  
8th Floor, Royal Darwin Hospital  
Darwin, Northern Territory 0801  
**[www.nationaltraumacentre.nt.gov.au](http://www.nationaltraumacentre.nt.gov.au)**  
e:[ncctrc.ths@nt.gov.au](mailto:ncctrc.ths@nt.gov.au)

# NCCTRC Introduction

The NCCTRC is a federally funded Organization based at Royal Darwin Hospital (RDH) in the Northern Territory of Australia. The Federal Department of Health and Ageing (DOHA) provide support to the NT Department of Health and the NCCTRC in recognition of previous responses to events such as the first and second Bali bombing, the Timor Leste unrest and responses to various northern Australian mass casualty events such as the Ashmore Reef refugee boat explosion. Recent deployments include the Boat explosion, and provision of the leadership, and largest proportion of civilian medical responders, and personal response equipment, to the AusAID and Australian Defence Force joint mission to flood relief in Pakistan. This has confirmed the NCCTRC's role in provision of a ready response medical team for the Northern Australian region and South East Asian.

The NCCTRC is tasked to enhance the capability of the RDH to respond to health events of national significance when tasked by the national incident room of DOHA, and to provide medical response teams when required. It provides a trauma patient management service for day to day operations in the RDH, as well as assisting in various other parts of the hospital with equipment and additional staff.

The NCCTRC has a regional and national role in preparedness, research and education. It leads several national disaster and trauma courses, as well as providing multiple trauma and related health courses for local staff. It has a key role in developing research in the areas of disaster preparedness, response and trauma. Heat trials in responders wearing CBRN (Chemical Biological Radiological and Nuclear) resistant suits, coupled with a series of trials on fire fighters wearing fire suits, were the first of several heat related trials planned at the centre. Work and initial trials have commenced on Australian Medical Assistance Teams (AusMAT) wearing tropical climate uniforms, and their physiological responses to work in the field during medical missions. The research programme also includes major projects such as the national disaster health capability audit for 2011 and for the development of a national bar-code tracking system for patients and evacuees during times of disaster. Multiple other research projects are ongoing covering novel approaches to the treatments and monitoring of mass casualties, burns and infectious disease patients during times of disaster, as well as hospital based studies related to our extensive trauma database. For more information see [www.nationaltraumacentre.nt.gov.au](http://www.nationaltraumacentre.nt.gov.au)

## EDITORS

### **Dr. Ian Norton**

**FACEM MB BAO BCh (Hons) MRCSI DTM DIH**

Director, Disaster Preparedness & Response, National critical Care and Trauma Response Centre, Emergency Physician. Clinical experience in South India and Indonesia, postgraduate qualifications in tropical medicine and international health and in surgery as well as being a specialist in emergency medicine. Team leader Ashmore Reef boat explosion 2009 and AusMAT team leader Pakistan August-October 2010. Involved with development and delivery of national AusMAT specialist training courses, AusMAT equipment, uniforms fitness and heat research. Research interests in mass casualty and humanitarian triage and tracking systems, heat illness and national surge capacity mapping.

### **Ms. Abigail Trewin**

**BHSc, PGDip ICPara.**

National Critical Care and Trauma Response Centre, AusMAT Operations. Intensive Care Paramedic who has worked across the NT including solitary remote postings. Currently involved with development and delivery of national AusMAT specialist training courses, and the preparation of AusMAT teams and equipment for deployment. Deployed to Pakistan 2010 as member of the first civilian team of Pakistan Assist II.

## CONTRIBUTORS

### **Dr. Benjamin L. D'Souza**

**FRACP; M.D (PED); DCH; MBBS; DCH(SA)**

Paediatric Emergency Physician, Dept. of Paediatric Emergency, Women's and Children's Hospital Clinical Senior Lecturer University of Adelaide (Acute Care). Trained in the Christian Medical College Vellore, India. Worked for a decade as a Consultant in Paediatric Medicine in rural and remote India. Moved to Australia and after sub-specialising in Paediatric Emergency Medicine, has been working at the Women's and Children's Hospital, Adelaide. Special Interest in Patient Safety and Relief work in disaster affected areas. He was deployed to Pakistan on the second of two civilian AusMAT teams.

### **Dr. Ruth Lennox**

**MB, ChB, FRACP**

Ruth Lennox is a general Paediatrician who worked in rural South Asia for 11 years in clinical medicine and latterly medical administration. She now works in the Northern Territory in clinical Paediatrics. She was an AusMAT member in the first civilian team during Pakistan Assist II.

### **Dr. Timothy Gray**

**MBBS (Hons) MPH&TM BMedSci (Hons)**

Tim has recently worked at the Royal Darwin Hospital and the Centre for Disease Control in Darwin. He is currently employed as the Microbiology Registrar, Concord Hospital in NSW. He was deployed to Pakistan with the first AusMAT team in response to the flood crisis of 2010.

### **Dr. Mark Little**

**MBBS FACEM MPH&TM DTM&H IDHA**

Mark is an emergency physician and clinical toxicologist, deployed with the Australian Army to Iraq in 1991 and on humanitarian missions to Earthquakes in Nias (2005) & Yogyakarta (2006), Pakistan floods (deputy team leader) (2010) and the Christchurch earthquake (team leader) (2011). Mark is on the teaching faculty of the International Diploma of Humanitarian Assistance course, Fordham University USA.

### **Ms. Angie Jackson**

**RN RM, B Health Sc (Nursing), Dip Health Sc, Crit Care Cert, MPH&TM, IDHA, LLB, Grad Dip Legal Studies**

Critical care nurse, midwife and lawyer, deployed on humanitarian missions to Earthquakes in Nias (2005) & Yogyakarta (2006), Pakistan floods (2010), and the Christchurch earthquake (2011) as the nurse leader. Angie is on the teaching faculty of the International Diploma of Humanitarian Assistance course, Fordham University USA.

### **MAJ Dick Stanworth**

Major Dick Stanworth is currently posted to HQ 1st Division in Brisbane in the G9 CIMIC Branch. He has completed the CIMIC Tactical Operators Course, the Joint CIMIC Staff Planning Course and the Asia Pacific Centre for Military Law CIMIC Course. He has also instructed on these courses as well as participating in many major exercises in a CIMIC capacity. He has previously deployed on operations to Iraq in 07/08 and Pakistan in 2010 in a CIMIC capacity.

### **Dr. Annette Holian**

**MBBS, FRACS,**

Annette is a Specialist Reservist who was deployed to the tsunamis in PNG Aitape, Banda Aceh and the Nias earthquake. Annette is also a veteran of deployments to East Timor, Solomon Islands and Afghanistan in 2008 and 2010.

### **Terry Trewin**

**DipHSc(PM) BEmergMgt (curr)**

Terry is a Station Officer attached to the operations section of the Northern Territory Fire and Rescue Service based in Darwin. Terry assists the NCCTRC Director of Preparedness and Response with capability and response logistics. Terry is involved in the development and research into personnel deployment equipment, communications and specialized logistics, this includes equipment deployed to the 2010 Pakistan floods for entire Australian civilian team (AusMAT) and the response kits and communication systems dispatched during Cyclone Yasi.

### **Dr. Matthew Brearley**

**phD BHMS (Hons) BBus**

Dr Matt Brearley is the Disaster Medical Research Program Manager of the NCCTRC, formerly holding the position of Athlete Services Manager at the Northern Territory Institute of Sport, Darwin. Matt earned a PhD in thermal physiology from Charles Darwin University in 2006 studying responses of athletes competing in the tropics and developing pre-cooling protocols. He has worked with elite junior and senior athletes to maximise their performance in the heat and was the heat specialist of the Australian team during the 2008 Olympic Games in Beijing, China.

### **Mick Kinnaird**

**B Applied Science**

Acting Manager Top End Remote Environmental Health with the Northern Territory Government. 15 years experience working with Indigenous communities in the Kimberley and the Territory. Humanitarian disaster response deployments to Iraq (5 months) and PNG (18 months). AusMAT team member.

**Xavier Schobben**

MIM, PGDip Mgt, B Bus Admin, Dip App Sc

Xavier is the Northern Territory Director Environmental Health and has worked extensively as an environmental health practitioner in both local and state government. He has been involved in responding to many Northern Territory emergencies and natural disasters, including the 1998 and 2006 Katherine Floods and various Tropical Cyclones. Special interest in public and environmental health aspects of disasters and health engineering.

**Peter Aitken**

MBBS, FACEM, EMDM, MCLinEd

Peter Aitken is a Senior Staff Specialist in the Emergency Department of The Townsville Hospital. He has post graduate qualifications in Emergency Medicine, Disaster Medicine and Clinical Education and is completing a doctorate in Disaster Health. He is an Associate Professor at the Anton Breinl Centre at James Cook University, where he co-coordinates the Disaster Health and Aeromedical Retrieval post-graduate education programs. He is also the Senior Medical Coordinator (Disaster Management) in the Emergency Management Unit of Qld Health. In this role he chairs Work Groups responsible for the development of the State Mass Casualty Sub Plan, the State Emergency Incident Education and Training program, the introduction of MIMMS to Qld and the AusMAT Leadership Group in Qld. He has previously been involved in the introduction of both the Emergo Train System (ETS) and PHTLS to Qld. At a national level he is a member of the HAHWG AusMAT Work Group and National Coordinating Committee for ETS.

**Frances Abbott**

Royal Darwin Hospital (RDH) Aboriginal Services Support Unit.

**Prof Hugh Grantham**

MBBS, FRACGP

As Medical Director of South Australia Ambulance Service (SAAS) for nineteen years, Hugh has contributed in advancing the role of paramedics through education, medical/clinical leadership and management. He holds an academic appointment as Professor of Paramedics at Flinders University. In South Australia he has been involved in the ambulance response to many incidents and in 1995 led the second Australian team into Banda Aceh following the Boxing Day tsunami. He played a key role in establishing the AusMAT team in South Australia following that event. Subsequently he has been involved in deployments within the state and to Samoa as part of Australia's first response team following the tsunami

**John Jalonka**

John Jablonka is principal of Cross Cultural Consultants International Development and is an associate trainer with RedR Australia. He has worked in community education in Australia since 1986 and internationally since

1999 including roles in Indonesia, Thailand, Cambodia, Vietnam, Laos, Indonesia, Kiribati, Tonga, Fiji, Vanuatu, Samoa. John has designed, managed and delivered training in Australia, the Pacific, South East Asia and the Middle East on programs for volunteers, students, communities, governments and NGO staff across all sectors including a number of projects in public health.

**Medical Entomology unit, Centre for Disease Control, Royal Darwin Hospital**

The Medical Entomology unit provides advice and carries out surveillance, monitoring, and control of insects of medical importance. The unit has been involved in survey and control to reduce endemic mosquito-borne diseases in the Northern Territory, and has been involved in dengue control in Timor-Leste. It advises on self-protection measures against mosquito-borne diseases. The unit's publications, guidelines and handouts can be accessed at:

[http://health.nt.gov.au/Medical\\_Entomology/](http://health.nt.gov.au/Medical_Entomology/)

**Red R Australia: Drasko Kraguljac, Alan Johnson, Richard Parker**

Red R Australia provides emergency assistance to communities devastated by conflict or major natural disasters by selecting, training and providing competent and effective personnel to humanitarian relief programs worldwide. Red R are actively involved in the delivery of AusMAT training, particularly in the areas of Safety and Security in Austere environments. They provide senior experienced personnel who impart practical skills and real life experience to the AusMAT programme.

**Response Psychological, Luke McCormack, BA (Hons), MA, Member APS Psychologist**

Response Psychological have been Australian leaders in the provision of deployment psychological support since 2003. Our range of services including selection, development and continuous psychological support are designed to improve deployee wellbeing while managing psychological risk throughout the deployment cycle.

Response Psychological Services specialise in deployed mental health support providing experienced, confidential and professional solutions 24/7 globally.

## PHOTO CREDITS

IRIN PHOTO Humanitarian news analysis. [www.irinnews.org](http://www.irinnews.org)

Australian Defence Force (Pakistan)

**Special thanks to the following photographic contributors;** Anne Weir (cover), Natasha Roberts, Dick Stanworth, Megan Chandler, Angie Jackson, Mark Little, Ronnie Taylor, Mark Haste, Tim Gray, Peter Norbury, Terry Trewin, Andrew Pearce, Ian Norton, Abigail Trewin, Leonia (ADF).

# Table of Contents

## PREFACE

## NCCTRC INTRODUCTION

## EDITORS - CONTRIBUTORS

## INDEX

### CHAPTER 1 8

#### AUSTRALIAN MEDICAL ASSISTANCE TEAMS

### CHAPTER 2 11

#### PRINCIPLES OF HUMANITARIAN PRACTICE

THE HUMANITARIAN CHARTER 13

MINIMUM STANDARDS IN WATER  
SUPPLY, SANITATION AND HYGIENE  
PROMOTION (WASH) 19

Hygiene Promotion 21

Water Supply 23

Excreta Disposal 25

Vector Control 26

Solid Waste Management 28

Drainage 29

THE IMPORTANCE OF FOOD SECURITY  
AND NUTRITION IN DISASTERS 31

Infant and young child feeding 33

Appendix 38

MINIMUM STANDARDS IN SHELTER,  
SETTLEMENT AND NON FOOD ITEMS 40

THE IMPORTANCE OF HEALTH ACTION  
IN DISASTERS 42

Health Systems 44

Essential Health Services 51

Control of communicable diseases 52

Child Health 57

Sexual and reproductive health 59

Injury 62

Mental Health 64

Non Communicable Diseases 66

Appendix Forms 67

### CHAPTER 3 71

#### CULTURE

NAVIGATING CULTURE IN EMERGENCIES 72

ABORIGINAL CULTURE AND  
MAJOR INCIDENTS 84

ANALYSIS 117

### CHAPTER 4 117

#### SECURITY

STATISTICS HUMANITARIAN CASUALTIES 120

PRINCIPLES OF SECURITY 126

GRAB BAGS 134

FIELD SECURITY 136

PREVENTING AND DEFUSING ANGER  
AND HOSTILITY 140

NEGOTIATION 152

DEALING WITH CORRUPTION 174

CROWDS, MOBS AND SAFETY 186

APPROACHING AND DEALING  
WITH CHECKPOINTS 188

CONVOY DRIVING 191

THE HUMANITARIAN SECURITY  
ENVIRONMENT TODAY 196

### CHAPTER 5 199

#### TEAM MANAGEMENT

DEPLOYED AUSMAT TEAM  
MEDICAL WELFARE 200

MANAGING STRESS 203

RETURNING HOME 213

FITNESS AND HEAT 215

TRAVEL TIPS 219

---

**CHAPTER 6** **235****MEDICAL**

INFECTIOUS DISEASES	236
USE OF RAPID DETECTION TEST FOR MALARIA ( RDTs)	246
COMMUNICABLE DISEASE OUTBREAK	248
MATERNAL AND NEONATAL HEALTH IN DISASTERS	252
Preventing Excess Maternal and Neonatal Mortality and Morbidity	253
During the emergency	256
MISP Objective	258
Traditional Birthing Attendants	263
Sexual Voilence	264
Reducing the Transmission of HIV	265
MEDICATION USED ON AUSMAT DEPLOYMENT	266
MALNUTRITION	269
Protien Energy Malnutrition	270
Mirconutrient Deficiency	276
MANAGEMENT OF THE DECEASED	279

---

**CHAPTER 7** **285****TECHNICAL ASPECTS**

LOGISTICS	286
FIELD HOSPITALS	290
RADIO COMMUNICATION	295
NAVIGATION	301
ENVIRONMENTAL MANAGEMENT	309
EQUIPMENT FOR DEPLOYMENT	316
Team Uniforms / Equipment	317

---

**CHAPTER 8** **321****ASSESSMENT**

FIELD REPORTS	339
ANALYSIS	348

---

**CHAPTER 9** **351****CIVIL AND MILITARY INTERACTION**

---

**CHAPTER 10** **359****THE MEDIA AND DISASTERS** **360****ANNEX** **366****REFERENCES** **367**

# Australian Medical Assistance Teams



## AusMAT Overview and Introduction

Australian Medical Assistance Teams are in various stages of development in each State and Territory. This textbook aims to go some way toward being a resource for such teams, particularly for overseas deployments. It is the 3rd revision of the AuMat textbook and replaces the previous two versions. AusMAT members may be asked to respond within their own state, or to neighbouring states, in times of catastrophe as seen after the floods in various states in 2011. AusMAT has responded to many regional disasters in the last decade, notably the Asian Tsunami, the Javanese Earthquake, the Samoan Tsunami and the Christchurch earthquake. Defence teams have responded to the earthquakes of Pakistan 2005 and Sumatra in 2009, but the Pakistan floods of late 2010 was the first example of a large scale medical joint task force deployment of civilian AusMAT and defence teams for a period almost four times longer than any previous civilian missions. Some of the learning from that and previous missions have gone into shaping this text.

The tasking and structure of AusMAT is undergoing refinement as this version of the text goes to print, but the principles of state based teams for intra and inter-state responses remains. Longer term, larger teams, as used for Pakistan Assist II highlighted the need for inter-compatibility between state teams, as both teams Alpha and Bravo, contained members from at least four different states and territories. AusMAT teams will be deployed overseas under AUSASSIST plan, and will be under the mission leadership of AusAID. AusAID will often have a raft of response measures to assist the disaster affected country, including donations through reputable NGOs, direct aid to the country and its government, and via response teams such as medical or USAR (Urban Search and Rescue) if required.

Need assessment will be carried out, either by the affected nation's government assessors, contacting the Australian government for assistance, and/or by a whole of government needs assessment team, deployed to the site of disaster as soon as practicable. In the event of medical assistance being required, AusMAT representation onboard this assessment mission will be vital, and may range from one to four candidates, covering medical, logistics, environmental health etc (or a person with experience in several). Whole of government decisions regarding types of assistance to be offered etc, are discussed at an inter-departmental level in Canberra, before dissemination to the key responding agencies.

AusMAT response will be assisted by the AHPC (Australian Health Protection Committee) who will set up a National Incident Room (NIR) and EMA (Emergency Management Australia) who will staff their Crisis Coordination centre. On hearing of the request for AusMAT, AHPC will convene, and discuss/nominate personnel and give other strategic health advice. Once nominated, AusMAT members will have their urgent travel coordinated by EMA either inter-state in domestic responses, or to the designated departure point if an international response. AusAID will then take over responsibility of transport of teams to the scene, and coordinate their response through their centre in Canberra. If the Australian Defence Force is involved, they will have been present at all strategic meetings, setting in train their own planning and logistics system in parallel to the civilian system.

Leadership during deployment, is generally under a mission lead from AusAID, and a leadership group of the mission leader, AusMAT team leader and EMA representative. This group provide situation reports to Canberra on a daily basis while deployed, as well as carrying out their roles and functions of mission management and delivery of goals, planning, team safety, health and welfare and delegation of logistics etc to their support team.

Team size and duration of mission is dependant on the medical task, but may become limited to a core group of no less than 15, to provide a usable and self sufficient medical response, while retaining easy deployment capability. The upper limit of team size, depends on tasks required, increases in leadership and logistics and limits of field space and sustainability, but is thought to be no more than 40 persons at this stage. (Larger missions may require several AusMAT teams).

This text will aim to give an overview of the Humanitarian aspects to AusMAT response, cultural awareness for some of our near neighbours, and including some basic medical terms. The security, team management and medical sections have been expanded to incorporate a standard approach to training for AusMAT teams. It is the firm belief of the writing team, and those with deployment experience, that no international response with AusMAT should occur before an AusMAT course teaching safety and security, and basics of humanitarian practice has been undertaken. This text may assist those conducting state based courses to this end, as well as being used by the NCCTRC for our state and national level courses preparing AusMAT teams, their leaders and specialist members.

Consider (and avoid) the Seven Sins of Humanitarian Medicine,  
as articulated by Welling et al (World J Surg (2010) 34:466-470)

## The Seven Sins of Humanitarian Medicine

<b>#1</b>	Leaving a mess behind
<b>#2</b>	Failing to match technology to local needs and abilities
<b>#3</b>	Failing of NGOs to cooperate and help each other, and to cooperate and accept help from military organizations
<b>#4</b>	Failing to have a follow-up plan
<b>#5</b>	Allowing politics, training, or other distracting goals to trump service, while representing the mission as “service”
<b>#6</b>	Going where we are not wanted, or needed and/or being poor guests
<b>#7</b>	Doing the right thing for the wrong reason



# Principles of Humanitarian Practice

The following are excerpts from UN Sphere Project.

## The Sphere Handbook

The new Sphere handbook was released globally in April 2011. It is the 3rd edition of the initiative, and it continues to be the most widely accepted humanitarian response handbook available. It was initiated in 1997 by a group of NGOs and the international red cross/red crescent movement, and quickly gained support from international agencies like the UN and WHO, Government agencies, including the Australian government and AusAID, and the majority of non-governmental organizations (NGOs) world-wide. Its main aims include improvement in the quality and accountability of humanitarian response.

*Sphere's philosophy is based on two core beliefs: first, that those affected by disaster or conflict have a right to life with dignity and, therefore, a right to assistance; and second, that all possible steps should be taken to alleviate human suffering arising out of disaster or conflict.*

Striving to support these two core beliefs, the Sphere Project framed a Humanitarian Charter and identified a set of minimum standards in key life-saving sectors which are now reflected in the Handbook's four technical chapters:

- water supply, sanitation and hygiene promotion;
- food security and nutrition;
- shelter, settlement and non-food items;
- health action.

The Core Standards are process standards and apply to all technical chapters.

The minimum standards are evidence-based and represent sector-wide consensus on best practice in humanitarian response. Key actions, key indicators and guidance notes (described in the 'How to use the standards' section below) accompany each standard, providing guidance on how to attain the standard.

This handbook is free for down-load, and the AusMAT text has been granted permission to reproduce excerpts from the text. The passages below cover sections most relevant to AusMAT deployments, but a full understanding of other aspects of humanitarian response, particularly the non-medical and the long term recovery sections, is recommended. AusMAT team members are encouraged to down-load and keep the entire text for reference from [www.sphereproject.org](http://www.sphereproject.org). The handbook has been paraphrased or quoted in this introduction, by the editors of the AusMAT text, but the remaining sections are quoted without alteration. Pages quoted in the following excerpts refer to the Sphere handbook page number.

### New developments and focus for this edition of the Sphere handbook include;

- Local and nationally focused response, with greater consultation with affected populations
- Proactive accountability (to the affected population) and coordination (cluster approach) under the auspices of the Inter-Agency Standing Committee (IASC)
- Increased focus on protection issues and responses
- Increased awareness of potential large scale forced migration due to climate change-induced disasters and an awareness that environmental degradation increases vulnerability
- Increased poor urban populations world wide
- New approaches to aid such as cash and voucher transfers for local purchase replacing in-kind shipments of humanitarian assistance
- Increased recognition of disaster risk reduction as both a sector and an approach
- Increased involvement of the military in humanitarian response, a set of actors not primarily driven by the humanitarian imperative, requiring the development of specific guidelines and coordination strategies for the humanitarian civil-military dialogue
- Increased involvement of the private sector in humanitarian response requiring similar guidelines and strategies as the civil-military dialogue

AusMAT members are encouraged to fully read the opening chapter and the humanitarian charter sections of the handbook.

Cross-cutting themes focus on particular areas of concern in disaster response and address individual, group or general vulnerability issues. They are detailed in full in the Sphere handbook introduction (Pg 14-17) and include;

### Individual and subgroup vulnerabilities

- Children
- Gender
- Older people
- HIV and AIDS
- Persons with disabilities
- Psychosocial support

### Entire affected population vulnerabilities

- Disaster risk reduction (including climate change)
- Environment

# The Humanitarian Charter

The Humanitarian Charter provides the ethical and legal backdrop to the Protection Principles and the Core Standards and minimum standards that follow in the Handbook. It is in part a statement of established legal rights and obligations; in part a statement of shared belief.



## Our beliefs

The Humanitarian Charter expresses our shared conviction as humanitarian agencies that all people affected by disaster or conflict have a right to receive protection and assistance to ensure the basic conditions for life with dignity. We believe that the principles described in this Humanitarian Charter are universal, applying to all those affected by disaster or conflict wherever they may be, and to all those who seek to assist them or provide for their security. These principles are reflected in international law, but derive their force ultimately from the fundamental moral principle of humanity: that all human beings are born free and equal in dignity and rights. Based on this principle, we affirm the primacy of the humanitarian imperative: that action should be taken to prevent or alleviate human suffering arising out of disaster or conflict, and that nothing should override this principle.

As local, national and international humanitarian agencies, we commit to promoting and adhering to the principles in this Charter and to meeting minimum standards in our efforts to assist and protect those affected. We invite all those who engage in humanitarian activities, including governmental and private sector actors, to endorse the common principles, rights and duties set out below as a statement of shared humanitarian belief.

## Our role

We acknowledge that it is firstly through their own efforts, and through the support of community and local institutions, that the basic needs of people affected by disaster or conflict are met. We recognise the primary role and responsibility of the affected state to provide timely assistance to those affected, to ensure people's protection and security and to provide support for their recovery. We believe that a combination of official and voluntary action is crucial to effective prevention and response, and in this regard National Societies of the Red Cross and Red Crescent Movement and other civil society actors have an essential role to play in supporting public authorities. Where national capacity is insufficient, we affirm the role of the wider international community, including governmental donors and regional organisations, in assisting states to fulfil their responsibilities. We recognise and support the special roles played by the mandated agencies of the United Nations and the International Committee of the Red Cross.

As humanitarian agencies, we interpret our role in relation to the needs and capacities of affected populations and the responsibilities of their governments or controlling powers. Our role in providing assistance reflects the reality that those with primary responsibility are not always fully able to perform this role themselves, or may be unwilling to do so. As far as possible, consistent with meeting the humanitarian imperative and other principles set out in this Charter, we will support the efforts of the relevant authorities to protect and assist those affected. We call upon all state and non-state actors to respect the impartial, independent and non-partisan role of humanitarian agencies and to facilitate their work by removing unnecessary legal and practical barriers, providing for their safety and allowing them timely and consistent access to affected populations.

## Common principles, rights and duties

We offer our services as humanitarian agencies on the basis of the principle of humanity and the humanitarian imperative, recognising the rights of all people affected by disaster or conflict – women and men, boys and girls.

These include the rights to protection and assistance reflected in the provisions of international humanitarian law, human rights and refugee law. For the purposes of this Charter, we summarize these rights as follows:

- the right to life with dignity
- the right to receive humanitarian assistance
- the right to protection and security.

While these rights are not formulated in such terms in international law, they encapsulate a range of established legal rights and give fuller substance to the humanitarian imperative.

**The right to life with dignity** is reflected in the provisions of international law, and specifically the human rights measures concerning the right to life, to an adequate standard of living and to freedom from torture or cruel, inhuman or degrading treatment or punishment. The right to life entails the duty to preserve life where it is threatened. Implicit in this is the duty not to withhold or frustrate the provision of life-saving assistance. Dignity entails more than physical well-being; it demands respect for the whole person, including the values and beliefs of individuals and affected communities, and respect for their human rights, including liberty, freedom of conscience and religious observance.

**The right to receive humanitarian assistance** is a necessary element of the right to life with dignity. This encompasses the right to an adequate standard of living, including adequate

food, water, clothing, shelter and the requirements for good health, which are expressly guaranteed in international law.

The Sphere Core Standards and minimum standards reflect these rights and give practical expression to them, specifically in relation to the provision of assistance to those affected by disaster or conflict. Where the state or non-state actors are not providing such assistance themselves, we believe they must allow others to help do so. Any such assistance must be provided according to the principle of impartiality, which requires that it be provided solely on the basis of need and in proportion to need. This reflects the wider principle of non-discrimination: that no one should be discriminated against on any grounds of status, including age, gender, race, colour, ethnicity, sexual orientation, language, religion, disability, health status, political or other opinion, national or social origin.

**The right to protection and security** is rooted in the provisions of international law, in resolutions of the United Nations and other intergovernmental organisations, and in the sovereign responsibility of states to protect all those within their jurisdiction. The safety and security of people in situations of disaster or conflict are of particular humanitarian concern, including the protection of refugees and internally displaced persons. As the law recognises, some people may be particularly vulnerable to abuse and adverse discrimination due to their status such as age, gender or race, and may require special measures of protection and assistance. To the extent that a state lacks the capacity to protect people in these circumstances, we believe it must seek international assistance to do so.

The law relating to the protection of civilians and displaced people demands particular attention here:

1. During armed conflict as defined in international humanitarian law, specific legal provision is made for protection and assistance to be given to those not engaged in the conflict. In particular, the 1949 Geneva Conventions and the Additional Protocols of 1977 impose obligations on the parties to both international and non-international armed conflicts. We stress the general immunity of the civilian population from attack and reprisals, and in particular the importance of the principle of distinction between civilians and combatants, and between civilian objects and military objectives; the principles of proportionality in the use of force and precaution in attack; the duty to refrain from the use of weapons which are indiscriminate or which, by their nature, cause superfluous injury or unnecessary suffering; and the duty to permit impartial relief to be provided.

Much of the avoidable suffering caused to civilians in armed conflicts stems from a failure to observe these basic principles.

2. The right to seek asylum or sanctuary remains vital to the protection of those facing persecution or violence. Those affected by disaster or conflict are often forced to flee their homes in search of security and the means of subsistence. The provisions of the 1951 Convention Relating to the Status of Refugees (as amended) and other international and regional treaties provide fundamental safeguards for those unable to secure protection from the state of their nationality or residence who are forced to seek safety in another country. Chief among these is the principle of non-refoulement: the principle that no one shall be sent back to a country where their life, freedom or physical security would be threatened or where they are likely to face torture or other cruel, inhuman or degrading treatment or punishment. The same principle applies by extension to internally displaced persons, as reflected in international human rights law and elaborated in the 1998 Guiding Principles on Internal Displacement and related regional and national law

Core humanitarian protection concerns in this context are freedom from violence and from coercion of various kinds and freedom from deliberate deprivation of the means of survival with dignity.

**These concerns give rise to four basic Protection Principles that inform all humanitarian action:**

- Avoid exposing people to further harm as a result of your actions
- Ensure people's access to impartial assistance – in proportion to need and without discrimination
- Protect people from physical and psychological harm arising from violence and coercion
- Assist people to claim their rights, access available remedies and recover from the effects of abuse.

In the context of humanitarian response, these four Principles reflect the more severe threats that people commonly face in times of conflict or disaster. The guidance notes address the related responsibilities and options for agencies, as well as particular protection needs.

**The four Protection Principles follow from the summary of rights set out in the Humanitarian Charter:**

- the right to life with dignity,
- the right to humanitarian assistance and
- the right to protection and security.

## Understanding the Protection Principles

**The following is a short guide to interpreting the Protection Principles:**

**Principle 1** (avoid causing harm) addresses those protection concerns that may be caused or exacerbated by humanitarian response. As stated in the Charter, those involved in humanitarian response must do all they reasonably can to avoid exposing people affected by disaster or armed conflict to further harm, for example by building settlements for displaced people in unsafe areas.

**Principle 2** (ensure access to impartial assistance) sets out the responsibility to ensure that humanitarian assistance is available to all those in need, particularly those who are most vulnerable or who face exclusion on political or other grounds. The denial of access to necessary assistance is a major protection concern. This may include (but is not limited to) denial of secure access for humanitarian agencies to provide assistance.

**Principle 3** (protect people from violence) is concerned with protection from violence and protection from being forced or induced to act against one's will, e.g. to take up arms, to be forcibly removed from a place or to be prevented from moving, or to be subjected to degrading treatment or punishment. It is concerned with preventing or mitigating physical and psychological harm, including the spread of fear and deliberate creation of terror or panic.

**Principle 4** (assist with rights claims, access to remedies and recovery from abuse) refers to the role of humanitarian agencies in helping affected people claim their entitlements and access remedies such as legal redress, compensation or restitution of property. It is also concerned with helping people overcome the effects of rape and, more generally, with helping people recover from the effects of abuse – physical and psychological, social and economic.

Together with the guidance notes, the four Protection Principles describe what humanitarian agencies can and should do to help protect the disaster-affected population. But it is essential to note that the roles and responsibilities of agencies in this context are generally secondary ones. As the Charter states, such roles must be seen in relation to the primary duty of the state or other relevant authorities, e.g.

parties to a conflict who control or occupy territory. Such authorities hold formal, legal responsibility for the welfare of people within their territory or control and, more generally, for the safety of civilians in armed conflict.

Ultimately, it is these authorities that have the means to ensure the affected population's security through action or restraint. The key role of agencies may be to encourage and persuade them to do so, and to assist people in dealing with the consequences when the authorities fail in their responsibility.

## Putting the Protection Principles into practice

In order to meet the standards of this Handbook, all humanitarian agencies should be guided by the Protection Principles, even if they do not have a distinct protection mandate or specialist capacity in protection.

The Principles are not 'absolute': it is recognised that circumstances may limit the extent to which agencies are able to fulfil them. In particular, aspects of Principle 3 may not lie within an agency's capacity. Nevertheless, the Principles reflect universal humanitarian concerns which should guide action at all times.

A number of humanitarian agencies have protection mandates or specific roles concerning vulnerable groups. Several of these agencies carry out protection activities as stand-alone programs or projects, or framed within 'protection cluster' or 'protection sector' responses with dedicated resources and specialized staff. In 2011, the Global Protection Cluster includes coordination structures with focal points for the following particular areas of concern:

- child protection
- gender-based violence
- housing, land and property
- mine action
- rule of law and justice.

This list illustrates some of the specific areas of protection. It is not a comprehensive list and it should be recognised that there are many other specific protection concerns. Taking particular note of the following checklist:

**Checklist:** When analyzing activities, regularly reflect on the following non-exhaustive list of questions, which could serve as a checklist, in terms of both the overall humanitarian response and specific actions:

- What does the affected population gain by our activities?
- What might be the unintended negative consequences of our activities for people's security, and how can we avoid or minimise these consequences?
- Do the activities take into consideration possible protection threats facing the affected population? Might they undermine people's own efforts to protect themselves?
- Do the activities discriminate against any group or might they be perceived as doing so? Do the activities protect the rights of people who have historically been marginalised or discriminated against?
- In protecting and promoting the rights of such groups, what will be the impact on the relationships within and beyond the community?
- Could the activities exacerbate existing divisions in the community or between neighbouring communities?
- Could the activities inadvertently empower or strengthen the position of armed groups or other actors?
- Could the activities be subject to criminal exploitation?

For Guidance notes on the protection principles please refer to The Sphere Project. Pg 33 - 47

## The Core Standards

**Each Core Standard is structured as follows:**

**The Core Standard:** It is qualitative in nature and specifies the level to be attained in humanitarian response

**Key actions:** These are suggested activities and inputs to help meet the standards

**Key indicators:** These are 'signals' that show whether a standard has been attained They provide a way of measuring and communicating the processes and results of key actions; they relate to the minimum standard, not to the key action

**Guidance notes:** These include specific points to consider when applying the Core Standard, key actions and key indicators in different situations

They provide guidance on tackling practical difficulties, benchmarks or advice on priority issues They may also include critical issues relating to the standards, actions or indicators, and describe dilemmas, controversies or gaps in current knowledge.

### Vulnerability

Sphere's focus is on meeting the urgent survival needs of people affected by disaster or conflict. However, the Core Standards can also support disaster preparedness and approaches that reduce future risk and vulnerability, enhance capacity and promote early recovery. Such approaches take account of the impact of the response on the natural environment and broader context and are highly relevant to the needs of the host and wider population.

Throughout the Handbook, 'vulnerable' refers to people who are especially susceptible to the effects of natural or man-made disasters or of conflict. People are, or become, more vulnerable to disasters due to a combination of physical, social, environmental and political factors. They may be marginalised by their society due to their ethnicity, age, sex, disability, class or caste, political affiliations or religion. A combination of vulnerabilities and the effect of an often volatile context all contribute to people being vulnerable for different reasons and in different ways.

Vulnerable people, like all those affected by disaster, have various capacities to manage and recover from disasters. A thorough understanding of vulnerable people's capacities and the barriers they may face in accessing humanitarian support is essential for a response that meets the needs of those who need it most.

### The importance of the Core Standards for all sectors

**The first Core Standard** recognizes that the participation of disaster-affected people – women, men, girls and boys of all ages – and their capacity and strategies to survive with dignity are integral to humanitarian response.

**Core Standard 2** addresses the need for an effective response to be coordinated and implemented with other agencies and governmental authorities engaged in impartial humanitarian action.

**Core Standard 3** describes the need for assessments systematically to understand the nature of the disaster, identify who has been affected and how, and assess people's vulnerability and capacities. It acknowledges the critical importance of understanding need in relation to the political, social, economic and environmental context and the wider population.

Agencies meeting **Core Standard 4** design their response based on an impartial assessment of needs, addressing unmet needs in relation to the context and capacity of affected people and states to meet their own needs.

**Core Standard 5** is attained by agencies that continually examine the effectiveness, quality and appropriateness of their response. Agencies adapt their strategies in accordance with monitoring information and feedback from people affected by disaster, and share information about their performance. They invest in unbiased reviews and evaluations and use the findings to improve their policy and practice.

**Core Standard 6** recognizes that humanitarian agencies have an obligation to disaster-affected people to employ aid workers with the appropriate knowledge, skills, behaviour and attitudes to deliver an effective humanitarian response. Equally, agencies are responsible for enabling aid workers to perform satisfactorily through effective management and support for their emotional and physical well-being.

Refer to The SPHERE Project for detail on each core standard. Of particular relevance to AusMAT is Core Standard 2, 3 & 6 page 58 – 73.

# Minimum Standards in Water Supply, Sanitation & Hygiene Promotion (WASH)

The Humanitarian Charter provides the ethical and legal backdrop to the Protection Principles and the Core Standards and minimum standards that follow in the Handbook. It is in part a statement of established legal rights and obligations; in part a statement of shared belief.



Water and sanitation are critical determinants for survival in the initial stages of a disaster. People affected by disasters are generally much more susceptible to illness and death from disease, which to a large extent are related to inadequate sanitation, inadequate water supplies and inability to maintain good hygiene. The most significant of these diseases are diarrhoeal and infectious diseases transmitted by the faeco-oral route.

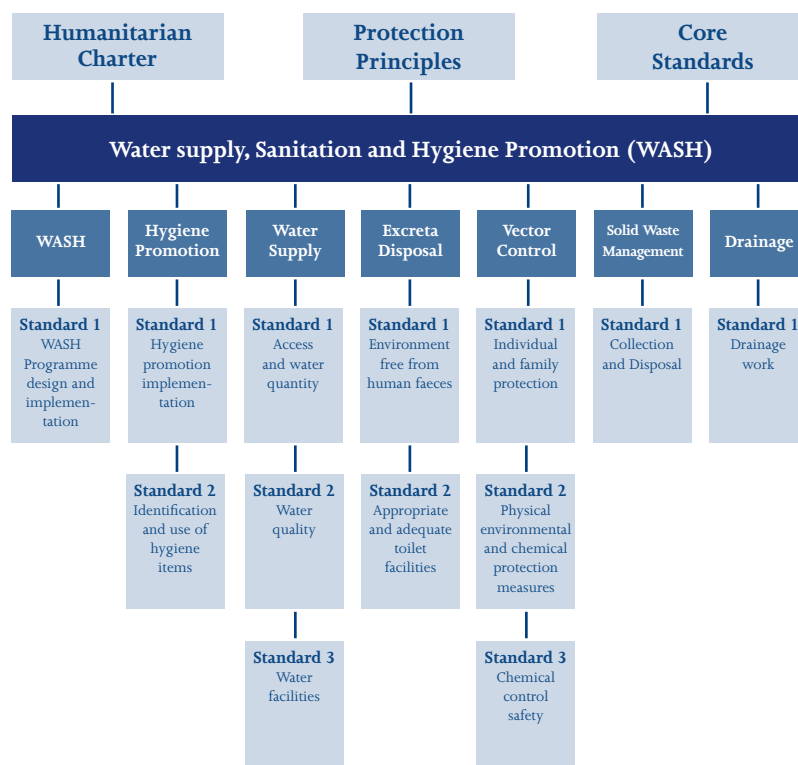
Other water- and sanitation-related diseases include those carried by vectors associated with solid waste and water. The term 'sanitation', throughout the Sphere Handbook, refers to excreta disposal, vector control, solid waste disposal and drainage.

The main objective of WASH programs in disasters is to reduce the transmission of faeco-oral diseases and exposure to disease-bearing vectors through the promotion of:

- good hygiene practices
- the provision of safe drinking water
- the reduction of environmental health risks
- the conditions that allow people to live with good health, dignity, comfort and security.

Simply providing sufficient water and sanitation facilities will not, on its own, ensure their optimal use or impact on public health. In order to achieve the maximum benefit from a response, it is imperative that disaster-affected people have the necessary information, knowledge and understanding to prevent water- and sanitation-related diseases and to mobilise their involvement in the design and maintenance of those facilities.

**The Minimum standard in water supply, sanitation and hygiene promotion is divided into seven main sections:**



## Hygiene promotion

Hygiene promotion is a planned, systematic approach to enable people to take action to prevent and/or mitigate water, sanitation and hygiene-related diseases. It can also provide a practical way to facilitate community participation, accountability and monitoring in WASH programs.

**Hygiene promotion should aim to draw on the affected population's knowledge, practices and resources, as well as on the current WASH evidence base to determine how public health can best be protected.**

Hygiene promotion involves ensuring that people make the best use of the water, sanitation and hygiene-enabling facilities and services provided and includes the effective operation and maintenance of the facilities. The three key factors are:

1. a mutual sharing of information and knowledge
2. the mobilisation of affected communities
3. the provision of essential materials and facilities.

Community mobilisation is especially appropriate during disasters as the emphasis must be on encouraging people to take action to protect their health. Promotional activities should include, where possible, interactive methods, rather than focusing exclusively on the mass dissemination of messages.

### Hygiene promotion standard 1: Hygiene promotion implementation

*Affected men, women and children of all ages are aware of key public health risks and are mobilized to adopt measures to prevent the deterioration in hygienic conditions and to use and maintain the facilities provided*

#### Key actions

**(to be read in conjunction with the Key Indicators and Guidance notes on pages 92-94 The Sphere Project)**

- Systematically provide information on hygiene-related risks and preventive actions using appropriate channels of mass communication.
- Identify specific social, cultural or religious factors that will motivate different social groups in the community and use them as the basis for a hygiene promotion communication strategy (see guidance note 2).
- Use interactive hygiene communication methods wherever feasible in order to ensure ongoing dialogue and discussions with those affected.
- In partnership with the affected community, regularly monitor key hygiene practices and the use of facilities provided

### Hygiene promotion standard 2: Identification and use of hygiene items

*The disaster-affected population has access to and is involved in identifying and promoting the use of hygiene items to ensure personal hygiene, health, dignity and well-being.*

For Key Actions and Key Indicators refer to The Sphere Project vvv 91. The following is taken from the Guidance Notes.

#### List of basic hygiene items

10-20 litre capacity water container for transportation	One per household
10-20 litre capacity water container for storage	One per household
250g bathing soap	One per person per month
200g laundry soap	One per person per month
Acceptable material for menstrual hygiene, e.g. washable cotton cloth	One per person



### Guidance notes:

1. **Basic hygiene items:** A basic minimum hygiene items pack consists of water containers (buckets), bathing and laundry soaps, and menstrual hygiene materials.
2. **Coordination:** Discuss with the shelter cluster and the affected population whether additional non-food items, such as blankets, which are not included in the basic hygiene items are required
3. **Timeliness of hygiene items distribution:** In order to ensure a timely distribution of hygiene items, it may be necessary to distribute some key generic items (soap, jerrycans, etc.) without the agreement of the affected population and come to an agreement concerning future distributions following consultation.
4. **Priority needs:** People may choose to sell the items provided if their priority needs are not appropriately met and so people's livelihoods need to be considered when planning distributions.
5. **Appropriateness:** Care should be taken to avoid specifying products that would not be used due to lack of familiarity or that could be misused (e.g. items that might be mistaken for food). Where culturally appropriate or preferred, washing powder can be specified instead of laundry soap.
6. **Replacement:** Consideration should be given for consumables to be replaced where necessary.
7. **Special needs:** Some people with specific needs (e.g. incontinence or severe diarrhoea) may require increased quantities of personal hygiene items such as soap. Persons with disabilities or those who are confined to bed may need additional items, such as bed pans. Some items may require adaptation for sanitary use (such as a stool with a hole or commode chair).
8. **Menstrual hygiene:** Provision must be made for discreet laundering or disposal of menstrual hygiene materials.
9. **Additional items:** Existing social and cultural practices may require access to additional personal hygiene items. Subject to availability, such items (per person per month) could include:
  - 75ml/100g toothpaste
  - one toothbrush
  - 250ml shampoo
  - 250ml lotion for infants and children up to 2 years of age
  - one disposable razor
  - underwear for women and girls of menstrual age
  - one hairbrush and/or comb
  - nail clippers
  - nappies (diapers) and potties (dependent on household need).



# Water Supply

Water is essential for life, health and human dignity. In extreme situations, there may not be sufficient water available to meet basic needs and in these cases supplying a survival level of safe drinking water is of critical importance. In most cases, the main health problems are caused by poor hygiene due to insufficient water and by the consumption of contaminated water.

## Water supply standard 1: Access and water quantity

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

### Key indicators

*(To be read in conjunction with the guidance notes. For Key Actions refer to the Sphere Project pg 97-102)*

- Average water use for drinking, cooking and personal hygiene in any household is at least 15 litres per person per day (see guidance notes 1–8).
- The maximum distance from any household to the nearest water point is 500 meters (see guidance notes 1, 2, 5 and 8).
- Queuing time at a water source is no more than 30 minutes (see guidance note 7).

### Guidance notes

1. Water sources selection: The following factors should be considered in water source selection: availability, proximity and sustainability of sufficient quantity of water; whether treatment is needed; and its feasibility, including the existence of any social, political or legal factors concerning the source. Generally, groundwater sources and/or gravity-flow supplies from springs are preferable, as they require less treatment and no pumping. In disasters, a combination of approaches and sources is often required in the initial phase. All sources need to be regularly monitored to avoid over-exploitation.
2. Needs: The quantities of water needed for domestic use is context based, and may vary according to the climate, the sanitation facilities available, people's habits, their religious and cultural practices, the food they cook, the clothes they wear, and so on. Water consumption generally increases the nearer the water source is to the dwelling. Where possible, 15 litres per person per day (l/p/d) can be exceeded to conform to local standards where that standard is higher.

## Basic survival water needs

1. Measurement: Household surveys, observation and community discussion groups are more effective methods of collecting data on water use and consumption than the measurement of water pumped into the pipeline network or the operation of hand pumps.
2. Quantity/coverage: In a disaster, and until minimum standards for both water quantity and quality are met, the priority is to provide equitable access to an adequate quantity of water even if it is of intermediate quality. Disaster-affected people are significantly more vulnerable to disease; therefore, water access and quantity indicators should be reached even if they are higher than the norms of the affected or host population. Particular attention should be paid to ensure the need for extra water for people with specific health conditions, such as HIV and AIDS, and to meet the water requirement for livestock and crops in drought situations. To avoid hostility, it is recommended that water and sanitation coverage address the needs of both host and affected populations equally.
3. Maximum numbers of people per water source: The number of people per source depends on the yield and availability of water at each source. The approximate guidelines are:

These guidelines assume that the water point is accessible for approximately eight hours a day only and water supply is constant during that time. If access is greater than this, people can collect more than the 15 litres/day minimum requirement. These targets must be used with caution, as reaching them does not necessarily guarantee a minimum quantity of water or equitable access.

1. Queuing time: Excessive queuing times are indicators of insufficient water availability due to either an inadequate number of water points or inadequate yields at water sources. The potential negative results of excessive queuing times are reduced per capita water consumption, increased consumption from unprotected surface sources and reduced time for other essential survival tasks for those who collect water.

2. Access and equity: Even if a sufficient quantity of water is available to meet minimum needs, additional measures are needed to ensure equitable access for all groups. Water points should be located in areas that are accessible to all, regardless of, for example, gender or ethnicity. Some hand pumps and water carrying containers may need to be designed or adapted for use by people living with HIV and AIDS, older people, persons with disabilities and children. In situations where water is rationed or pumped at given times, this should be planned in consultation with the users including women beneficiaries.

## Water supply standard 2: Water quality

Water is palatable and of sufficient quality to be drunk and used for cooking and personal and domestic hygiene without causing risk to health.

### Key actions

(to be read in conjunction with the key indicators and guidance notes from the Sphere Project pg 100)

- Undertake a rapid sanitary survey and, where time and situation allow, implement a water safety plan for the source (see guidance notes 1–2).
- Implement all necessary steps to minimise post-delivery water contamination (see guidance notes 3–4 and Hygiene promotion standard 1).
- For piped water supplies, or all water supplies at times of risk of diarrhoeal epidemics, undertake water treatment with disinfectant so that there is a chlorine residual of 0.5mg/l and turbidity is below 5 NTU (nephelometric turbidity units) at the tap. In the case of specific diarrhoeal epidemics, ensure that there is residual chlorine of above 1mg/l (see guidance notes 5–8).

Where household-level water treatment is proposed, ensure that it is accompanied by appropriate promotion, training and monitoring.

## Water supply standard 3: Water facilities

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

### Key indicators

(to be read in conjunction with the guidance notes. For Key Actions refer to the Sphere Project pg 103)

- Each household has at least two clean water collecting containers of 10–20 litres, one for storage and one for transportation (see guidance note 1 and Hygiene promotion standard 2, guidance note 1).
- Water collection and storage containers have narrow necks and/or covers for buckets or other safe means of storage, for safe drawing and handling, and are demonstrably used (see guidance note 1).
- There is at least one washing basin per 100 people and private laundering and bathing areas available for women. Enough water is made available for bathing and laundry (see guidance note 2).
- Water at household level is free from contamination at all times (see guidance note 1).
- All people are satisfied with the adequate facilities they have for water collection, storage, bathing, hand washing and laundry (see guidance note 2).
- Regular maintenance of the installed systems and facilities is ensured and users are involved in this where possible (see guidance note 3).

Health centres and hospitals	5 litres per outpatient 40–60 litres per inpatient per day Additional quantities may be needed for laundry equipment, flushing toilets, etc.
Cholera centres	60 litres per patient per day 15 litres per carer per day
Therapeutic feeding centres	30 litres per inpatient per day 15 litres per carer per day
Reception/transit centres	15 litres per person per day if stay is more than one day 3 litres per person per day if stay is limited to day-time
Schools	3 litres per pupil per day for drinking and hand washing (Use for toilets not included: see Public toilets below)
Mosques	2–5 litres per person per day for washing and drinking
Public toilets	1–2 litres per user per day for hand washing 2–8 litres per cubicle per day for toilet cleaning
All flushing toilets	20–40 litres per user per day for conventional flushing toilets connected to a sewer 3–5 litres per user per day for pour-flush toilets
Anal washing	1–2 litres per person per day
Livestock	20–30 litres per large or medium animal per day 5 litres per small animal per day

# Excreta Disposal

Safe disposal of human excreta creates the first barrier to excreta-related disease, helping to reduce disease transmission through direct and indirect routes. Safe excreta disposal is, therefore, a major priority and in most disaster situations should be addressed with as much speed and effort as the provision of a safe water supply.

## Excreta disposal standard 1: Environment free from human faeces

*The living environment in general and specifically the habitat, food production areas, public centres and surroundings of drinking water sources are free from human faecal contamination.*

### Key indicators

*(To be read in conjunction with the guidance notes. For Key Actions refer to the Sphere Project pg105)*

- The environment in which the affected population lives is free from human faeces.
- All excreta containment measures, i.e. trench latrines, pit latrines and soak-away pits, are at least 30 meters away from any groundwater source. The bottom of any latrine or soak-away pit is at least 1.5 meters above the water table.
- In flood or high water table situations, appropriate measures are taken to tackle the problem of faecal contamination of groundwater sources.
- Drainage or spillage from defecation systems does not contaminate surface water or shallow groundwater sources.
- Toilets are used in the most hygienic way possible and children's faeces are disposed of immediately and hygienically.

### Guidance notes

*(For Guidance notes 1-3 please refer to The Sphere Project pg 106)*

Containment of children's faeces: Give particular attention to the disposal of children's faeces, as they are commonly more dangerous than those of adults (excreta-related infection among children is frequently higher and children may not have developed antibodies to infections). Parents and caregivers should be provided with information about safe disposal of infants' faeces, laundering practices and the use of nappies (diapers), potties or scoops for effectively managing safe disposal.



## Excreta disposal standard 2: Appropriate and adequate toilet facilities

*People have adequate, appropriate and acceptable toilet facilities, sufficiently close to their dwellings, to allow rapid, safe and secure access at all times, day and night.*

### Key indicators

*(to be read in conjunction with the guidance notes. For Key Actions refer to The Sphere Project pg107)*

- Toilets are appropriately designed, built and located to meet the following requirements:
- They can be used safely by all sections of the population, including children, older people, pregnant women and persons with disabilities (see guidance note 1)
- They are sited in such a way as to minimise security threats to users, especially women and girls, throughout the day and the night.
- They provide a degree of privacy in line with the norms of the users .
- They are sufficiently easy to use and keep clean and do not present a health hazard to the environment. Depending on the context, the toilets are appropriately provided with water for hand washing and/or for flushing.
- They allow for the disposal of women's menstrual hygiene materials and provide women with the necessary privacy for washing and drying menstrual hygiene materials they minimise fly and mosquito breeding.
- They are provided with mechanisms for desludging, transport and appropriate disposal in the event that the toilets are sealed or are for long-term use and there is a need to empty them.
- In high water table or flood situations, the pits or containers for excreta are made watertight in order to minimise contamination of groundwater and the environment.
- A maximum of 20 people use each toilet Separate, internally lockable toilets for women and men are available in public places, such as markets, distribution centres, health centres, schools, etc.
- Toilets are no more than 50 meters from dwellings.
- Use of toilets is arranged by household(s) and/or segregated by sex.

### Vector Control

A vector is a disease-carrying agent and vector-borne diseases are a major cause of sickness and death in many disaster situations. Mosquitoes are the vector responsible for malaria transmission, which is one of the leading causes of morbidity and mortality.

- All the affected population is satisfied with the process of consultation and with the toilet facilities provided and uses them appropriately.
- People wash their hands after using toilets and before eating and food preparation.

**Mosquitoes also transmit other diseases, such as yellow fever, dengue and haemorrhagic fever.** Non-biting or synanthropic flies, such as the house fly, the blow fly and the flesh fly, play an important role in the transmission of diarrhoeal disease. Biting flies, bedbugs and fleas are a painful nuisance and in some cases transmit significant diseases such as murine typhus, scabies and plague. Ticks transmit relapsing fever, while human body lice transmit typhus and relapsing fever. Rats and mice can transmit diseases, such as leptospirosis and salmonellosis, and can be hosts for other vectors, e.g. fleas, which may transmit Lassa fever, plague and other infections.

Vector-borne diseases can be controlled through a variety of initiatives, including appropriate site selection and provision of shelter, water supply, excreta disposal, solid waste management and drainage, provision of health services (including community mobilisation and health promotion), use of chemical controls, family and individual protection, and effective protection of food stores. The nature of vector-borne disease is often complex and addressing vector-related problems may demand specialist attention. However, there is often much that can be done to help prevent the spread of such diseases with simple and effective measures, once the disease, its vector and their interaction with the population have been identified.



#### Vector control standard 1: Individual and family protection

All disaster-affected people have the knowledge and the means to protect themselves from disease and nuisance vectors that are likely to cause a significant risk to health or well-being.

##### Key actions

*(to be read in conjunction with the guidance notes. For Key Indicators refer to The Sphere Project 111)*

- Raise the awareness of all affected people who are at risk from vector-borne diseases about possible causes of vector-related diseases, methods of transmission and possible methods of prevention.
- Help the affected population to avoid exposure to mosquitoes during peak biting times by using all non-harmful means (such as bed nets, repellent lotions, etc.) that are made available to them.
- Pay special attention to the protection of high-risk groups such as pregnant and feeding mothers, babies, infants, older people, those with restricted mobility and the sick.
- Carry out control of human body lice where louse-borne typhus or relapsing fever is a threat.
- Ensure that bedding and clothing are aired and washed regularly.

##### Guidance notes

1. **Defining vector-borne disease risk:** Decisions about vector control interventions should be based on an assessment of potential disease risk, as well as on clinical evidence of a vector-borne disease problem. Factors influencing this risk include:  
Immunity status of the population, including previous exposure, nutritional stress and other stresses. Movement of people (e.g. refugees, internally displaced people (IDPs)) from a non-endemic to an endemic area is a common cause of epidemics.  
Pathogen type and prevalence, in both vectors and humans -vector species, behaviours and ecology -vector numbers (season, breeding sites, etc.) -increased exposure to vectors: proximity, settlement pattern, shelter type, existing individual protection and avoidance measures.
2. **Indicators for vector control programs:** Commonly used indicators for measuring the impact of vector

control activities are vector-borne disease incidence rates (from epidemiological data, community-based data and proxy indicators, depending on the response) and parasite counts (using rapid diagnostic kits or microscopy).

3. **Individual malaria protection measures:** If there is a significant risk of malaria, the systematic and timely provision of protection measures is recommended, such as insecticide-treated materials, e.g. tents, curtains and bed nets. Impregnated bed nets have the added advantage of giving some protection against body and head lice, fleas, ticks, cockroaches and bedbugs. Long-sleeved clothing, household fumigants, burning coils, aerosol sprays and repellents are among other protection methods that can be used against mosquitoes. It is vital to ensure that users understand the importance of protection and how to use the tools correctly so that the protection measures are effective. Where resources are scarce, they should be directed at individuals and groups most at risk, such as children under 5 years old, non-immunes and pregnant women.
4. **Individual protection measures** for other vectors: Good personal hygiene and regular washing of clothes and bedding are the most effective protection against body lice. Infestations can be controlled by personal treatment (powdering), mass laundering or delousing campaigns and by treatment protocols as newly displaced people arrive in a settlement. A clean house-hold environment, together with good waste disposal and good food storage (cooked and uncooked), will deter rats, other rodents and insects (such as cockroaches) from entering houses or shelters.
5. **Water-borne diseases:** People should be informed of health risks and should avoid entering bodies of water where there is a known risk of contracting diseases such as schistosomiasis, Guinea worm or leptospirosis (transmitted by exposure to mammalian urine, especially that of rats)

## Vector control standard 2: Physical, environmental and chemical protection measures

*The environment where the disaster-affected people are placed does not expose them to disease-causing and nuisance vectors, and those vectors are kept to a reduced level where possible.*

### Guidance notes

(for Key indicators and Key Actions and guidance notes 1, 4, 5 refer to The Sphere Project pg 114)

1. Environmental mosquito control: Environmental control aims primarily at eliminating mosquito breeding sites. The three main species of mosquitoes responsible for transmitting disease are Culex (filariasis), Anopheles (malaria and filariasis) and Aedes (yellow fever and dengue). Culex mosquitoes breed in stagnant water loaded with organic matter such as latrines, Anopheles in relatively unpolluted surface water such as puddles, slow-flowing streams and wells, and Aedes in water receptacles such as bottles, buckets, tyres, etc. Examples of environmental mosquito control include good drainage, properly functioning VIP (ventilated improved pit) latrines, keeping lids on the squatting hole of pit latrines and on water containers, and keeping wells covered and/or treating them with a larvicide (e.g. for areas where dengue fever is endemic).
2. Malaria treatment: Malaria control strategies that aim to reduce the mosquito population density should be carried out simultaneously with early diagnosis and treatment with effective anti-malarials. Such strategies will include eliminating breeding sites, reducing the mosquito daily survival rate and restricting the habit of biting humans. Campaigns to encourage early diagnosis and treatment should be initiated and sustained. An integrated approach, combining active case finding by trained outreach workers and treatment with effective antimalarials, is more likely to reduce the malaria burden than passive case finding through centralised health services.

# Solid Waste Management

Solid waste management is the process of handling and disposal of organic and hazardous solid waste which, if unattended appropriately, can pose public health risks to the affected population and can have a negative impact on the environment.

Such risks can arise from the breeding of flies and rodents that thrive on solid waste (see Vector control section in *The Sphere Project*) and the pollution of surface- and groundwater sources due to leachate from mixed household and clinical or industrial waste. Uncollected and accumulating solid waste and the debris left after a natural disaster may also create an ugly and depressing environment, which might help discourage efforts to improve other aspects of environmental health. Solid waste often blocks drainage channels and leads to an increased risk of flooding, resulting in environmental health problems associated with stagnant and polluted surface water. Waste pickers, who gain a small income from collecting recyclable materials from waste dumps, may also be at risk of infectious disease from hospital waste mixed with household waste.

## Solid waste management standard 1: Collection and disposal

*The affected population has an environment not littered by solid waste, including medical waste, and has the means to dispose of their domestic waste conveniently and effectively.*

### Key actions

*(to be read in conjunction with the guidance notes – all other Key actions can be found in *The Sphere Project* pg 117)*

- Provide personnel who deal with the collection and disposal of solid waste material and those involved in material collection for recycling with appropriate protective clothing and immunisation against tetanus and hepatitis B (see guidance note 7).
- In the event that the appropriate and dignified disposal of dead bodies is a priority need, coordinate with responsible agencies and authorities dealing with it.



### Key indicators

*(to be read in conjunction with the guidance notes – all remaining Key indicators can be found in *The Sphere Project* pg 117)*

- All medical waste (including dangerous waste such as glasses, needles, dressings and drugs) is isolated and disposed of separately in a correctly designed, constructed and operated pit or incinerator with a deep ash pit, within the boundaries of each health facility.
- **Guidance notes:**  
*(Refer to *The Sphere Project* for guidance notes related to solid waste management)*
  1. **Medical waste:** Poor management of healthcare waste exposes the population, healthcare workers and waste handlers to infections, toxic effects and injuries. In a disaster situation, the most hazardous types of waste are likely to be infectious sharps and non-sharps (wound dressings, blood-stained cloth and organic matter such as placentas, etc.). The different types of waste should be separated at source. Non-infectious waste (paper, plastic wrappings, food waste, etc.) can be disposed of as solid waste. Contaminated sharps, especially used needles and syringes, should be placed in a safety box directly after use. Safety boxes and other infectious waste can be disposed of on-site by burial, incineration or other safe methods (see Health systems standard 1, guidance note).
  2. **Staff welfare:** All involved in the collection, transport, disposal and recycling of solid waste should be provided with protective clothing, including at minimum gloves but ideally overalls, boots and protective masks. When necessary, immunisation against tetanus and hepatitis B should also be provided. Water and soap should be available for hand and face washing. Staff who come into contact with medical waste should be informed of the correct methods of storage, transport and disposal and the risks associated with improper management of the waste.
  3. **Management of dead bodies:** The management and/or burial of dead bodies from natural disasters should be dealt with in an appropriate and dignified manner. It is usually handled by search and recovery teams, in coordination with responsible government agencies and authorities. The burial of people who have died due to communicable diseases also needs to be managed appropriately and in consultation and coordination with health authorities (see Health systems standard 1, guidance note 12). Further information on how to deal with appropriate burial of dead bodies can be obtained from the materials in the References and further reading section.

## Drainage

Surface water in or near settlements may come from household and water point wastewater, leaking toilets and sewers, rainwater or rising floodwater. The main health risks associated with surface water are contamination of water supplies and the living environment, damage to toilets and dwellings, vector breeding, and drowning.

**Rainwater and rising floodwaters can worsen the drainage situation in a settlement and further increase the risk of contamination.** A proper drainage plan, addressing stormwater drainage through site planning and wastewater disposal using small-scale, on-site drainage, should be implemented to reduce potential health risks to the disaster-affected population. This section addresses small-scale drainage problems and activities. Large-scale drainage is generally determined by site selection and development.

### Drainage standard 1: Drainage work

*People have an environment in which health risks and other risks posed by water erosion and standing water, including stormwater, floodwater, domestic wastewater and wastewater from medical facilities, are minimized.*

#### Key actions

(to be read in conjunction with the guidance notes)

- Provide appropriate drainage facilities so that dwelling areas and water distribution points are kept free of standing wastewater and that stormwater drains are kept clear
- Seek an agreement with the affected population on how to deal with the drainage problem and provide sufficient numbers of appropriate tools for small drainage works and maintenance where necessary.
- Ensure that all water points and hand washing facilities have effective drainage to prevent muddy conditions.





# The Importance of Food Security and Nutrition in Disasters

The minimum standards in this chapter reflect the core content of the right to food and contribute to the progressive realization of this right globally.

Access to food and the maintenance of an adequate nutritional status are critical determinants of people's survival in a disaster (see The place of Sphere within humanitarian action on page 9). The people affected are often already chronically undernourished when the disaster hits. Undernutrition is a serious public health problem and among the lead causes of death, whether directly or indirectly.



Nutrition is a broad term referring to processes involved in eating, digestion and utilisation of food by the body for growth and development, reproduction, physical activity and maintenance of health. The term 'malnutrition' technically includes undernutrition and over-nutrition. Undernutrition encompasses a range of conditions, including acute malnutrition, chronic malnutrition and micronutrient deficiencies. Acute malnutrition refers to wasting (thinness) and/ or nutritional oedema, while chronic malnutrition refers to stunting (shortness). Stunting and wasting are two forms of growth failure. In this chapter, we refer to undernutrition and revert to malnutrition specifically for acute malnutrition.

The vulnerability of infants and young children means that addressing their nutrition should be a priority. Prevention of undernutrition is as important as treatment of acute malnutrition. Food security interventions may determine nutrition and health in the short term and their survival and well-being in the long term.

Women often play a greater role in planning and preparation of food for their households. Following a disaster, household livelihood strategies may change. Recognising distinct roles in family nutrition is key to improving food security at the household level. Understanding the unique nutritional needs of pregnant and lactating women, young children, older people and persons with disabilities is also important in developing appropriate food responses.

Food security and nutrition assessment standard 2 is of particular relevance to AusMAT. Refer to the The Sphere Project for the remaining key standards page 150.

## Food security and nutrition assessment standard 2: Nutrition

Where people are at increased risk of undernutrition, assessments are conducted using internationally accepted methods to understand the type, degree and extent of undernutrition and identify those most affected, those most at risk and the appropriate response.

### Key actions

(to be read in conjunction with the guidance notes. For Key indicators refer to The Sphere Project pg 150)

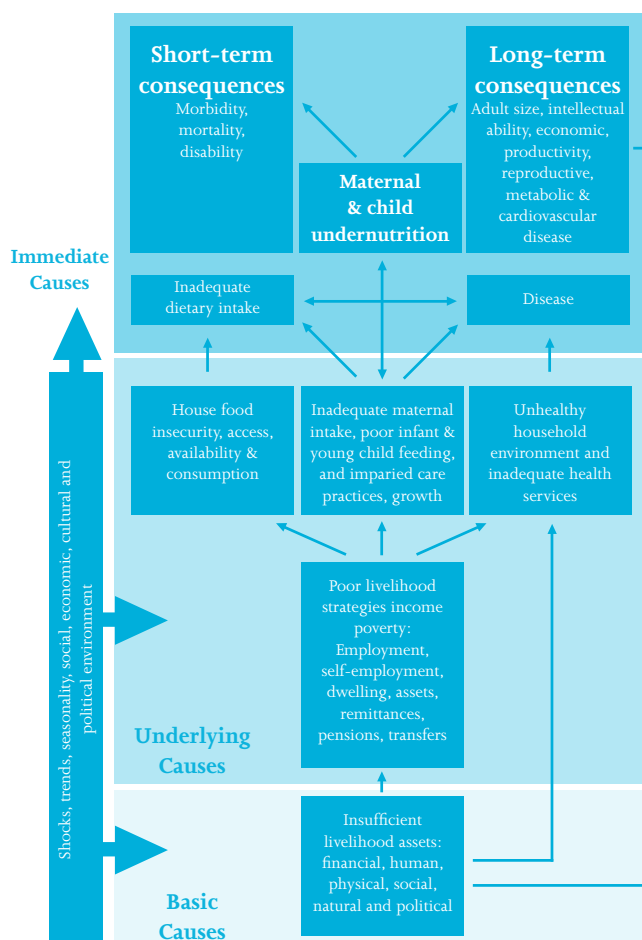
- Compile existing information from pre-disaster and initial assessments to highlight the nature and severity of the nutrition situation.
- Identify groups with the greatest nutritional support needs and the underlying factors that potentially affect nutritional status.
- Determine if population-level qualitative or quantitative assessments are needed to better measure and understand anthropometric status, micronutrient status, infant and young child feeding, maternal care practices and associated potential determinants of undernutrition.

- Consider the opinions of the local community and other local stakeholders on the potential determinants of undernutrition.
- Include an assessment of national and local capacity to lead and/or support response.
- Use nutrition assessment information to determine if the situation is stable or declining.

### Guidance Notes:

(Exerts from the guidance notes, refer to The Sphere Project for guidance notes 1, 3, 4-10 pg151-153).

**Methodology:** Nutrition assessments of any type should have clear objectives, use internationally accepted methods, identify nutritionally vulnerable individuals and create an understanding of factors that may contribute to undernutrition. The assessment and analysis process should be documented and presented in a timely report in a logical and transparent manner. Assessment approaches need to be impartial, representative and well coordinated among agencies and governments so information is complementary, consistent and comparable. Multi-agency assessments may be beneficial in assessing large-scale multi-technical and wide geographical areas.



# Infant and young child feeding

Suboptimal infant and young child feeding practices increase vulnerability to undernutrition, disease and death. The risks are heightened in disasters and the youngest are most vulnerable. Optimal feeding practices that maximize survival and reduce morbidity in children under 24 months are early initiation of exclusive breastfeeding, exclusive breastfeeding for 6 months, continued breastfeeding to 24 months or beyond, and introduction of adequate, appropriate and safe complementary foods at 6 months.

## Infant and young child feeding standard 1: Policy guidance and coordination

*Safe and appropriate infant and young child feeding for the population is protected through implementation of key policy guidance and strong coordination*

### Key actions

*(to be read in conjunction with the guidance notes. Key indicators and guidance notes can be found in The Sphere Project pg 159)*

- Uphold the provisions of the Operational Guidance on infant feeding in emergencies (IFE) and the International Code of Marketing of Breast milk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions (collectively known as the Code).
- Avoid soliciting or accepting donations of breast milk substitutes (BMS), other milk products, bottles and teats.

## Infant and young child feeding standard 2: Basic and skilled support

*Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimizes risks and optimizes nutrition, health and survival outcomes.*

### Key actions

*(to be read in conjunction with the guidance notes)*

1. Undertake integrated multisector interventions to protect and support safe and appropriate IYCF (see guidance note 1).
2. Give priority to pregnant and breastfeeding women to access food, cash and/or voucher transfers and other supportive interventions (see guidance note 1).
3. Integrate skilled breastfeeding counselling in interventions that target pregnant and breastfeeding women and children aged 0–24 months (see guidance notes 2–7).

4. Target mothers of all newborns with support for early initiation of exclusive breastfeeding (see guidance note 3).
5. Support timely, safe, adequate and appropriate complementary feeding (see guidance note 5).
6. Enable access for mothers and caregivers whose infants require artificial feeding to an adequate amount of an appropriate BMS and associated support (see guidance note 6).
7. Give special consideration to feeding support of infants and young children in exceptionally difficult circumstances (orphans, acutely malnourished children, LBW infants and those affected by HIV) (see guidance notes 4–7).

### Key indicators

*(to be read in conjunction with the guidance notes)*

- Measurement of standard WHO indicators for early initiation of breastfeeding, exclusive breastfeeding rate in children <6 months, and continued breast-feeding rate at 1 and 2 years (see guidance notes 2–3, 5–6).
- Caregivers have access to timely, appropriate, nutritionally adequate and safe complementary foods for children 6 to <24 months (see guidance notes 5–6).
- Breastfeeding mothers have access to skilled breastfeeding support (see guidance notes 1–3).
- There is access to Code-compliant supplies of appropriate BMS and associated support for infants who require artificial feeding (see guidance note 5).



### Guidance notes

1. Simple measures and basic interventions are needed to create a protective and supportive environment for IYCF. Be alert to and investigate reports of difficulties in breastfeeding, complementary feeding and/or practice of artificial feeding in children aged 0–24 months. Non-breastfed infants need urgent support. Support should be prioritised for mothers, caregivers and pregnant and breastfeeding women to meet immediate essential needs. Households with children under 24 months and breastfeeding mothers of all newborns should be registered and linked to food security programs to ensure access to adequate food. Designated shelters for mothers and caregivers enables access to peer-to-peer and basic IYCF support. Breast-feeding support should be integrated within key services such as reproductive health, primary healthcare, psychosocial services and selective feeding programs from the outset.
2. Pregnant and breastfeeding women: Inadequate nutrient intakes for pregnant and breastfeeding women risk pregnancy complications, maternal mortality, LBW infants and decline in maternal nutritional status associated with lower concentrations of certain nutrients in breastmilk. Low maternal body weight at conception is strongly associated with infant LBW and is a feature of adolescent pregnancy. Pregnant and breastfeeding women should receive daily supplements providing one daily requirement of multiple micronutrients to protect maternal stores and breastmilk content, whether they receive fortified rations or not. Iron and folic acid supplements when already provided should be continued. Women should also receive Vitamin A within six to eight weeks of delivery. Micronutrient supplementation should be in accordance with international recommendations on doses and timing. Referral to psychosocial services may be needed, especially in traumatised populations. Although nutrition support of the adolescent mother is important, programs to prevent adolescent pregnancy are likely to have the most impact on LBW incidence.
3. Early initiation of exclusive breastfeeding (within one hour of birth) is a priority intervention to safeguard the health of both the mother and the infant. LBW infants and their mothers will benefit especially from continued skin-to-skin contact at birth and early initiation of exclusive breastfeeding (see Essential health services – child health standard 2, guidance note 1).
4. Breastfeeding : Exclusive breastfeeding requires an infant to receive only breastmilk and no water, other liquids or solids, with the exception of necessary micronutrient supplements or medicines. It guarantees food and fluid security in infants for the first six months and provides active immune protection. Breastfeeding also protects older infants and children, especially in contexts where water, sanitation and hygiene conditions are lacking, so is important to sustain to 24 months or beyond. Mothers, families, communities and health workers should be reassured of the resilience of breastfeeding; confidence can be undermined by acute emergency situations. Planning and resource allocation should allow for skilled breastfeeding support in managing more difficult situations including stressed populations and acutely malnourished infants under 6 months (see Management of acute malnutrition and micronutrient deficiencies standard 2), populations where mixed feeding is common, and infant feeding in the context of HIV (see guidance note 7).
5. Complementary feeding is the process of giving other food in addition to breastmilk from the age of 6 months (or to an appropriate breastmilk substitute in non-breastfed infants). During the complementary feeding period (6–24 months), breastfeeding continues to significantly contribute to food and fluid security. Non-breastfed infants need support to make up the nutritional shortfall. Links with food security programs are essential to support complementary feeding. Where a population is dependent on food aid, a suitable micronutrient-fortified food should be included in the general ration; blanket provision of complementary food may be needed. Clear criteria for the inclusion, use and duration of lipid-based nutrient supplements during the complementary feeding period are needed for different emergency contexts. Ready-to-use therapeutic foods are not a complementary food. Distribution of complementary food should be accompanied with practical guidance and demonstration on their preparation. The use of micronutrient supplementation, including Vitamin A, should be in accordance with the latest recommendations. LBW infants and young children may benefit from iron supplementation. If the population is in a malaria-endemic area, iron supplementation should be targeted to children who are anaemic and iron deficient with appropriate malaria control measures. Refer: Nutritional chapter in this clinical chapter.

6. **Artificial feeding:** Infants who are not breastfed require early identification and assessment by skilled personnel to explore feeding options. Where maternal breastfeeding is not available, donor breastmilk, particularly as wet nursing, has a valuable role, especially in feeding young and LBW infants. Where artificial feeding is indicated, mothers and caregivers need assured access to adequate amounts of an appropriate BMS for as long as is necessary (until infants are at least 6 months old) as well as to the associated essential supports (water, fuel, storage facilities, growth monitoring, medical care, time). Infants under 6 months who are mixed fed should be supported to move to exclusive breastfeeding. Feeding bottles should not be used due to difficulties in cleaning. Programs that support artificial feeding should monitor the community's IYCF practices using standard indicators to ensure that breastfeeding is not undermined. Morbidity surveillance should be conducted at individual and population levels, with a particular focus on diarrhoea. Low-dose supplemental Vitamin A should be considered for nonbreastfed infants under 6 months.
7. **HIV and infant feeding:** Maximising the survival of HIV-free children is a primary consideration in determining the best feeding option for infants born to HIV-infected mothers. Mothers of unknown or negative HIV status should be supported to breastfeed as per general IYCF recommendations for populations (see guidance notes 3–5). For HIV-infected mothers, combining anti-retroviral (ARV) interventions with breastfeeding can significantly reduce post-natal HIV transmission. Accelerated access to ARVs should be prioritized (see Essential health services – sexual and reproductive health standard 2). The risks to infants associated with replacement feeding are even greater under emergency conditions. This means that breastfeeding offers the greater likelihood of survival for infants born to HIV-infected mothers and for survival of HIV-infected infants, including where ARVs are not yet available. Urgent artificial feeding assistance is needed for infants already established on replacement feeding. (see guidance note 6)

## Management of acute malnutrition and micronutrient deficiencies

Acute malnutrition and micronutrient deficiencies are associated with an increased risk of morbidity and mortality for affected individuals. Therefore, when such prevalence or risk is high, it is necessary to ensure access to services which both correct and prevent undernutrition. The impact of these services will be considerably reduced if the underlying causes of undernutrition are not addressed simultaneously through other interventions to support health, WASH, food transfers and food security.

Moderate acute malnutrition can be addressed in a number of ways. In disasters, supplementary feeding is often the primary strategy for prevention and treatment of moderate acute malnutrition and prevention of severe acute malnutrition. This may be blanket or targeted depending on the levels of acute malnutrition, vulnerable population groups and risk of an increase in acute malnutrition. The indicators in Management of acute malnutrition and micronutrient deficiencies standard 1 refer primarily to targeted supplementary feeding. While there are no defined impact indicators for blanket supplementary feeding, monitoring of coverage, acceptability and rations provided are important.

### Management of acute malnutrition and micronutrient deficiencies standard 1: Moderate acute malnutrition is addressed.

#### Guidance notes

(For Key Action and Key Indicators please refer to The Sphere Project pg 165. Guidance notes 1-5 are found in The Sphere Project pg 166)

1. **Health inputs and considerations:** Targeted supplementary feeding programs are an important contact point for screening and referring for illness. Programs should take into account the capacity of existing health services and ensure effective provision of antihelminthics, Vitamin A supplementation, iron and folic acid combined with malaria screening and treatment, zinc for treatment of diarrhoea and immunizations (see Essential health services – control of communicable disease standard 2 and Essential health services – child health standards 1–2). In areas of high HIV prevalence, HIV testing and prophylactic treatment should be available and the quality and quantity of the supplementary food ration should be given special consideration.
2. **Breastfeeding mothers** of acutely malnourished infants under 6 months should be admitted to supplementary feeding, independent of maternal nutrition status. Moderately malnourished mothers can successfully breastfeed and need adequate nutrition support to protect their own nutritional status. Mothers should receive supplementary feeding rations, skilled breastfeeding support on exclusive breastfeeding and advice on safe, nutritious and responsive complementary feeding. Infants under 6 months who are acutely malnourished should be referred appropriately for skilled breastfeeding support and inpatient care as necessary.
3. **Rations:** Dry rations or ready-to-use foods provided on a weekly or bi-weekly basis are preferred to on-site feeding but their composition and size should take into account household food security and the likelihood of sharing. Clear information should be given on how to prepare and store supplementary food in a hygienic manner, how and when it should be consumed (see Food security – food transfers standard 6, guidance note 1) and the importance of continued breastfeeding for children under 24 months of age. Vulnerable people, such as those with mobility challenges, may require programme adaptations to meet their specific needs.

### Management of acute malnutrition and micronutrient deficiencies standard 2: Severe acute malnutrition

#### Guidance notes

(For Key Action and Key Indicators refer to The Sphere Project pg169.

For guidance notes 1-5, 7-8 please refer to The Sphere Project pg171)

1. **Discharge criteria and recovery:** Discharged individuals must be free from medical complications, have regained their appetite and have achieved and maintained appropriate weight gain without nutrition-related oedema (e.g. for two consecutive weighings). Breastfeeding status is especially important for infants under 6 months as well as for children to 24 months. Non-breastfed infants will need close follow-up. Discharge criteria should be adhered to in order to avoid the risks associated with premature discharge. Guidelines define limits for the mean length of stay for treatment and are aimed at avoiding prolonged recovery periods. Mean length of stay will differ depending on the guidelines in use and so should be adjusted to national context and guidelines in use. Mean weight gain should be calculated separately for individuals with and without nutritional oedema. HIV, AIDS and TB may result in some malnourished individuals failing to respond to treatment. Options for longer-term treatment or care should be considered in conjunction with health services and other social and community support services
2. **Breastfeeding support:** Infants who are admitted for inpatient care tend to be among the most unwell. Mothers need skilled breastfeeding support as part of nutritional rehabilitation and recovery, particularly for children <6 months. Sufficient time and resources should be provided for this – a designated area (breastfeeding corner) to target skilled support and enable peer support may help. Breastfeeding mothers of severely malnourished infants under 6 months should receive a supplementary ration regardless of their nutritional status unless they meet the anthropometric criteria for severe acute malnutrition in which case they should also be admitted for treatment.

## Management of acute malnutrition and micronutrient deficiencies standard 3: Micronutrient deficiencies

*Micronutrient interventions accompany public health and other nutrition interventions to reduce common diseases associated with emergencies and address micronutrient deficiencies.*

### Key actions

*(to be read in conjunction with the guidance notes)*

- Train health staff in how to identify and treat micronutrient deficiencies (see guidance notes 1–2).
- Establish procedures to respond effectively to the types of micronutrient deficiencies from which the population may be at risk (see guidance note 2).

### Key indicators

*(to be read in conjunction with the guidance notes)*

- Cases of micronutrient deficiencies are treated according to current best clinical practice (see guidance notes 1–2).
- Micronutrient interventions accompany public health interventions to reduce common diseases associated with emergencies such as measles (Vitamin A) and diarrhoea (zinc) (see guidance notes 3–4).

### Guidance notes

*(guidance notes 2–3 can be found in The Sphere Project pg173)*

1. Diagnosis and treatment of clinical micronutrient deficiencies: Diagnosis of some clinical micronutrient deficiencies is possible through simple examination. Clinical indicators of these deficiencies can be incorporated into health or nutritional surveillance systems, although careful training of staff is required to ensure that assessment is accurate. Case definitions are problematic and in emergencies can often only be determined through the response to supplementation by individuals who present themselves to health staff. Treatment of micronutrient deficiencies should involve active case-finding and the use of agreed case definitions and guidelines for treatment. Case-finding and treatment should take place both within the health system and within feeding programs (see Food security and nutrition assessment standard 2, guidance note 6), Blanket treatment of the population with supplements may be appropriate. Scurvy (Vitamin C), pellagra (niacin), beriberi (thiamine) and ariboflavinosis (riboflavin) are the most commonly observed epidemics to result from inadequate access to micronutrients in food aid-dependent populations. With this in mind, deficiencies should be tackled by population-wide interventions as well as individual treatment.
2. Use of micronutrients in the treatment of common diseases: Micronutrient supplementation should be integrated in the prevention and treatment of certain diseases. This includes the provision of Vitamin A supplementation alongside measles vaccination and inclusion of zinc with oral rehydration salts (ORS) in guidelines to treat diarrhoea (see Essential health services – child health standards 1–2 on pages 321–323 and Infant and young child feeding standard 2).

# Appendix

See Malnutrition section pg. 271

## Measuring acute malnutrition

In major nutritional emergencies, it may be necessary to include infants aged less than 6 months, pregnant and breastfeeding women, older children, adolescents, adults or older people in nutrition assessments or nutritional programs.

### Surveys of age groups other than children aged 6–59 months should only be undertaken if:

- a thorough contextual analysis of the situation is undertaken, including an analysis of the causes of malnutrition. Only if the results of this analysis suggest that the nutritional status of young children does not reflect the nutritional status of the general population should a nutrition survey for another age group be considered
- technical expertise is available to ensure a high quality of data collection, adequate analysis and correct presentation and interpretation of results
- the resource and/or opportunity costs of including other age groups in a survey have been considered
- clear and well-documented objectives for the survey are formulated.

## Infants under 6 months

While research is ongoing for this age group, the evidence base for assessment and management is currently limited. Most guidelines recommend the same anthropometric case definitions of acute infant malnutrition as for older children aged 6–59 months (except for mid upper arm circumference (MUAC) which is not presently recommended for infants <6 months). Admission criteria focus on current size rather than an assessment of growth. The switch from NCHS growth references to WHO 2006 growth standards results in more cases of infant <6 month wasting. The implications of this change should be considered and addressed. Potential issues include more infants presenting to feeding programs or caregivers becoming concerned about the adequacy of exclusive breastfeeding. It is important to assess and consider:

- the infants longitudinal growth – is the rate of growth good despite body size being small (some infants may for example be ‘catching up’ following low birth weight)?
- infant feeding practices – is the infant exclusively breastfeeding? – clinical status – does the infant have any medical complications or conditions which are treatable or which make him/her high risk?

- maternal factors – e.g. does the mother lack family support or is she depressed? Inpatient admission to therapeutic feeding programs should be a priority for high risk infants.

## Children 6–59 months

The table below shows the commonly used indicators of different grades of malnutrition among children aged 6–59 months. Weight for height (WFH) indices should be calculated using the WHO 2006 child growth standards. The WFH Z score (according to WHO standards) is the preferred indicator for reporting anthropometric survey results. MUAC is an independent criterion for acute malnutrition and is one of the best predictors of mortality. The prevalence of low MUAC is also investigated in surveys to predict case loads for supplementary feeding and therapeutic care programs. The cut-offs commonly used are <11.5cm for severe acute malnutrition, and 11.5–<12.5cm for moderate acute malnutrition. It is also often used, with a higher cut-off, as part of a two-stage screening process. It should not be used alone in anthropometric surveys but can be used as sole admission criteria for feeding programs.

## Children aged 5–19 years

Use of the WHO 2007 growth standards is recommended to determine nutrition status in children aged 5–19 years. These growth reference data curves are a reconstruction of the 1977 NCHS/WHO reference and are closely aligned with the WHO child growth standards for children 6–59 months and the recommended cut-offs for adults. The use of MUAC in older children and adolescents, particularly in the context of HIV, may be considered. As this is a developing technical area, it is important to refer to latest guidance and technical updates.

## Adults (20–59.9 years)

There is no agreed definition of acute malnutrition in adults, but evidence suggests that cut-offs for severe acute malnutrition could be lower than a body mass index (BMI) of 16 and lower than 18.5 for mild and moderate acute malnutrition. Surveys of adult malnutrition should aim to gather data on weight, height, sitting height and MUAC measurements. These data can be used to calculate BMI. BMI should be adjusted for Cormic index (the ratio of sitting height to standing height) only to make comparisons between populations. Such adjustment can substantially change the apparent prevalence of undernutrition in adults and may have important programmatic ramifications.

MUAC measurements should always be taken. If immediate results are needed or resources are severely limited, surveys may be based on MUAC measurements alone.

Because the interpretation of anthropometric results is complicated by the lack of validated functional outcome data and benchmarks for determining the meaning of the result, such results must be interpreted along with detailed contextual information. Guidance on assessment can be found under References and further reading.

For screening individuals for nutritional care admission and discharge, criteria should include a combination of anthropometric indices, clinical signs (particularly weakness, recent weight loss) and social factors (access to food, presence of caregivers, shelter, etc.). Note that oedema in adults can be caused by a variety of reasons other than malnutrition, and clinicians should assess adult oedema to exclude other causes. Individual agencies should decide on the indicator to determine eligibility for care, taking into account the known shortcomings of BMI and the lack of information on MUAC and the programme implications of their use. As this is a developing technical area, it is important to refer to latest guidance and technical updates.

MUAC may be used as a screening tool for pregnant women, e.g. as a criterion for entry into a feeding programme. Given their additional nutritional needs, pregnant women may be at greater risk than other groups in the population. MUAC does not change significantly through pregnancy. MUAC <20.7cm (severe risk) and <23cm (moderate risk) have been shown to carry a risk of growth retardation of the foetus. Suggested cut-off points for risk vary by country and range from 21cm to 23cm. Less than 21cm has been suggested as an appropriate cut-off for selection of women at risk during emergencies.

## Older people

There is currently no agreed definition of malnutrition in older people and yet this group may be at risk of malnutrition in emergencies. WHO suggests that the BMI thresholds for adults may be appropriate for older people aged 60–69 years and above. However, accuracy of measurement is problematic because of spinal curvature (stooping) and compression of the vertebrae. Arm span or demi-span can be used instead of height, but the multiplication factor to calculate height varies according to the population. Visual assessment is necessary. MUAC may be a useful tool for measuring malnutrition in older people but research on appropriate cut-offs is currently still in progress.

## Persons with disabilities

No guidelines currently exist for the measurement of individuals with physical disabilities and therefore they are often excluded from anthropometric surveys. Visual assessment is necessary. MUAC measurements may be misleading in cases where upper arm muscle might build up to aid mobility. There are alternatives to standard measures of height, including length, arm span, demi-span or lower leg length. It is necessary to consult the latest research to determine the most appropriate way of measuring disabled individuals for whom standard weight, height and MUAC measurement is not appropriate.

# Minimum Standards in Shelter, Settlement and Non Food Items



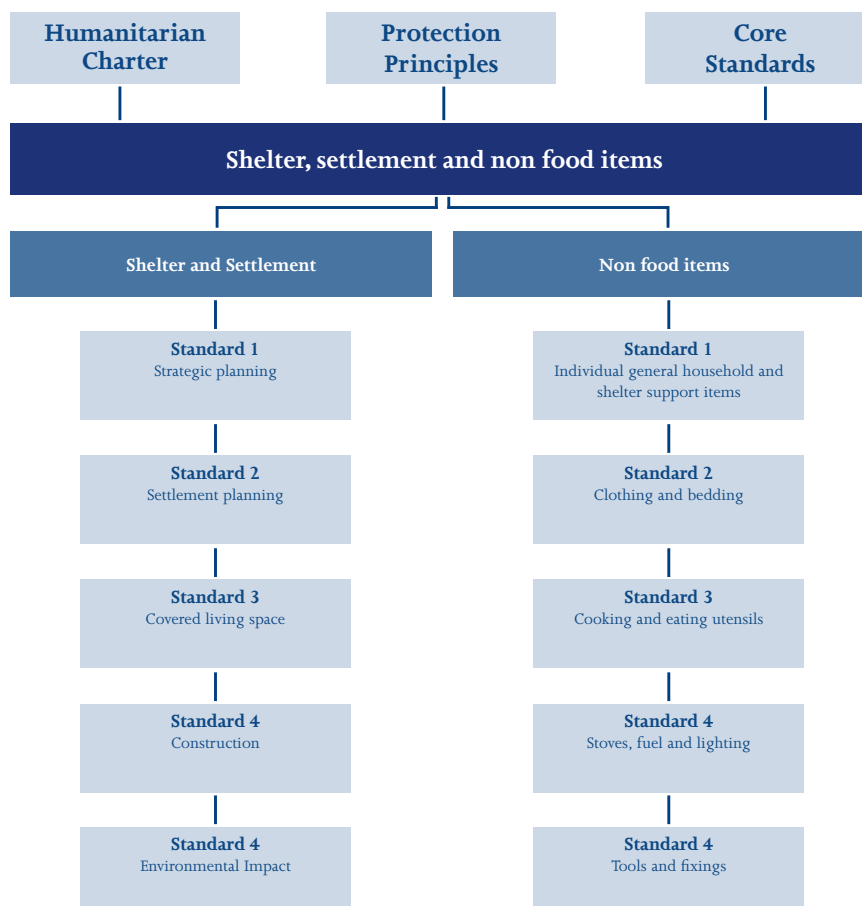
## Introduction

**Shelter is a critical determinant for survival in the initial stages of a disaster.** Beyond survival, shelter is necessary to provide security, personal safety and protection from the climate and to promote resistance to ill health and disease. It is also

important for human dignity, to sustain family and community life and to enable affected populations to recover from the impact of disaster.

The shelter, settlement and non-food item needs of populations affected by a disaster are determined by the type and scale of the disaster and the extent to which the population is displaced. The response will also be informed by the ability and desire of displaced populations to return to the

site of their original dwelling and to start the recovery process: where they are unable or unwilling to return, they will require temporary or transitional shelter and settlement solutions (see the diagram opposite). The local context of the disaster will inform the response, including whether the affected area is rural or urban; the local climatic and environmental conditions; the political and security situation; and the ability of the affected population to contribute to meeting their shelter needs.



# The Importance of Health Action in Disasters

Access to healthcare is a critical determinant for survival in the initial stages of disaster. Disasters almost always have significant impacts on the public health and well-being of affected populations.



**The public health impacts may be described as direct (e.g. death from violence and injury) or indirect (e.g. increased rates of infectious diseases and/or malnutrition).** These indirect health impacts are usually related to factors such as inadequate quantity and quality of water, breakdowns in sanitation, disruption of or reduced access to health services and deterioration of food security. Lack of security, movement constraints, population displacement and worsened living conditions (overcrowding and inadequate shelter) can also pose public health threats. Climate change is potentially increasing vulnerability and risk.

The primary goals of humanitarian response to humanitarian crises are to prevent and reduce excess mortality and morbidity. The main aim is to maintain the crude mortality rate (CMR) and under-5 mortality rate (U5MR) at, or reduce to, less than double the baseline rate documented for the population prior to the disaster (see table on baseline reference mortality data by region). Different types of disaster are associated with differing scales and patterns of mortality and morbidity (see table on public health impact of selected disasters opposite), and the health needs of an affected population will therefore vary according to the type and extent of the disaster.

The contribution from the health sector is to provide essential health services, including preventive and promotive interventions that are effective in reducing health risks. Essential health services are priority health interventions that are effective in addressing the major causes of excess mortality and morbidity. The implementation of essential health services must be supported by actions to strengthen the health system. The way health interventions are planned, organised and delivered in response to a disaster can either enhance or undermine the existing health systems and their future recovery and development.

## Public health impact of selected disasters

The health system standards of Sphere are organised according to the WHO health system framework, consisting of six building blocks: leadership, human resources, drugs and medical supplies, health financing, health information management and service delivery. There are many interconnections and interactions between each of these functions and an action affecting one component can affect the others. These health system building blocks are the functions that are required to deliver essential health services. Health interventions during disaster response should be designed and implemented in a way that contributes to strengthening health systems.



# Health systems

The World Health Organization (WHO) defines health systems as: “all the organizations, institutions and resources that are devoted to producing health actions”. It includes the full range of players engaged in the provision, financing and management of health services, efforts to influence determinants of health as well as providing direct health services, and encompassing all levels: central, regional, district, community and household.

## Health systems standard 1: Health service delivery

*People have equal access to effective, safe and quality health services that are standardised and follow accepted protocols and guidelines.*

### Key actions

(to be read in conjunction with the guidance notes)

- Provide health services at the appropriate level of the health system. Levels include household and community, clinic or health post, health centre and hospital (see guidance note 1).
- Adapt or establish standardised case management protocols for the most common diseases, taking account of national standards and guidelines (see guidance note 2).
- Establish or strengthen a standardised referral system and ensure it is utilised by all agencies (see guidance note 1).
- Establish or strengthen a standardised system of triage at all health facilities to ensure those with emergency signs receive immediate treatment.
- Initiate health education and promotion at community and health facility levels (see guidance note 3).
- Establish and follow safe and rational use of blood supply and blood products (see guidance note 5).
- Ensure that laboratory services are available and used when indicated (see guidance note 6).
- Avoid the establishment of alternative or parallel health services, including mobile clinics and field hospitals (see guidance notes 7–8).
- Design health services in a manner that ensures patients' rights to privacy, confidentiality and informed consent (see guidance note 9).
- Implement appropriate waste management procedures, safety measures and infection control methods in health facilities (see guidance notes 10–11 and Solid waste management standard 1).
- Dispose of dead bodies in a manner that is dignified, culturally appropriate and based on good public health practice (see guidance note 12 and Solid waste management standard 1, guidance note 8).

### Key indicators

(to be read in conjunction with the guidance notes)

- There are an adequate number of health facilities to meet the essential health needs of all the disaster-affected population:
- one basic health unit/10,000 population (basic health units are primary healthcare facilities where general health services are offered) -one health centre/50,000 people -one district or rural hospital/250,000 people ->10 inpatient and maternity beds/10,000 people (see guidance note 1).
- Utilisation rates at health facilities are 2–4 new consultations/person/year among the disaster-affected population and >1 new consultations/person/ year among rural and dispersed populations (see guidance note 4 and Appendix 3: Formulas for calculating key health indicators).

### Guidance notes

1. **Level of care:** Health facilities are categorised by level of care according to their size and the services provided. The number and location of health facilities required can vary from context to context. Health systems must also develop a process for continuity of care. This is best achieved by establishing an effective referral system, especially for life-saving interventions. The referral system should function 24 hours a day, seven days a week.
2. **National standards and guidelines:** In general, agencies should adhere to the health standards and guidelines of the country where the disaster response is being implemented, including treatment protocols and essential medicines lists. When they are outdated or do not reflect evidence-based practice, international standards should be used as reference and the lead agency for the health sector should support the Ministry of Health (MOH) to update them.
3. **Health promotion:** An active program of community health promotion should be initiated in consultation with local health authorities and community representatives, ensuring a balanced representation of women and men. The program should provide information on the major health problems, health risks, the availability and location of health services

and behaviours that protect and promote good health, and address and discourage harmful practices. Public health messages and materials should utilise appropriate language and media, be culturally sensitive and easy to understand. Schools and child-friendly spaces are important venues for spreading information and reaching out to children and parents (see INEE Minimum Standards for Education – access and learning environment standard 3).

4. **Utilisation rate of health services:** There is no minimum threshold figure for the use of health services, as this will vary from context to context. Among stable rural and dispersed populations, utilisation rates should be at least 1 new consultation/person/year. Among disaster-affected populations, an average of 2–4 new consultations/person/year may be expected. If the rate is lower than expected, it may indicate inadequate access to health services. If the rate is higher, it may suggest over-utilisation due to a specific public health problem or under-estimation of the target population. In analysing utilisation rates, consideration should ideally also be given to utilisation by sex, age, ethnic origin and disability (see Appendix 3: Formulas for calculating key health indicators).
5. **Safe blood transfusion:** Efforts should be coordinated with the national blood transfusion service (BTS), if one exists. Collection of blood should only be from voluntary non-remunerated blood donors. Good laboratory practice should be established, including screening for transfusion-transmissible infections, blood grouping, compatibility testing, blood component production and the storage and transportation of blood products. Unnecessary transfusions can be reduced through the effective clinical use of blood, including the use of alternatives to transfusion (crystalloids and colloids), wherever possible. Appropriate clinical staff should be trained to ensure the provision of safe blood and its effective clinical use.
6. **Laboratory services:** The most common communicable diseases can be diagnosed clinically (e.g. diarrhoea, acute respiratory infections) or with the assistance of rapid diagnostic tests or microscopy (e.g. malaria). Laboratory testing is most useful for confirming the cause of a suspected outbreak, testing for culture and antibiotic sensitivity to assist case management decisions (e.g. dysentery) and selecting vaccines where mass immunisation may be indicated (e.g. meningococcal meningitis). For certain non-communicable diseases, such as diabetes, laboratory testing is essential for diagnosis and treatment.
7. **Mobile clinics:** During some disasters, it may be necessary to operate mobile clinics in order to meet the needs of isolated or mobile populations who have limited access to healthcare. Mobile clinics have also been proven crucial in increasing access to treatment in outbreaks where a large number of cases are expected, such as malaria outbreaks. Mobile clinics should be introduced only after consultation with the lead agency for the health sector and with local authorities (see Health systems standard 6 on page 307).
8. **Field hospitals:** Occasionally, field hospitals may be the only way to provide healthcare when existing hospitals are severely damaged or destroyed. However, it is usually more effective to provide resources to existing hospitals so that they can start working again or cope with the extra load. It may be appropriate to deploy a field hospital for the immediate care of traumatic injuries (first 48 hours), secondary care of traumatic injuries and routine surgical and obstetrical emergencies (days 3–15) or as a temporary facility to substitute for a damaged local hospital until it is reconstructed. Because field hospitals are highly visible, there is often substantial political pressure from donor governments to deploy them. However, it is important to make the decision to deploy field hospitals based solely on need and value added.
9. **Patients' rights:** Health facilities and services should be designed in a manner that ensures privacy and confidentiality. Informed consent should be sought from patients (or their guardians if they are not competent to do so), prior to medical or surgical procedures. Health staff should understand that patients have a right to know what each procedure involves, as well as its expected benefits, potential risks, costs and duration.

### 10. Infection control in healthcare settings and

**patient safety:** For an effective response during disasters, continuing infection prevention and control (IPC) programs should be enforced at both national and peripheral levels, and at the various healthcare facility levels. Such an IPC program at a healthcare facility should include:

- defined IPC policies (e.g. routine and additional infection control measures to address potential threats)
- qualified, dedicated technical staff (IPC team) to run infection control program with a defined scope, function and responsibility.
- early warning surveillance system for detection of communicable disease outbreaks.
- defined budget for activities (e.g. training of staff) and supplies in response to an emergency. reinforced standard precautions and additional specific precautions defined for an epidemic disease.
- administrative controls (e.g. isolation policies) and environmental and engineering controls (e.g. improving environmental ventilation).
- personal protective equipment used.
- IPC practices monitored and recommendations reviewed regularly.

**11. Healthcare waste:** Hazardous waste generated in healthcare facilities can be segregated into infectious non-sharp waste, sharps and non-infectious common wastes. Poor management of healthcare waste potentially exposes health staff, cleaners, waste handlers, patients and others in the community to infections such as HIV and hepatitis B and C. Proper separation at the point of origin of the waste through to final category specific disposal procedures must be implemented in order to minimise the risk of infection. The personnel assigned to handle healthcare waste should be properly trained and should wear protective equipment (gloves and boots are minimum requirements). Treatment should be done according to the type of waste: for example, infectious non-sharp waste as well as sharps should be either disposed of in protected pits or incinerated.

**12. Handling the remains of the dead:** When disasters result in high mortality, the management of a large number of dead bodies will be required. Burial of large numbers of human remains in mass graves is often based

on the false belief that they represent a health risk if not buried or burned immediately. In only a few special cases (e.g. deaths resulting from cholera or haemorrhagic fevers) do human remains pose health risks and require specific precautions. Bodies should not be disposed of unceremoniously in mass graves. People should have the opportunity to identify their family members and to conduct culturally appropriate funerals. Mass burial may be a barrier to obtaining death certificates necessary for making legal claims. When those being buried are victims of violence, forensic issues should be considered (see Managing the dead in the clinical chapter. See Shelter and settlement standard 2, guidance note 3 on page 255 of The Sphere Project).

## Health systems standard 2: Human Resources

*Health services are provided by trained and competent health work-forces who have an adequate mix of knowledge and skills to meet the health needs of the population.*

*(See The Sphere Project for standard 2 Key Actions, Key Indicators and Guidance notes)*

## Health systems standard 3: Drugs and medical supplies

*People have access to a consistent supply of essential medicines and consumables.*

### Key actions (to be read in conjunction with the guidance notes)

Review the existing lists of essential medicines of the disaster-affected country early in the response to determine their appropriateness (see guidance note 1).

- Establish and endorse a standardised essential medicines and medical equipment list that contains items appropriate for the health needs and the competence level of health workers (see guidance notes 1–2).
- Establish or adapt an effective medicines management system (see guidance note 3).
- Ensure essential medicines for the treatment of common illnesses are available.

- Accept donations of medicine only if they follow internationally recognised guidelines. Do not use donations that do not follow these guidelines and dispose of them safely.

#### Key indicator

(to be read in conjunction with the guidance notes)

- No health facility is out of stock of selected essential medicines and tracer products for more than one week (see guidance note 4).

#### Guidance notes

- **Essential medicines list:** Most countries have an established essential medicines list. This document should be reviewed, when necessary, in consultation with the lead health authority early in the disaster response to determine its appropriateness. Occasionally, alterations to essential medicines lists may be necessary, e.g. if there is evidence of resistance to recommended antimicrobials. If an updated list does not already exist, guidelines established by WHO should be followed, e.g. the WHO Model Lists of Essential Medicines. The use of standard pre-packaged kits should be limited to the early phases of a disaster.
- **Medical equipment:** Care should be taken in defining a list of the necessary equipment available at different healthcare levels. This should also be linked to the required competency of the staff.
- **Drug management:** Health agencies need to establish an effective system of drug management. The goal of such a system is to ensure the efficient, cost-effective and rational use of quality medicines, storage and correct disposal of expired medicines. This system should be based on the four key elements of the medicines management cycle: selection, procurement, distribution and use.
- **Tracer products:** These include a list of essential or key medicines that are selected to regularly evaluate the functioning of the drug management system. The items to be selected as tracer products should be relevant to local public health priorities and should be available at all times at the health facilities. Examples include amoxicillin and paracetamol.

## Health systems standard 4: Health financing

*People have access to free primary healthcare services for the duration of the disaster.*

#### Key actions

(to be read in conjunction with the guidance notes)

- Identify and mobilise financial resources for providing free health services at the point of delivery to the affected population for the duration of the disaster (see guidance note 1).
- Where user fees are charged through the government system, make arrangements for their abolition or temporary suspension for the duration of the disaster response (see guidance note 2).
- Provide financial and technical support to the health system to cover any financial gaps created by the abolition and/or suspension of user fees and to cope with the increased demand for health services (see guidance note 1).

#### Key indicator

(to be read in conjunction with the guidance notes)

- Primary healthcare services are provided to the disaster-affected population free of charge at all government and non-governmental organisation facilities for the duration of the disaster response.

#### Guidance notes

- **Health financing:** The cost of providing essential health services varies according to the context. Such a context includes the existing health system, the population affected by the disaster and the specific health needs determined by the disaster. According to the WHO Commission on Macroeconomics and Health, providing a minimum package of essential health services would require expenditure of at least US\$ 40/person/year in low-income countries (2008 figures). Providing health services in disaster settings is likely to incur higher costs than in stable settings.
- User fees refer to direct payments by beneficiaries at the point of service delivery. User fees impede access to healthcare and result in poor and vulnerable people not always seeking appropriate healthcare when it is needed. A basic humanitarian principle is that services

and goods provided by aid agencies should be free of charge to recipients. In contexts where this is not possible, providing members of the affected population with cash and/or vouchers can be considered to enable access to health services (see Food security – cash and voucher transfers standard 1 in The Sphere Project). Removal of user fees must be accompanied by other measures to support the health system to compensate for the revenue forgone and increase use (e.g. paying incentives to health staff, providing additional supplies of medicine). The accessibility and quality of services must be monitored after the removal of user fees.

### Health systems standard 5: Health information management

*The design and delivery of health services are guided by the collection, analysis, interpretation and utilisation of relevant public health data.*

#### Key actions

*(to be read in conjunction with the guidance notes)*

- Decide on the use of the existing health information system (HIS), its adaptation or the use of alternative HIS (see guidance note 1).
- When relevant, conduct assessments and surveys to collect information that is not available from the HIS and is critical for deciding on priority health services (see guidance note 2).
- Develop and/or utilise standardised case definitions for all reportable diseases and health conditions and ensure they are used by all agencies.
- Design surveillance and early warning (EWARN) systems for detection of outbreaks as a component of the HIS and build upon existing HIS whenever possible (see Essential health services – control of communicable diseases standard 3 and Appendix 2: Sample weekly surveillance reporting forms).
- Identify and report priority diseases and health conditions through the HIS.
- All responding agencies agree upon and use a common figure, such as population (see guidance note 3).
- Health facilities and agencies submit surveillance and other HIS data to the lead agency on a regular basis. The frequency of these reports will vary according to the context and to the type of data, e.g. daily, weekly, monthly.

- Use supplementary data consistently from other relevant sources, such as surveys, to interpret surveillance data and to guide decision-making (see guidance note 2).
- Take adequate precautions for the protection of data to guarantee the rights and safety of individuals and/or populations (see guidance note 4).

#### Key indicators

*(to be read in conjunction with the guidance notes)*

- All health facilities and agencies regularly provide a HIS report within 48 hours of the end of the reporting period to the lead agency.
- All health facilities and agencies report cases of epidemic-prone diseases within 24 hours of onset of illness (see Essential health services – control of communicable diseases standard 3).
- The lead agency produces a regular overall health information report, including analysis and interpretation of epidemiological data, as well as a report on the coverage and utilisation of the health services.

#### Guidance notes

1. **Health information system:** A surveillance system should build upon the existing HIS whenever possible. In some disasters, a new or parallel HIS may be required. This is determined by an assessment of the performance and adequacy of the existing HIS and the information needs for the current disaster. During the disaster response, health data should include, but not be limited to, the following:
  - deaths recorded by health facilities including under-5 deaths
  - proportional mortality -cause-specific mortality
  - incidence rates for most common morbidities
  - proportional morbidity
  - health facility utilisation rate
  - number of consultations/clinician/day.
2. **Sources of data:** The interpretation and use of health facility data need to take into account the source of the information and its limitations. The use of supplemental data for decision-making is essential in a comprehensive HIS, for example estimates of prevalence of diseases or information on health-seeking behaviour. Other sources of data that may improve the analysis include population-based surveys, laboratory reports and quality of service measurements. Surveys and assessment must

follow internationally recognised quality criteria and use standardised tools and protocols and, where possible, be submitted to a peer-review process.

3. **Disaggregation of data:** Data should be disaggregated by sex, age, vulnerability of particular individuals, affected and host populations, and context (e.g. camp versus non-camp situation) as far as is practical to guide decision-making. Detailed disaggregation may be difficult during the early stages of an emergency. However, mortality and morbidity data should at least be disaggregated for children under 5 years old. As time and conditions allow, more detailed disaggregation should be sought to help detect potential inequalities and vulnerable people (see Core Standard 3).
4. **Confidentiality:** Adequate precautions should be taken to protect the safety of the individual, as well as the data itself. Staff members should never share patient information with anyone not directly involved in the patient's care without the patient's permission. Special consideration should be given to persons with intellectual, mental or sensory impairment, which may compromise their ability to give informed consent. Data that relate to injury caused by torture or other human rights violations including sexual assault must be treated with the utmost care. Consideration may be given to passing on this information to appropriate actors or institutions if the individual gives their informed consent (see Health systems standard 1 and Protection Principle 1, guidance notes 7–12). See Appendix 2 for sample mortality, EWARN and morbidity monitoring forms. See Appendix 3 for formulas for calculating key health indicators.

## Health systems standard 6: Leadership and coordination

*People have access to health services that are coordinated across agencies and sectors to achieve maximum impact.*

### Key actions

*(to be read in conjunction with the guidance notes)*

- Ensure that representatives of the Ministry of Health lead or at the very least are closely involved in the health sector coordination, whenever possible.
- When the MOH lacks the necessary capacity or willingness to provide leadership in the response, an alternate agency with the requisite capacity must be identified to take the lead in health sector coordination (see guidance notes 1–2).
- Hold regular health coordination meetings for local and external partners at central, sub-national and field levels within the health sector, and between health and other sectors and appropriate cross-cutting theme groups (see guidance note 3 and Core Standard 2).
- Clarify and document the specific responsibilities and capacities of each health agency to ensure optimal coverage of the population (see guidance note 1).
- Establish working groups within the health coordination mechanism whenever a particular situation may require it (e.g. outbreak preparedness and response, reproductive health).
- Regularly produce and disseminate updates and health sector bulletins.

### Key indicator

(to be read in conjunction with the guidance notes)

- The lead agency has developed a health sector response strategy document to priorities interventions and define the role of the lead and partner agencies at the onset of emergency response (see guidance note 2).

### Guidance notes

1. **Lead health agency:** The Ministry of Health should be the lead health agency and be responsible for leading the health sector response. In some situations, the MOH may lack capacity or willingness to assume the leadership role in an effective and impartial manner. In this situation, WHO, as a lead agency for the global health cluster, will generally take on this responsibility. On occasion, when both the MOH and WHO lack capacity, another agency may be required to coordinate activities. The lead health agency should ensure that responding health agencies coordinate with local health authorities and that they support the capacities of local health systems (see Core Standard 2).
2. **Health sector strategy:** An important responsibility of the lead health agency is to develop an overall strategy for the emergency response within the health sector. Ideally, a document should be produced that specifies health sector priorities and objectives and outlines the strategies for achieving them. This document should be developed after consultation with relevant agencies and community representatives ensuring as inclusive a process as possible.
3. **Coordination meetings** should be action-oriented and provide a forum in which information is shared, priorities are identified and monitored, common health strategies are developed and adapted, specific tasks are allocated and standardised protocols and interventions are agreed upon. They should be used to ensure that all health partners use common denominators and other relevant figures, tools, guidelines and standards, whenever possible. Meetings should be held more frequently at the beginning of the disaster.



## Essential health services

Essential health services are preventive and curative health services that are appropriate to address the health needs of populations affected by disasters. They include interventions that are most effective in preventing and reducing excess morbidity and mortality from communicable and non-communicable diseases, the consequences of conflict and mass casualty events. During disasters, death rates can be extremely high and identification of the major causes of morbidity and mortality is important for the design of appropriate essential health services. This part of the health chapter outlines the essential health service standards categorized under six sections: control of communicable diseases; child health; sexual and reproductive health; injury; mental health; and non-communicable diseases.

### Essential health services standard 1: Prioritising health services

People have access to health services that are prioritised to address the main causes of excess mortality and morbidity.

#### Key actions

(to be read in conjunction with the guidance notes)

- Collect and analyze data on health problems and risks with the aim of targeting the major causes of excess mortality and morbidity, in coordination with local health authorities (see Core Standard 3).
- Identify vulnerable people (e.g. women, children, older people, persons with disabilities, etc.) who may be at particular risk (see Protection Principle 2).
- Priorities and implement health services that are appropriate, feasible and effective to reduce excess morbidity and mortality, in coordination with local health authorities (see guidance note 1).
- Identify barriers that impede access to prioritised health services and establish practical solutions to address them (see guidance note 2).
- Implement priority health services in coordination with all other sectors and/ or clusters and cross-cutting themes (see Core Standard 2).

#### Key indicators

(to be read in conjunction with the guidance notes)

- The crude mortality rate (CMR) is maintained at, or reduced to, less than double the baseline rate documented for the population prior to the disaster (see guidance note 3).
- The under-5 mortality rate (U5MR) is maintained at, or reduced to, less than double the baseline rate documented for the population prior to the disaster (see guidance note 3).

#### Guidance notes

- **Priority health services** are essential health services that are effective in addressing the major causes of excess mortality and morbidity. They vary according to the context, including the type of disaster and its impact. As far as possible, priority

health services should be based on the principle of evidence-based practice and have a demonstrated public health benefit. Once mortality rates have declined to near-baseline levels, a more comprehensive range of health services can be introduced over time (see Core Standard 4).

- **Access to health services** should be based on the principles of equity and impartiality, ensuring equal access according to need without any discrimination. In practice, the location and staffing of health services should be organised to ensure optimal access and coverage. The particular needs of vulnerable people should be addressed when designing health services. Barriers to access may be physical, financial, behavioural and/or cultural, as well as communication barriers. Identifying and overcoming such barriers to the access of prioritised health services are essential (see Core Standard 3 and Protection Principle 2).
- **Crude mortality rate and under-5 mortality rate:** The CMR is the most useful health indicator to monitor and evaluate the severity of an emergency situation. A doubling or more of the baseline CMR indicates a significant public health emergency, requiring immediate response. When the baseline rate is unknown or of doubtful validity, agencies should aim to maintain the CMR at least below 1.0/10,000/day.

The U5MR is a more sensitive indicator than CMR. When the baseline rate is unknown or of doubtful validity, agencies should aim to maintain the U5MR at least below 2.0/10,000/day (see Appendix 3: Formulas for calculating key health indicators).

#### Baseline reference mortality data by region

Region	CMR (deaths/ 10,000/day)	CMR emergency threshold	U5MR (deaths/ 10,000/day)	U5MR emergency threshold
Sub-Saharan Africa	0.41	0.8	1.07	2.1
Middle East and North Africa	0.16	0.3	0.27	0.5
South Asia	0.22	0.4	0.46	0.9
East Asia and Pacific	0.19	0.4	0.15	0.3
Latin America and Caribbean	0.16	0.3	0.15	0.3
Central and Eastern European region/CIS* and Baltic States	0.33	0.7	0.14	0.3
Industrialised countries	0.25	0.5	0.03	0.1
Developing countries	0.22	0.4	0.44	0.9
Least developed countries	0.33	0.7	0.82	1.7
World	0.25	0.5	0.40	0.8

\* Commonwealth of Independent States Source: UNICEF, State of the World's Children 2009 (data from 2007)

# Control of communicable diseases

Morbidity and mortality due to communicable diseases tend to increase with disasters. In many conflict-affected settings, between 60 per cent and 90 per cent of deaths have been attributed to four major infectious causes: acute respiratory infections, diarrhoea, measles and malaria where endemic. Acute malnutrition exacerbates these diseases, especially in children under 5 years of age. Outbreaks of communicable diseases are far less commonly associated with acute-onset natural disasters. When outbreaks occur, they are generally associated with risk factors such as population displacement, overcrowding, inadequate shelter, insufficient and unsafe water and inadequate sanitation.

## Essential health services – control of communicable diseases

Morbidity and mortality due to communicable diseases tend to increase with disasters. In many conflict-affected settings, between 60 per cent and 90 per cent of deaths have been attributed to four major infectious causes: acute respiratory infections, diarrhoea, measles and malaria where endemic. Acute malnutrition exacerbates these diseases, especially in children under 5 years of age. Outbreaks of communicable diseases are far less commonly associated with acute-onset natural disasters. When outbreaks occur, they are generally associated with risk factors such as population displacement, overcrowding, inadequate shelter, insufficient and unsafe water and inadequate sanitation.

## Essential health services – control of communicable diseases standard 1: Communicable disease prevention

*People have access to information and services that are designed to prevent the communicable diseases that contribute most significantly to excess morbidity and mortality.*

### Key actions

*(to be read in conjunction with the guidance notes)*

- Develop and implement general prevention measures in coordination with relevant sectors (see guidance note 1).
- Implement appropriate vector control methods for malaria, dengue and other vector-borne diseases depending on local epidemiology (see guidance notes 2–3).
- Implement disease-specific prevention measures, e.g. mass vaccination against measles as indicated (see Essential health services – child health standard 1).

### Key indicator

*(to be read in conjunction with the guidance notes)*

Incidence of major communicable diseases relevant to the context are stable (not increasing).

### Guidance notes

1. **General prevention measures:** This includes good site planning, provision of clean water and proper sanitation, access to hygiene facilities, vaccination against specific diseases, sufficient and safe food supply, personal protection and vector control, and community health education and social mobilisation. Most of these intervention should be developed in coordination with other sectors, including:
  - shelter – adequate numbers of shelters and sufficient space between them, adequately ventilated, insect-proofed and sited away from standing water, close enough to water and sanitation facilities (see Shelter and settlement standards 1–3 and Non-food items standard 2)
  - water, sanitation, hygiene – sufficient quantities of safe water and adequate sanitation facilities and hygiene promotion (see Hygiene promotion standards 1–2, Water supply standards 1–3 and Excreta disposal standards 1–2)
  - environmental sanitation and safe waste management and vector control (see guidance notes 2–3, Shelter and settlement standard 4 on page 262, Vector control standards 1–3, Solid waste management standard 1 and Drainage standard 1)
  - food security, nutrition and food assistance – access to adequate food and management of malnutrition (see Infant and young child feeding standards 1–2, Management of acute malnutrition and micronutrient deficiencies standards 1–3 and Food security standard 1)
  - health education and social mobilisation – develop messages to ensure the effective implementation of the above preventive measures.

2. **Malaria prevention:** Implement malaria prevention methods according to the risk of infection, the phase of the emergency and mobility of the population, the type of shelters and behaviour of the local vector in a malaria-endemic region. Vector control measures such as indoor residual spraying (IRS) with an effective insecticide and the distribution of long-lasting insecticide-treated nets (LLINs) should be guided by entomological assessments and expertise. To be effective as a community control measure, IRS requires coverage of at least 80 per cent of dwellings. LLINs provide long-term personal protection and are the standard net of choice. Distributions of untreated nets are not recommended (see Non-food items standard 2 and Vector control standards 1–3).
3. Prioritisation for LLIN distribution to risk groups depends on the phase of the disaster and level of malaria transmission. In the early phase of disasters in areas of high to moderate malaria transmission, hospital patients, severely malnourished people and members of their households, pregnant women and children under 2 years of age should be prioritised. The next priority is those enrolled in supplementary feeding programs, children under 5 years of age and households of pregnant women and children under 2 years of age. Eventually, the entire population at risk would require protection with LLINs. In the early phase of disasters in low transmission areas, LLINs should be used in clinical settings (for example, residential therapeutic feeding centres and hospitals).
4. **Dengue prevention:** Vector (larval and adult) control is the main method of dengue prevention. Dengue vector control should be guided by surveillance data on the distribution of human cases and vector density. The most productive breeding sites, which vary from place to place, need to be targeted. In urban areas, *Aedes* mosquitoes breed in water storage containers and other artificial water accumulation sites (plastic cups, used tyres, broken bottles, flower pots, etc.). Periodic draining and removal of containers is the most effective way of reducing the number of breeding grounds. Water stored in houses should be covered at all times and the containers cleaned and scrubbed weekly. The disaster-affected population should be provided with proper water storage containers with lids. Treatment of containers with an approved larvicide is also effective in eliminating larvae. Spraying with insecticide is effective in reducing the number of adult mosquitoes. Personal protection measures should also be promoted (see Non-food items standard 2 and Vector control standards 1–3).

## Essential health services – control of communicable diseases standard 2: Communicable disease diagnosis and case management

*People have access to effective diagnosis and treatment for those infectious diseases that contribute most significantly to preventable excess morbidity and mortality.*

### Key actions

*(to be read in conjunction with the guidance notes)*

- Develop public health education messages to encourage people to seek care early for fever, cough, diarrhoea, etc.
- Provide healthcare at all first-level health facilities based upon standard case management protocol, or the Integrated Management of Childhood Illnesses (IMCI) and Integrated Management of Adult Illness (IMAI) where implemented and referral care for management of severe illness (see guidance note 1).
- Implement triage, diagnostic and case management protocols for early treatment of conditions such as pneumonia, malaria, diarrhoea, measles, meningitis, malnutrition and dengue and train staff on treatment protocols (see guidance notes 2–3 and Essential health services – child health standard 2).
- Introduce tuberculosis control programs only after recognised criteria are met (see guidance note 4).

### Key indicator

*(to be read in conjunction with the guidance notes)*

- Standardised case management protocols for the diagnosis and treatment of common infectious diseases are readily available and consistently used (see guidance notes 1–3 and Health systems standard 1).

### Guidance notes

1. Integrated Management of Childhood Illnesses and Integrated Management of Adult Illness: Mortality from communicable diseases can be reduced by early and accurate diagnosis and appropriate treatment. Use of IMCI and IMAI where implemented, or other national diagnostic algorithms, are important to triage and classify disease according to type and severity and to aid the administering of appropriate treatments. Danger signs are indications for referral to an inpatient facility. Standard case management protocols allow for

appropriate diagnosis and rational drug use (see also Essential health services – child health standard 2).

2. **Pneumonia:** The key to reducing mortality from pneumonia is prompt administration of oral antibiotics, such as amoxicillin, according to national protocols. Severe pneumonia will require hospitalisation and parenteral therapy.
3. **Malaria:** Access to prompt and effective treatment is key for successful malaria control. In malaria-endemic regions, establish a protocol for early (less than 24 hours) diagnosis of fever and treatment with highly effective first-line drugs. Artemisinin-based combination therapies (ACTs) are the norm for treatment of falciparum malaria. Drug choice should be determined in consultation with the lead health agency and the national malaria control program. Consider drug quality when sourcing supplies. Malaria should preferably be diagnosed by laboratory test (rapid diagnostic test, microscopy) before treatment is started. However, treatment of clinical malaria should not be delayed if laboratory diagnosis is unavailable.
4. **Tuberculosis (TB) control:** Poorly implemented TB control programs can potentially do more harm than good, by prolonging infectivity and by contributing to the spread of multidrug-resistant bacilli. While the management of individual patients with TB may be possible during disasters, a comprehensive program of TB control should only be implemented if recognised criteria are met. These criteria include commitment and resources of agency, an assured stability of the population for at least 12–15 months and that a good quality program can be delivered. When implemented, TB control programs should be integrated with the national country program and follow the Directly-Observed Therapy, Short-course strategy.



In the acute phase of an emergency, the potential interruption of all treatments for all chronic diseases including TB and loss of patient follow-up are likely to be a significant problem. Strong collaboration must be established between the emergency health workers and the established national TB program services. This will help ensure that people who were already on treatment prior to the disaster continue with their treatment (see Essential health services – non-communicable diseases standard 1).

### Essential health services – control of communicable diseases standard 3: Outbreak detection and response

Outbreaks are prepared for, detected, investigated and controlled in a timely and effective manner.

**Key actions**  
(to be read in conjunction with the guidance notes)

#### Detection

- Establish a disease EWARN (early warning) surveillance and response system based on a comprehensive risk assessment of communicable diseases, as part of the broader health information system (see guidance note 1 and Health systems standard 5 on page 305).
- Train healthcare staff and Community Health Workers to detect and report potential outbreaks.
- Provide populations with simple information on symptoms of epidemic-prone diseases and where to go for help.

#### Preparedness

- Prepare an outbreak investigation and response plan (see guidance note 2).
- Ensure that protocols for the investigation and control of common outbreaks, including relevant treatment protocols, are available and distributed to relevant staff.
- Ensure that reserve stocks of essential material are available for priority diseases or can be procured rapidly from a pre-identified source (see guidance note 3).
- Identify sites for isolation and treatment of infectious patients in advance, e.g. cholera treatment centres.
- Identify a laboratory, whether locally, regionally, nationally or in another country, that can provide confirmation of outbreaks (see guidance note 4).

- Ensure that sampling materials and transport media are available on-site for the infectious agents most likely to cause a sudden outbreak (see guidance note 5).

### Control

- Describe the outbreak according to time, place and person, leading to the identification of high-risk individuals and adapted control measures (see guidance notes 6–8).
- Implement appropriate control measures that are specific to the disease and context (see guidance note 9).

### Key indicators

(to be read in conjunction with the guidance notes)

- A written outbreak investigation and response plan is available or developed at the beginning of disaster response.
- Health agencies report suspected outbreaks to the next appropriate level within the health system within 24 hours of detection.
- The lead health agency initiates investigation of reported cases of epidemic-prone diseases within 48 hours of notification.
- Case fatality rates (CFRs) are maintained below acceptable levels:
  - cholera – 1 per cent or lower
  - Shigella dysentery – 1 per cent or lower
  - typhoid – 1 per cent or lower
  - meningococcal meningitis – varies, 5–15 per cent
  - malaria – varies, aim for <5 per cent in severely ill malaria patients
  - measles – varies, 2–21 per cent reported in conflict-affected settings, aim for <5 per cent (see guidance note 10).

### Guidance notes

1. **Early warning system for outbreak detection:** The key elements of such a system will include:
  - a network of implementing partners -implementation at all health facilities and at community level if possible -a comprehensive risk assessment of all potential epidemic-prone diseases
  - identification, based on risk assessment, of a small number of priority conditions (10–12) for weekly surveillance and a select number

of diseases for immediate 'alert' reporting (see Appendix 2: Sample weekly surveillance reporting forms)

- clear case definitions for each disease or condition on the standard surveillance form
- alert thresholds defined for each priority disease or condition to initiate investigation
- communications to ensure rapid notification of formal or informal alerts (rumours, media reports, etc.) to relevant health authorities
- a system for recording and responding to immediate alerts -data reporting, entry into standard database and analysis on a weekly basis -feedback of weekly surveillance and immediate alert information to all partners
- regular supervision to ensure data quality as well as timeliness and completeness of reporting
- standard case investigation protocols and forms -standard procedures for information-sharing and initiation of outbreak response.

2. **Outbreak investigation and control plan:** This must be prepared with full participation of all stakeholders. The following issues should be addressed:

- the criteria under which an outbreak control team is to be convened -the composition of the outbreak control team
- the specific roles and responsibilities of organisations and positions in the team
- the arrangements for consulting and information-sharing at local and national levels -the resources and facilities available to investigate and respond to outbreaks
- the list of essential medicines, supplies and diagnostics needed.

3. **Reserve stocks:** On-site reserves should include material to use in response to likely outbreaks. A pre-packaged diarrhoeal disease or cholera kit may be needed in some circumstances. It may not be practical to keep some stocks on-site, such as meningococcal vaccine. For these items, procedures for prompt procurement, shipment and storage should be determined in advance so that they can be rapidly obtained.

4. **Reference laboratories:** Laboratory testing is useful for confirming the diagnosis during a suspected outbreak for which mass immunisation may be indicated

(e.g. meningococcal meningitis) or where culture and antibiotic sensitivity testing may influence case management decisions (e.g. shigellosis). A reference laboratory should also be identified either regionally or internationally that can assist with more sophisticated testing, e.g. serological diagnosis of measles, yellow fever, dengue fever and viral haemorrhagic fevers.

5. **Transport media and rapid tests:** Sampling materials (e.g. rectal swabs) and transport media (e.g. Cary-Blair media for cholera, Shigella, E. coli and Salmonella) and cold chain material for transport should be available on-site or readily accessible. In addition, several rapid tests are available that can be useful in screening for communicable diseases in the field, including malaria and meningitis.
6. **Outbreak investigation:**
  - The ten key steps in outbreak investigation are:
  - establish the existence of an outbreak
  - confirm the diagnosis
  - define a case
  - count cases
  - perform descriptive epidemiology (time, person, place)
  - determine who is at risk
  - develop hypotheses explaining exposure and disease
  - evaluate hypotheses
  - communicate findings
  - implement control measures.

These steps do not need to be implemented in any strict order and control measures should be implemented as soon as possible.

7. **Confirmation of the existence of an outbreak:** It is not always straightforward to determine whether an outbreak is present, and clear definitions of outbreak thresholds do not exist for all diseases. Nevertheless, thresholds exist for the diseases listed below:
  - diseases for which a single case may indicate an outbreak: cholera, measles, yellow fever, viral haemorrhagic fevers
  - diseases for which an outbreak should be suspected when cases of, or deaths due to, the disease exceed the number expected for the location or are double the previous weekly averages; shigellosis – in non-endemic regions and in refugee camps, a single case of shigellosis should raise concern about a potential outbreak
  - malaria – definitions are situation-specific; an increase in the number of cases above what is expected for the time

of year among a defined population in a defined area may indicate an outbreak. Without historic data, warning signals include a considerable increase in the proportion of fever cases that are confirmed as malaria in the past two weeks and an increasing trend of case fatality rates over past weeks

- meningococcal meningitis – in the meningitis belt, for populations above 30,000, 15 cases/100,000 persons/week; however, with high outbreak risk (i.e. no outbreak for 3+ years and vaccination coverage <80 per cent), this threshold is reduced to 10 cases/100,000 persons/week. In populations of less than 30,000, five cases in one week or a doubling of cases over a three-week period confirms an outbreak. In a camp, two confirmed cases in one week indicate an outbreak
  - dengue – increase in fever cases in the past two weeks that show increased IgG levels (based on paired testing of consecutive sera-samples) of a febrile patient with 3–5 days illness and decreasing platelet count (<20,000).
8. **Outbreak response:** Key components of outbreak response are coordination, case management, surveillance and epidemiology, laboratory, specific preventive measures such as water and sanitation improvement depending on disease, risk communication, social mobilisation, media relations and information management, logistics and security.
  9. **Control measures:** Control measures must be specifically developed to halt transmission of the agent causing the outbreak. Often, existing knowledge about the agent can guide the design of appropriate control measures in specific situations. In general, response activities include controlling the source and/or preventing exposure (e.g. through improved water source to prevent cholera), interrupting transmission and/or preventing infection (e.g. through mass vaccination to prevent measles or use of LLINs to prevent malaria) and modifying host defences (e.g. through prompt diagnosis and treatment or through chemoprophylaxis) (see Health systems standard 5, Water supply standards 1–2, Hygiene promotion standards 1–2 and Vector control standards 1–3).
  10. **Case fatality rates:** The acceptable CFRs for communicable diseases vary according to the general context, accessibility to health services and the quality and rapidity of case management. In general, aim to reduce CFRs to as low as possible. If CFRs exceed the minimum expected levels, an immediate evaluation of control measures should be undertaken and corrective steps followed to ensure CFRs are maintained at acceptable levels.

# Child Health

During emergencies, children are especially vulnerable to increased rates of morbidity and mortality. Addressing their specific health needs requires child-focused interventions. Child health interventions must include those that address the major causes of excess morbidity and mortality, including acute respiratory infections, diarrhoea, measles, malnutrition and neonatal causes.

## Essential health services – child health standard 1: Prevention of vaccine-preventable diseases

*Children aged 6 months to 15 years have immunity against measles and access to routine Expanded Program on Immunization (EPI) services once the situation is stabilized.*

### Key actions

*(to be read in conjunction with the guidance notes)*

- Make an estimation of measles vaccination coverage of children aged 9 months to 15 years at the outset of the disaster response, to determine the risk of outbreaks (see guidance note 1).
- When measles vaccination coverage is <90 per cent or unknown, conduct a mass measles vaccination campaign for children aged 6 months to 15 years, including the administration of Vitamin A to children aged 6–59 months (see guidance notes 1–2).
- Ensure that all infants vaccinated between 6–9 months of age receive another dose of measles vaccine upon reaching 9 months (see guidance note 3).
- For mobile or displaced populations, establish an ongoing system to ensure that at least 95 per cent of newcomers to a camp or community aged between 6 months and 15 years receive vaccination against measles.
- Re-establish the EPI as soon as conditions permit to routinely immunize children against measles and other vaccine-preventable diseases included in the national schedule (see guidance note 4).

### Key indicators

*(to be read in conjunction with the guidance notes)*

- Upon completion of measles vaccination campaign:
  - at least 95 per cent of children aged 6 months to 15 years have received measles vaccination
  - at least 95 per cent of children aged 6–59 months have received an appropriate dose of Vitamin A.
- Once routine EPI services have been re-established, at least 90 per cent of children aged 12 months have had three doses of DPT (diphtheria, pertussis and tetanus), which is the proxy indicator for fully immunized children.

### Guidance notes

- **Measles vaccination coverage:** Determine measles vaccination coverage in the affected population through review of immunization coverage data. Based on this review, determine if routine measles immunization coverage has been ≥90 per cent for the preceding five years and/or if a measles vaccination campaign conducted in the preceding 12 months has reached ≥90 per cent of children aged 9 months to 5 years. If measles vaccination coverage is <90 per cent, unknown or doubts remain regarding the coverage estimates, the campaign should be carried out on the assumption that the coverage is inadequate to prevent outbreaks.
- **Age ranges for measles vaccination:** Some older children may have escaped both previous measles vaccination campaigns and measles disease. These children remain at risk of measles and can serve as a source of infection for infants and young children who are at higher risk of dying from the disease. This is the reason for the recommendation to vaccinate up to the age of 15 years. In resource-poor settings, it may not be possible to vaccinate all children aged 6 months to 15 years. In these settings, priority should be given to children aged 6–59 months. All children in the target age group should be immunized against measles regardless of their previous immunization status.
- **Repeat measles vaccination for children aged 6–9 months:** All children aged 6–9 months who received the measles vaccine should receive an additional dose of measles vaccine upon reaching 9 months of age, with at least one month between the two doses.
- **Re-establishment of the national EPI program:** At the same time as the preparation of the mass vaccination campaign against measles, plans should begin to re-establish the EPI program in coordination with national authorities. The prompt re-establishment of EPI vaccination not only protects children directly against diseases such as measles, diphtheria and pertussis, but has the added value of reducing the risk of respiratory infections.

## Essential health services – child health standard 2: Management of newborn and childhood illness

*Children have access to priority health services that are designed to address the major causes of newborn and childhood morbidity and mortality.*

### Key actions

*(to be read in conjunction with the guidance notes)*

- Design health education messages to encourage the affected population to seek early care for any illness (fever, cough, diarrhea, etc.) in the newborn. In the design of health education messages, consider children who do not have an adult caring for them (see Health systems standard 1, guidance note 3).
- Provide essential newborn care to all newborns according to Integrated Management of Pregnancy and Childbirth (IMPAC) guidelines where possible (see guidance note 1).
- Provide healthcare to children at first-level health facilities using national protocol, or the IMCI guidelines where implemented, and hospital care for severely ill children (see guidance note 2).
- Establish a standardised system of emergency assessment and triage at all health facilities providing care to sick children to ensure those with emergency signs receive immediate treatment (see guidance note 3).
- Ensure that children attending health services are screened for their nutritional status and referred to nutritional services (see Management of acute malnutrition and micronutrient deficiencies standards 1–3).
- Establish an appropriate case management protocol for the treatment of diphtheria and pertussis in situations where the risk of outbreaks of these diseases is high (see guidance note 6).
- Make available essential medicines for treatment of common childhood illnesses in the appropriate dosages and formulations.

### Key indicators

*(to be read in conjunction with the guidance notes)*

- All children under 5 years old presenting with malaria have received effective antimalarial treatment within 24 hours of onset of their symptoms (see Essential health services – control of communicable diseases standard 2).
- All children under 5 years of age presenting with diarrhoea have received both oral rehydration salts (ORS) and zinc supplementation (see guidance note 3).
- All children under 5 years of age presenting with pneumonia have received appropriate antibiotics (see guidance note 5).

### Guidance notes

- **Care of the newborn:** All newborns should ideally receive skilled care at birth (preferably in a health facility), be kept warm and receive early and exclusive breastfeeding. All newborns should be assessed for any problems, particularly feeding difficulties. All sick newborns should be assessed for possible sepsis and local infections.
- **Integrated Management of Childhood Illness (IMCI):** IMCI is an integrated approach to child health that focuses on the care of children under 5 at primary-care level. Where IMCI has been developed in a country, and clinical guidelines adapted, these guidelines should preferably be incorporated into the standardised protocols, and health professionals trained appropriately.
- **Triage:** IMCI and referral care guidelines can be enhanced when used in combination with rapid triage and treatment. Triage is the sorting of patients into priority groups according to their medical need, the resources available and their chances of survival. Clinical staff involved in the care of sick children should be trained using Emergency Triage, Assessment and Treatment (ETAT) guidelines to conduct rapid assessments.
- **Management of diarrhoea:** Children with diarrhoea must be treated with low osmolality ORS and receive zinc supplementation. Low osmolality ORS shortens the duration of the diarrhoeal episode and reduces the need for intravenous fluid.
- **Management of pneumonia:** Children with a cough should be assessed for fast and/or difficult breathing and chest indrawing. Those with fast and/or difficult breathing should receive an appropriate oral antibiotic; those with chest indrawing should be referred to hospital.
- **Pertussis or diphtheria outbreaks:** Pertussis outbreaks are common in settings of population displacement. A vaccination campaign in response to a pertussis outbreak is usually avoided due to concerns about adverse events among older recipients of whole-cell DPT vaccine. However an outbreak can be used to address routine immunization gaps. Case management includes antibiotic treatment of cases and early prophylactic treatment of contacts in households where there is an infant or a pregnant woman. Diphtheria outbreaks are less common but always a threat in populations with low diphtheria immunity in crowded settings. Mass vaccination campaigns with three separate doses of vaccine have been conducted in camp settings in response to diphtheria outbreaks. Case management includes the administration of both antitoxin and antibiotics.

# Sexual and reproductive health

All individuals, including those living in disaster-affected areas, have the right to reproductive health (RH). To exercise this right, affected populations must have access to comprehensive RH information and services to make free and informed choices. Quality RH services must be based on the needs of the affected population. They must respect the religious beliefs, ethical values and cultural backgrounds of the community, while conforming to universally recognised international human rights standards.

*People have access to the priority reproductive health services of the Minimum Initial Service Package (MISP) at the onset of an emergency and comprehensive RH as the situation stabilizes.*

## Key actions

*(to be read in conjunction with the guidance notes)*

- Identify a lead RH agency within the health sector or cluster to facilitate the coordination and implementation of the MISP and ensure that an RH officer (nominated by lead RH agency) is in place and functioning within the health sector or cluster (see guidance note 1).
- Implement measures to reduce the risk of sexual violence, in coordination with other relevant sectors or clusters (see guidance note 3).
- Ensure services for clinical management of sexual violence, including access to mental health and psychosocial support and legal assistance (see guidance note 3 and Protection Principle 2, guidance note 7).
- Establish the minimum set of HIV prevention, treatment, care and support services to reduce the transmission of HIV (see Essential health services – sexual and reproductive health standard 2).
- Ensure that emergency obstetric and newborn care services are made available and accessible including:
  - at health centres – skilled birth attendants and supplies for normal births and basic management of emergency obstetric and newborn complications; basic emergency obstetric care (BEmOC) and newborn care
  - at referral hospitals – skilled medical staff and supplies for comprehensive management of obstetric and newborn complications; comprehensive emergency obstetric care (CEmOC) and newborn care
  - a communication and transportation system to manage obstetric and newborn emergencies is established and functioning 24 hours a day, seven days a week from the community to the health centre and between the health centre and referral hospital (see guidance note 4).
- Provide clean delivery kits to visibly pregnant women and birth attendants for clean home deliveries when access to

a skilled health provider and health facility is not possible (see guidance note 4).

- Inform populations about the benefits and availability of clinical services for survivors of sexual violence and the emergency referral system for complications of pregnancy and childbirth (see guidance notes 3–4).
- Ensure that common contraceptive methods are available to meet demand (see guidance note 2).
- Plan to implement comprehensive RH services, integrated into primary healthcare, as soon as possible (see guidance note 1).

## Key indicators

*(to be read in conjunction with the guidance notes)*

- All health facilities have trained staff, sufficient supplies and equipment for clinical management of rape survivor services based on national or WHO protocols.
- All pregnant women in their third trimester have received clean delivery kits.
- There are at least four health facilities with BEmOC and newborn care/ 500,000 population.
- There is at least one health facility with CEmOC and newborn care/ 500,000 population.
- The proportion of deliveries by caesarean section is not less than 5 per cent or more than 15 per cent (see guidance note 4).

## Guidance notes

1. **Minimum Initial Service Package:** The MISP defines those services that are most important for preventing RH-related morbidity and mortality among women, men and adolescents in disaster settings. It comprises a coordinated set of priority RH services that must be implemented simultaneously to prevent and manage the consequences of sexual violence, reduce the transmission of HIV, prevent excess maternal and newborn morbidity and mortality, and begin planning for comprehensive RH services as soon as the situation stabilizes. Planning for the integration of good-quality comprehensive RH activities into primary healthcare at the onset of an emergency is essential to ensuring a continuum of care. Comprehensive RH care involves upgrading existing services, adding missing services and enhancing service quality.

2. **RH supplies:** Supplies for the MISP must be ordered, distributed and stored to avoid delay in getting these essential products to the population. The Interagency Emergency Health Kit includes a limited quantity of medicines for patient post-exposure prophylaxis, magnesium sulphate and instruments and medicines for midwifery care, but not all supplies required for the MISP. The Interagency Reproductive Health Kits, developed by the Interagency Working Group on RH in crises, contain medicines and supplies for a three-month period.
3. **Sexual violence:** All actors in disaster response must be aware of the risk of sexual violence including sexual exploitation and abuse by humanitarians, and must work to prevent and respond to it. Aggregate information on reported incidents must be safely and ethically compiled and shared to inform prevention and response efforts. Incidence of sexual violence should be monitored. Measures for assisting survivors must be in place in all primary-level health facilities and include skilled staff to provide clinical management that encompasses emergency contraception, post-exposure prophylaxis to prevent HIV, presumptive treatment of sexually transmitted infections (STIs), wound care, tetanus prevention and hepatitis B prevention. The use of emergency contraception is a personal choice that can only be made by the women themselves. Women should be offered unbiased counselling so as to reach an informed decision. Survivors of sexual violence should be supported to seek and be referred for clinical care and have access to mental health and psychosocial support.

At the survivor's request, protection staff should provide protection and legal support. All examination and treatment should be done only with informed consent of the survivor. Confidentiality is essential at all stages (see Health systems standard 5, guidance note 4 and Protection Principle 1, guidance notes 7–12).

4. **Emergency obstetric and newborn care:** Approximately 4 per cent of the disaster-affected population will be pregnant women. Approximately 15 per cent of all pregnant women will experience an unpredictable obstetric complication during pregnancy or at the time of delivery that will require emergency obstetric care and 5–15 per cent of all deliveries will require surgery, such as caesarean section. In order to prevent maternal and newborn mortality and morbidity resulting from complications, skilled birth attendance at all births,

BEmOC and neonatal resuscitation should be available at all primary healthcare facilities. BEmOC functions include parenteral antibiotics, parenteral uterotonic drugs (oxytocin), parenteral anticonvulsant drugs (magnesium sulfate), manual removal of retained products of conception using appropriate technology, manual removal of placenta, assisted vaginal delivery (vacuum or forceps delivery) and maternal and newborn resuscitation. CEmOC functions include all of the interventions in BEmOC as well as surgery under general anaesthesia (caesarean delivery, laparotomy) and rational and safe blood transfusion.

The referral system should ensure that women or newborns are referred and have the means to travel to and from a primary healthcare facility with BEmOC and newborn care, and to a hospital with CEmOC and newborn care services.

### Essential health services – sexual and reproductive health standard 2: HIV and AIDS

*People have access to the minimum set of HIV prevention, treatment, care and support services during disasters.*

#### Key actions

(to be read in conjunction with the guidance notes)

- Establish standard precautions and safe procedures for waste disposal within all healthcare settings (see guidance note 2 and Health systems standard 1, guidance notes 10–11).
- Establish and follow safe blood supply and rational use of blood transfusion (see guidance note 2 and Health systems standard 1, guidance note 5).
- Establish access to good-quality free male and female condoms, including information on proper condom use.
- Ensure that health facilities provide syndromic management to all patients presenting with symptoms of a sexually transmitted infection.
- Ensure that post-exposure prophylaxis (PEP) services are provided to individuals within 72 hours of the incident of potential exposure to HIV (see guidance note 3).
- Provide information in accessible formats and education on HIV prevention to both the general public and high-risk groups (e.g. sex workers).

- Ensure prevention of mother-to-child transmission (PMTCT) of HIV by ensuring access to contraceptives, clean and safe child deliveries (including emergency obstetric care) and provision of anti-retroviral (ARV) drugs (see guidance note 4).
- Provide treatment, care and support for infants born from mothers known to be HIV positive, including guidance and counselling on infant feeding (see Infant and young child feeding standard 2).
- Ensure that people living with HIV (PLHIV) receive healthcare including co-trimoxazole prophylaxis for HIV-related infections.
- Ensure that people who were previously on anti-retroviral therapy (ART) continue to receive treatment (see guidance note 4).
- Establish links between HIV and tuberculosis programs where they exist.
- Ensure that people at higher risk of exposure to HIV have access to HIV prevention interventions for sexual transmission of HIV and access to clean injecting equipment for known injecting drug users where these services already exist.
- Initiate plans to broaden the range of HIV control services in the post-disaster phase (see guidance note 1).

#### Key indicators

(to be read in conjunction with the guidance notes)

- People most at risk of exposure to HIV are targeted with a HIV prevention program.
- Pregnant women known to be HIV positive have received ARV drugs for PMTCT.
- 100 per cent of transfused blood is screened for transfusion-transmissible infections including HIV.
- Individuals potentially exposed to HIV (occupational exposure in healthcare settings and non-occupational exposure) have received PEP within 72 hours of an incident.
- All primary healthcare facilities have antimicrobials to provide syndromic management to patients presenting with symptoms of an STI.

#### Guidance notes

1. **HIV control:** The minimum set of HIV prevention, treatment, care and support described in the key actions for this standard is comprised of actions that the health sector must take to prevent HIV transmission and to

provide care and support to PLHIV. They should be implemented during the early stages of any disaster response.

2. **Prevention of HIV transmission in healthcare settings:**

The prevention of transmission of HIV in healthcare settings (e.g. hospitals, health-care clinics, vaccination campaigns) is a priority during the early stages of disaster response. Essential actions are ensuring the application of standard precautions, establishing safe and rational blood transfusion practices and the correct disposal of healthcare waste (see Health systems standard 1, guidance notes 5, 10–11 on pages 298–300).

3. **Post-exposure prophylaxis:** PEP to prevent HIV infection includes counseling, HIV exposure risk assessment, informed consent, assessment of the source and provision of ARV medicines. However, PEP should not be provided to a person who is known to be HIV positive; counselling and testing should never be mandatory nor should the provision of PEP be delayed while waiting for the test results.

4. **Anti-retroviral drugs:** The provision of ARV for PMTCT, PEP and long-term ART in disaster situations is feasible. Continuation of ART for those already on treatment prior to the disaster must be considered a priority during disaster response. Pregnant women already taking ART should continue taking ARV without interruption. Pregnant women known to be HIV positive should receive ARV for PMTCT according to the national protocol where possible.

### Injury

Injury is usually the major cause of excess mortality and morbidity following acute-onset natural disasters such as earthquakes. Many acute-onset natural disasters are mass casualty events, meaning more people are made patients than the locally available resources can manage using routine procedures. Injury due to physical violence is also associated with complex emergencies. During armed conflict for example, most trauma-related deaths occur in insecure regions away from health facilities and therefore cannot usually be prevented by medical care. Interventions that aim to protect the civilian population are required to prevent these deaths (see Protection Principle 3, guidance notes 1–5).

#### Essential health services – injury standard 1: Injury care

*People have access to effective injury care during disasters to prevent avoidable morbidity, mortality and disability.*

##### Key actions

*(to be read in conjunction with the guidance notes)*

- Ensure that local health workers and those coordinating the health-sector response are familiar with mass casualty management (see guidance note 1).
- In mass casualty events, establish a standardised system of triage with clear guidance on assessment, prioritisation, basic resuscitation and referral (see guidance note 1).
- Ensure essential principles and skills for provision of first aid and basic resuscitation are widely understood by health workers (see guidance note 2).
- Ensure that local health workers are familiar with core principles of wound management (see guidance note 3).
- Provide a tetanus vaccine that contains toxoid to those with dirty wounds and to those involved in rescue or clean-up operations (see guidance note 4).
- Establish standardised protocols for the referral of injured patients for advanced care, including surgery and post-operative care (see guidance note 5).
- Ensure that definitive trauma and surgical services and post-trauma and post-surgical rehabilitation are established only by agencies with appropriate expertise and resources (see guidance note 5).
- Ensure standard assistive devices and mobility aids (e.g. wheelchairs, crutches) are available for injured patients and persons with disabilities as soon as practical and that these aids can be repaired locally (see guidance note 6).

##### Key indicator

*(to be read in conjunction with the guidance notes)*

- All health facilities have trained staff and systems for the management of multiple casualties.



## Guidance notes

1. **Triage:** Triage is the process of categorising patients according to the severity of their injuries or illness, and prioritising treatment according to the availability of resources and the patients' chances of survival. In mass casualty events, those with severe, life-threatening injuries may receive a lower priority than those with more survivable injuries. There is no standardised system of triage and several are in use throughout the world. The most common classification uses the four-colour code system: red signals high priority, yellow for medium priority, green is used for ambulatory patients and black for deceased.
2. **First aid and basic medical care:** Critical procedures include restoring and maintaining breathing which may require clearing and protecting the airway, along with controlling bleeding and administering intravenous fluids when required. These procedures may help to stabilize individuals with life-threatening injuries before transfer to a referral centre and greatly increase their chances of survival, even for severe injuries. Other non-operative procedures are equally vital, such as cleaning and dressing wounds and administering antibiotics and tetanus prophylaxis.
3. **Wound management:** In most disasters, many patients will present for care more than six hours after injury. Delayed presentation greatly increases the risk of wound infection and preventable excess mortality. It is, therefore, critical that local healthcare workers are familiarised with appropriate principles and protocols to prevent and manage wound infection, which include delayed primary closure and wound toilet and surgical removal of foreign material and dead tissue.
4. **Tetanus:** In sudden-onset natural disasters where there are usually a large number of injuries and trauma cases, risk of tetanus can be relatively high. While mass tetanus immunization is not recommended, tetanus toxoid-containing vaccine (DT or Td – diphtheria and tetanus vaccines – or DPT, depending on age and vaccination history) is recommended for those with dirty wounds and for those involved in rescue or clean-up operations that put them at risk. Individuals with dirty wounds who have not previously been vaccinated against tetanus should receive a dose of tetanus immune globulin (TIG), if available.
5. **Trauma and surgical care:** Trauma surgical care and war surgery save lives and long-term disability and require specific training and resources that few agencies possess. Inappropriate or inadequate surgery may do more harm than doing nothing. Moreover, surgery provided without any immediate rehabilitation can result in a complete failure in restoring functional capacities of the patient. Only organizations and professionals with the relevant expertise should, therefore, establish these services that save lives and prevent disability.
6. **Post-operative rehabilitation for trauma-related injury:** Early rehabilitation can greatly increase survival and enhance the quality of life for injured survivors. Patients requiring assistive devices (such as prostheses and mobility devices) will also need physical rehabilitation. Where available, partnership with community-based rehabilitation programs can optimize the post-operative care and rehabilitation for injured survivors.

### Mental health

Mental health and psychosocial problems occur in all humanitarian settings. The horrors, losses, uncertainties and numerous other stressors associated with conflict and other disasters place people at increased risk of diverse social, behavioural, psychological and psychiatric problems. Mental health and psychosocial support involves multi-sectorial supports (see the 'intervention pyramid' diagram below). These supports require coordinated implementation e.g. through a cross-cluster or cross-sectorial working group. The mental health standard below focuses on actions by health actors. Readers should also consult Core Standard 1 on page 55 and Protection Principle 3 in The Sphere Project.

#### Essential health services – mental health standard 1: Mental health

*People have access to health services that prevent or reduce mental health problems and associated impaired functioning.*

##### Key actions

*(to be read in conjunction with the guidance notes)*

- Ensure interventions are developed on the basis of identified needs and resources.
- Enable community members including marginalized people to strengthen community self-help and social support (see guidance note 1).
- Ensure that community workers including volunteers and staff at health services offer psychological first aid to people in acute distress after exposure to extreme stressors (see guidance note 2)
- Ensure that there is at least one staff member at every health facility who manages diverse, severe mental health problems in adults and children (see guidance note 3).
- Address the safety, basic needs and rights of people with mental health problems in institutions (see guidance note 4).
- Minimise harm related to alcohol and drugs.
- As part of early recovery, initiate plans to develop a sustainable community mental health system (see guidance note 5).

##### Key indicator

*(to be read in conjunction with the guidance notes)*

All health facilities have trained staff and systems for the management of mental health problems.



## Guidance notes

**Community self-help and social support:** Community self-help and social support form a key element of overall mental health and psychosocial multisectoral supports (see diagram below) (see Core Standard 1 on page 55 and Protection Principle 4, guidance notes 2–4). Health agencies often employ or engage community workers and volunteers who can enable community members, including marginalized people, to increase self-help and social support.

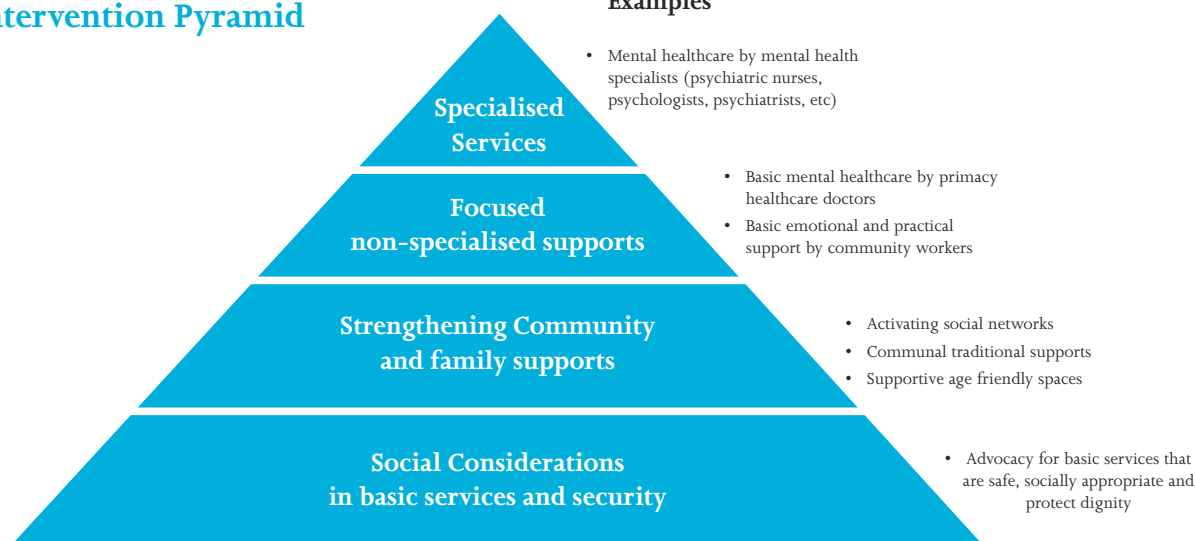
**Psychological first aid:** Acute anxiety after exposure to extreme stressors (e.g. traumatic events) is best managed following the principles of psychological first aid, which is often mistakenly seen as a clinical intervention. Rather, it is a description of a humane, supportive response to a fellow human being who is suffering and who may need support. It entails basic, non-intrusive pragmatic care with a focus on listening but not forcing talk, assessing needs and concerns, ensuring that basic needs are met, encouraging social support from significant others and protecting from further harm. Psychological debriefing (i.e. the promotion of ventilation by encouraging the person to briefly but systematically recount perceptions, thoughts and emotional reactions experienced during a recent, stressful event) is at best ineffective and should not be applied. Similarly, benzodiazepines should be avoided in the management of acute distress because they may interfere with natural recovery.

**Basic mental healthcare:** People's mental health problems may be emergency-induced, pre-existing or both. People with severe mental health problems should have access to a network of community-based social supports as well as clinical care through available health services (e.g. general hospitals, primary care clinics, etc.). Organising basic clinical mental healthcare usually involves either organising rapid training and supervision of general health staff or adding a mental health professional to the health clinic. Essential psychotropics and anti-epileptics need to be available. Individuals who have been receiving mental health treatment before the crisis need to have access to continued treatment.

**People in institutions:** Mental hospitals and residential homes for people with severe mental problems need to be visited regularly, especially early in the crisis, because the risk of severe neglect or abuse of people in institutions is extremely high. Safety, basic physical needs (water, food, shelter, sanitation and medical care), human rights surveillance and basic psychiatric and psychosocial care must be provided throughout the crisis.

**Early recovery:** Because humanitarian crises increase the rates of a broad range of mental disorders, plans need to be initiated to develop the mental health system to scale up effective mental health treatment coverage across the affected area (see Core Standard 4 on page 65).

## Intervention Pyramid



Mental healthcare by mental health specialists (psychiatric nurses, psychologists, psychiatrists, etc.) Source: Interagency Steering Committee Reference Group on Mental Health and Psychosocial Support, 2010

# Non communicable diseases

Population ageing and increase in life expectancy have shifted disease profiles from infectious to non-communicable diseases (NCDs) in many countries including low and middle-income countries. As a result, NCDs are growing in importance as a major public health issue in disaster settings. Increases in health problems due to the exacerbation of existing chronic health conditions have become a common feature of many disasters.

### Essential health services – non-communicable diseases standard 1: Non-communicable diseases

*People have access to essential therapies to reduce morbidity and mortality due to acute complications or exacerbation of their chronic health condition.*

#### Key actions

*(to be read in conjunction with the guidance note)*

- Assess and document the prevalence of NCDs and share the data with agencies responding to the disaster (see guidance note 1).
- Ensure identification of individuals with NCDs who were receiving treatment before the emergency and ensure that they continue to do so. Avoid sudden discontinuation of treatment.
- Ensure that people with acute complications and exacerbations of NCDs that pose a threat to their life (e.g. heart diseases, severe hypertension) and individuals in pain (e.g. pain due to advanced cancer) receive treatment.
- In situations where treatments for NCDs are unavailable, establish clear standard operating procedures for referral.
- Ensure that essential diagnostic equipment, core laboratory tests and medication for the routine, ongoing management of NCDs are available through the primary healthcare system. This medication must be specified on the essential medicines list.
- Ensure that assistive devices (e.g. walking aids) are available for people with mobility or communication difficulties.

#### Key indicators

*(to be read in conjunction with the guidance note)*

- All primary healthcare facilities have clear standard operating procedures for referrals of patients with NCDs to secondary and tertiary care facilities.
- All primary healthcare facilities have adequate medication for continuation of treatment to individuals with NCDs who were receiving treatment before the emergency.

#### Guidance note

1. **Non-communicable diseases** include heart disease, stroke, hypertension, chronic renal failure, bronchial asthma, dialysis-dependent chronic renal failure, insulin-dependent diabetes and epilepsy. During emergencies, individuals with chronic medical conditions are particularly vulnerable to exacerbations of their condition or to complications such as secondary infections and are at risk when treatment is interrupted. Clinical stabilization and maintenance of therapy should be the mainstay of the health-sector response in humanitarian settings.

People with NCDs need long-term medication and follow-up. The routine, ongoing management of NCDs should be available through the primary healthcare system, using medications from the essential medicines list. But it is generally not recommended to introduce new therapeutic regimens or programs for the management of chronic health conditions during the relief effort especially if the regimen or program is unlikely to be continued after the emergency phase.

# | Appendix Forms

# Appendix

## Sample Weekly Surveillance Reporting Forms

### Mortality Surveillance Form 1\*

Site .....

Date from Monday ..... To Sunday: .....

Total population at beginning of this week: .....

Births this week: ..... Deaths this week: .....

Arrivals this week (if applicable): ..... Departures this week: .....

Total population at end of week: ..... Total under 5 years population: .....

	0-4 yrs		5+ yrs		Total
	male	female	male	female	
<b>Immediate cause</b>					
Acute lower resp. infection					
Cholera (suspected)					
Diarrhoea – bloody					
Diarrhoea – watery					
Injury – non-accidental					
Malaria					
Maternal death – direct					
Measles					
Meningitis (suspected)					
Neonatal (0-28 days)					
Other					
Unknown					
Total by age and sex					
<b>Underlying cause</b>					
AIDS (suspected)					
Malnutrition					
Maternal death – indirect					
Other					
Total by age and sex					

\* This form is used when there are many deaths and therefore more detailed information on individual deaths cannot be collected due to time limitations.

- Frequency of reporting (i.e. daily or weekly) depends upon the number of deaths.
- Other causes of mortality can be added according to the context and epidemiological pattern.
- Ages can be further disaggregated (0-11 mths, 1-4 yrs, 5-14 yrs, 15-49 yrs, 50-59 yrs, 60+ yrs) as feasible.
- Deaths should not be reported solely from site health facilities, but should include reports from site and religious leaders, community workers, women's groups and referral hospitals.
- Whenever possible, case definitions should be put on back of form.

## Weekly Morbidity Surveillance Reporting Form

Site .....

Date from Monday: ..... To Sunday: .....

Total population at beginning of this week: .....

Births this week: ..... Deaths this week: .....

Arrivals this week (if applicable): ..... Departures this week: .....

Total population at end of week: ..... Total under 5 years population: .....

Morbidity Diagnosis*	Under 5 years (new cases)			5 years and over (new cases)			Total new cases	Repeat cases Total
	Male	Female	Total	Male	Female	Total		
Acute respiratory infections**								
AIDS (suspected)								
Anaemia								
Cholera (suspected)								
Diarrhoea – bloody								
Diarrhoea – watery								
Eye diseases								
Malaria								
Malnutrition								
Measles								
Meningitis (suspected)								
Injuries – accidental								
Injuries – non-accidental								
Sexually transmitted infections								
Genital ulcer disease								
Male urethral discharge								
Vaginal discharge								
Lower abdominal pain								
Scabies								
Skin diseases (excluding scabies)								
Worms								
Others								
Unknown								
Total								

\* More than one diagnosis is possible; diseases can be removed or added as fits the current situation.

\*\* Acute respiratory tract infections: In some countries, this category may be divided into upper and lower tract infections.

– Causes of morbidity can be added or subtracted according to context and epidemiological pattern.

– Ages can be further disaggregated (0-11 mths, 1-4 yrs, 5-14 yrs, 15-49 yrs, 50-59 yrs, 60+ yrs) as feasible.

Visits to health facility	Under 5 years			5 years and over			Total	
	Male	Female	Total	Male	Female	Total	Male	Female
Total visits								

Utilisation rate: Number of visits per person per year to health facility = total number of visits in 1 week / total population x 52 weeks

– Ages can be further disaggregated (0-11 mths, 1-4 yrs, 5-14 yrs, 15-49 yrs, 50-59 yrs, 60+ yrs) as feasible.

Number of consultations per clinician: Number of total visits (new and repeat) / FTE clinician in health facility/ number of days health facility functioning per week.

## Mortality Surveillance Form 2\*

Site: .....

Date from Monday: ..... To Sunday: .....

Total population at beginning of this week: .....

Births this week: .....

Arrivals this week (if applicable): .....

Total population at end of week: .....

Deaths this week: .....

Departures this week: .....

Total under 5 years population: .....

No	Sex (m, f)	Age (days=d mths=m yrs=y)	Direct Cause of Death												Underlying Causes				Location in site (a.g. block no.)	Date (dd/mm /yy)	Died in hospital or at home
			Acute lower resp. infection	Cholera (suspected)	Diarrhoea - bloody	Diarrhoea - watery	Injury - non-accidental	Malaria	Maternal death - direct	Measles	Meningitis (suspected)	Neonatal (0-28 days)	Other (specify)	Unknown	AIDS (suspected)	Malnutrition	Maternal death - indirect	Other (specify)			
1																					
2																					
3																					
4																					
5																					
6																					
7																					
8																					
9																					
10																					

\* This form is used when there is enough time to record data on individual deaths; it allows analysis by age, outbreak investigation by location and facility utilisation rates.

- Frequency of reporting (i.e. daily or weekly) depends upon the number of deaths.
- Other causes of death can be added as fits the situation.
- Deaths should not be reported solely from site health facilities, but should include reports from site and religious leaders, community workers, women's groups and referral hospitals
- Whenever possible, case definitions should be put on back of form.

# Culture

# Navigating Culture in Emergencies



We have spent some time looking at the overarching principles of humanitarian practice and the factors affecting this on a global scale. This section examines culture - one of the cross cutting issues that affects how we as individuals, teams, organisations and inter-organisational groups deliver humanitarian action. It discusses some of the skills for effectively dealing with the impacts cultural diversity can have on these spheres of action.

## Introduction

This section and the topic, links and cuts across many other aspects of the training. The intention is to bring an awareness of culture to the foreground and ensure that it is considered along with the range of other issues that impinge on emergency workers and teams – operational systems, security, safety, stress, gender, guidelines, etc. We encourage you to weave cultural issues into all aspects of the training. Much of this topic crosscuts other aspects of the training and resources provided.

In team building / maintenance you may wish to consider which aspects of interactions are human responses, which culturally bounded, and which are personality driven. How this plays out in different civil and military cultures and their relationships as well as local / international / and multinational interactions such as clusters, will vary from place to place and time to time.

Anyone working in emergencies brings some experience of navigating culture in their work and personal lives. However while many people have had vast experience working across cultures they may not have processed this information beyond cultural awareness. The skills for working in multicultural Australia where there are shared norms in public interactions are very different to an international setting - particularly that of a developing country in a crisis. As well as training, reviewing your ideas about cultural issues is always useful pre-mission. One of the key competencies for cross cultural competency is being a reflective practitioner, recognising that it is a lifelong learning process. And discussing ideas with your fellow team members is essential to clarifying your approach to cultural issues.

**Navigating culture in emergencies can involve a range of aspects including:**

- Negotiating with host country officials
- Engaging with the beneficiaries
- Use of interpreters / translators
- Working with local staff.
- Working in diverse international teams
- Coordinating in the cluster system

## Some Key questions to consider:

- What are the characteristics of emergencies which make cultural sensitivity so important?
- What is culture? When we use the word what do we really mean? How does this affect our work in emergencies?
- What are some guiding principles for effectively navigating culture in a humanitarian setting?

*Imagine ... your team has just landed in country and is entering a village to conduct a needs assessment in an immediate post disaster situation. How will you do this? How will you know what the local norms are? How will you conduct yourselves without making a mistake and causing offence?*

No matter how well researched and prepared- this is next to impossible. Because the behaviour of the people you observe and interact with is influenced by a complex mix of cultural factors, human responses to a crisis, personality differences and most importantly the culture you bring to the situation.

### So begin (or refresh) by considering your own view of culture:

- What experiences do I have of moving to, living in or working in a different culture to the one I was accustomed?
- How do they affect my expectations of interacting with others?
- What skills and strengths do I have that enable effective relationship building across cultures?
- What expectations and assumptions do I hold based on my life, work or travel experiences about the 'right way to do things'?
- Do I get frustrated when things don't go according to my usual expected way of doing things? How do I manage this frustration?

Knowing how to navigate culture in emergency situations is not something you can learn about or develop sensitivity to from simply reading a book or attending an information session. It is an ongoing learning process which requires interaction, participation, reflection and engagement. The most valuable learning is that which is negotiated by the parties involved in working together to deliver a coordinated humanitarian response – beneficiaries, hosts and international actors.

### Why is culture important in emergencies?

Culture affects all areas of our work (and personal lives) - within teams, between agencies and with beneficiaries. Beneficiaries are not 'neutral': People take pride in culture and its practices are central to their lives. Other actors are not neutral: international deployees bring our own ways of doing things. Even if these are unconscious, we cannot help being bound by our cultural habits.

Organisations too have cultures – civil, military, UN, NGO, and different Governmental agencies all have ways of working that make internal sense to that context (perhaps) but may clash with another system or group.

While your AusMAT team may all come from Australia they are no doubt diverse in background and experience. When this is overlaid with a potential joint military / AusMAT mission and the interactions with others in the health cluster in an emergency setting the dynamics will be quite different to one's usual workplace or the training setting. Cultural

adjustment during a deployment cycle can be a major challenge to success despite technical proficiency and preparedness.

Failure to take culture (ours and others) into account in our work is one of the most common causes of friction in humanitarian assistance. For instance, systems of triage may not recognise local processes for determining access to service. Or communication in the heat of an emergency may not consider hidden messages and rules of face and shame that prevent clear mutual understanding. This friction can range from being annoying to causing danger to staff and beneficiaries. Ill-will may be quick to develop after a misunderstanding and much slower or impossible to defuse. Thus awareness of our own cultural assumptions, traits and what may be different in the contexts in which we deliver assistance, is one of the fundamental skills of humanitarian assistance.

This means that while we may not in the short term be able to learn detailed information about the host society (which may in any case have been disrupted due to the emergency) we can be self-aware and conscious of the preconceptions we take for granted. This requires an open attitude and willingness to discuss assumptions with your team mates and counterparts. We need to be critically aware of stereotypes which may seem helpful in simplifying complex situations but also can lead to discrimination or misdirected action.

People often say: 'but there is no time to consider all this stuff - we just have to get on with meeting the emergency need.' While the intention to do good is to be celebrated, many experienced humanitarians argue that we cannot afford not to take the time needed to clarify cultural issues and design our approaches sensitively – without this we risk doing less good or even worse doing some harm.

The risk is to assume that our way of doing things is the only or best way. Our cultural programming shapes everything we do especially our view of 'normal'. It is perceived deviation by other cultures from our version of normality that causes 'us' and 'them' attitudes.

## What is Culture?

Culture is one of the most variably defined words in the English language. At the simplest level it is used to describe the specific food, religion, holidays, sports, music, dance, festivals and activities of a group. Most often it describes the ideal nostalgic set of these traditions as the view of a past that should be preserved.

But cultures are made up of a much deeper set of factors: values, beliefs and rules that guide those behaviours and often persist despite visible change in dress or food. By only seeing the visible we miss key differences that can lead to conflict. Culture shapes the way we look upon the world and influences our behaviour, thoughts and emotions. It can be seen as a set of unconscious and conscious rules that guide behaviour of a group and aim to ensure harmony and order, continuity and membership and secure survival for the group in a context. When this setting changes cultures face challenges to adapt or fade.

The visible and to a lesser extent the invisible parts of culture are always changing in response to external and internal dynamics. No culture is identical today to its version 5 years ago due to the influences of globalisation, migration and mass communications. All cultures are diverse and often disputed by the members within as to the true definition of what is the cultural norm. This is another reason there are no hard and fast tips for how to do things – it all depends on many contextual variables.



So for humanitarian workers if culture is simply the way a group does things, when new or hybrid groups form or meet, it is important to clarify how all members / groups will do things together, whether/all in the group support this, how consensus will be achieved and how change will be managed. Coordination mechanisms and standards such as Sphere provide guidelines for us. But implementing these standards in human societies will always require negotiation. Thus the emphasis in humanitarian approaches is on

ensuring participation and willing cooperation of disaster-affected people and communities at all stages of programs. Programs of assistance in turn should respect local cultures and rights as well as the links between and within people and communities.

We can't know everything about all cultures ways of doing things (or agree with these anyway). In times of crisis everyone accepts some compromise on the ideal. We may be balancing a range of requirements from donors, local governments, beneficiaries and our own hierarchies. We do need to be conscious of how our interventions can be respectful in the short term so as to have a credible mandate for action while at the same time ensuring results are sustainable in the longer term, securing the benefits to the community of the humanitarian action.

## Hidden and Visible Rules – the culture iceberg.

We tend to only notice cultural issues when they 'bump' or shock us because they are noticeably different. Like the fish out of water we only notice our own culture's ways of working when we are transplanted to another place (or something challenges the status quo.)



The iceberg metaphor has been used to illustrate the way there may be obvious aspects of culture that are visible but the larger body of values and rules is hidden. It is these things that we clash with inadvertently.

So for example while you may observe and respect the obvious local norms of modesty in clothing, you can be easily betrayed by habitual mannerisms of touching

co-workers on the arm or shoulder or making direct eye contact. These only feel 'strange' when they don't get the usual response or cause some discomfort to others.

Emergency situations are even more complicated because suddenly diverse populations may be thrown together in one location, international humanitarian workers fly in from diverse countries and new teams and coordination mechanisms have to be formed and functioning rapidly. Multiple icebergs grind against each other below the surface with conflict occasionally splashing up above the surface. Our ability to think about the underlying assumptions made by us and others and how they impact on our work is another critical competency for humanitarian action.

### Culture and Human Rights

*But why is culture even an issue? Surely universal human rights override culture?*

A common myth pits human rights against cultural values as if they are mutually exclusive – extreme examples of gender discrimination are cited as evidence for ignoring culture. However this discrimination may or may not be wholly driven by cultural values but also human power dynamics, political issues or other historical forces as no culture is homogenous or static.

Universal human rights instruments are increasingly being seen in a more nuanced way to accommodate diverse expressions of these rights in cultural contexts without compromising the fundamental nature of rights as applying to all. And we can see cultural aspects as potential vehicles to achieving humanitarian and human rights goals.

So for example Article 27 of the Universal Declaration of Human Rights (UDHR) states that

*Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.*

While all people have rights to enjoy cultural identity these are limited at the point at which they infringe on others' human rights. Cultural rights cannot be invoked to justify any act leading to the denial or violation of other human rights and fundamental freedoms. This universality is legitimised not only by UN human rights instruments but those adopted by African nations, Latin American nations and those to which many countries of the world are signatories. For example, no culture today can legitimately claim a right to

Culture is the framework out of which we are socialised and developed, it shapes the way we look upon the world and influences our behaviour, thoughts and emotions.

Culture is the filter for all we are exposed to: it screens messages, shapes our perceptions and interpretations and influences our behaviour, thoughts and emotions.

It's more than the sum of its parts.

UNFPA

practise slavery or torture or abuse regardless of its practice throughout history.

UNFPA's 'culture lens' approach encourages looking for locally grown solutions to ensure ownership and sustainability of results. It includes acknowledging, appreciating and working with the social capital that exists in many communities such as businesses, relationships, religious bodies and other frameworks - especially critical in situations where traditions and socio-cultural assets have or are being eroded by impacts of emergency and pre-existing vulnerabilities.

Because culture is more than the sum of its parts, identifying and understanding cultural traits from other societies can be harder and the need for sensitivity greater because we don't have clear cues. This is particularly prevalent in humanitarian work where in order to assist those most in need we need to try and understand cultural significance very quickly when making decisions about how to implement assistance.

Personally we need to be aware that some cultural behaviours may seem challenging to us when on a mission, and consider how we will manage this impact on our lives and work. We may need strategies for dealing with confronting attitudes and choosing carefully which battles to take on.

There is no right or wrong, better or worse culture – though there may be practices that are not acceptable, all cultures have a place and context and outsiders – especially short term cannot expect to change things. This idea of cultural difference rather than deficit is key to starting from a position of respect for local staff and their cultures as equal and essential participants in humanitarian action.

It is also important to distinguish when something is a result of cultural factors or other factors. A useful tool for considering this is the pyramid that illustrates the basic common human factors affecting all of us, overlaid with particular cultural expressions of this and again overlaid with individual's learned ways of doing things and personal preferences.

While culture is central and it mediates human behaviour it is not the only factor. Human factors include the experiences of an emergency or disaster as well as the impacts of crisis, trauma, alcohol, education, health, opportunity. Cultural responses to emergencies cannot be generalised as people inhabit multiple groups. Their responses will also be subject to Individual personalities and experiences. As most humanitarian outsiders interact first with local people who have some English language ability; they may receive a non-representative view of the community.

## Cultural frameworks, models, and dimensions as tools.

So how can we make sense of culture – especially in an emergency where time is short?

- We can be aware of our own cultural baggage
- We can research the host culture(s)

But as noted this is so dynamic and diverse that much of the information even on the World Wide Web is not current as soon as it is posted. It needs careful assessment in terms of the perspectives of the authors and consideration of the diversity, changes and tensions within cultures as well as between cultures.

Social scientists propose a number of models to understand culture as difference not deficit. These generalise types of cultures and may be useful to help us identify factors affecting a particular situation. However like all models they are approximate and should not be seen universally applicable to all members of a group. Rather they should be used with caution, respect and a healthy dose of critical inquiry to explore why something may be occurring.

Often these models use a compare and contrast approach but this may be better seen as a spectrum of positions relative to each other. So for example cultures are defined as being more individualist or more group-oriented in the way that relationships are managed. While an Australian city may seem highly individualist to people from a south East Asian agrarian community, many New Yorkers find Sydney more collectivist and egalitarian than their home culture in decision making eg. Decision making in work teams or in attitudes to 'service' in restaurants.



As humanitarians we can prepare for these differences and possible stress or friction points by being attuned to them knowing where they might arise and being able to see them for what they are: differences rather than disrespect, rudeness or wrongness. It means bringing to our attention the below the surface reasons why cultures organise in particular ways.

Some cultural dimensions and examples of how they impact on emergencies are:

- **Power Distance**, that is the extent to which the less powerful members of organizations and institutions (like the family) accept and expect that power is distributed unequally. Access to emergency care and attention may be seen as less of a priority depending on social standing within a local community. Attitudes of respect and gratitude to 'experts' such as medical staff may be unusually extreme compared to the usual 'thanks mate' you receive back home...
- **Individualism** characterises societies where people have loose ties, tend to look after him/herself and immediate family. Collectivist oriented societies place emphasis on large extended family or kinship networks and give emphasis to geographical or ethnic markers as key aspects of identity. People from birth onwards are integrated into strong, cohesive in-groups, which protect them in exchange for loyalty and mutual support.
- **Uncertainty Avoidance** looks at the society's tolerance for unexpected events and ambiguity and the way a culture programs its members to deal with unstructured situations. This affects people's adherence to laws and rules, comfort levels with chaos and sense of fatalism. This may challenge one's sense of 'right' or justice as a humanitarian observing no seeming pattern to events.
- **Masculinity and Femininity** on a society-wide level refer to the degree to which power is allocated to 'typically' masculine roles or not and the degree of gender equality. All societies resolve and express this in different ways that impact on overt and hidden decision making processes opportunities for cross gender interaction. All these have direct impacts on the design and practice of humanitarian action.
- **Long Term Orientation** expresses orientation towards or away from future rewards, perseverance and thrift, immediate demands versus long term goals. Short term oriented cultures may foster virtues related to maintenance of tradition, preservation of 'face' and fulfilling social obligations.

Of course, when a culture has an existing orientation this may shift in the face of pressures associated with disasters, displacement or rapid change.

So how can these be useful tools for humanitarians navigating culture? Through reflection and increased self-awareness of our own assumed and preferred ways of:

- Forming and maintaining relationships - work and social.
- Relating to your boss or team leader
- Relating to people you are coordinating or managing as a team leader?
- Making decisions in a team
- Handling extreme emotions
- Problem solving
- Making a complaint or raising negative issues
- Managing time and expectations about punctuality and use of time
- Showing respect, listening, attentive communication

### Questions to consider:

1. What are some implications of these cultural dimensions on your work and functioning in a humanitarian emergency?
2. Discuss with others how and any ideas you have about managing or navigating these...
3. What areas of conflict may arise?
4. How will you approach these challenges?

## Stereotyping and self awareness

As noted, cultural dimensions can lead to stereotyping. To some extent it is an automatic human response to form stereotypes to try and gain some predictability that will simplify our interactions with different groups. Stereotypes never describe individual behavior; rather, they describe a perceived norm. In addition they often attribute a negative connotation to this (which usually reflects one's own cultural bias). So for example the idea that all Asians are inscrutable because emotions are not shown and eye contact is avoided is seen as suspicious (though it is more likely a mark of respect). This view says more about the values held by many Australians that showing respect means looking people directly in the eye and being honest about how you feel.

These ideas inhibit potential strengths of having a number of different approaches in a team environment and maximising outcomes. Another potential negative of stereotypes is

entering situations with ideas about how people will behave to find these are inaccurate and that your assumptions have had a negative impact on interactions. Or having others assume you will be a certain way due to your background. As we have discussed, cultural change, diversity, human and personality factors all make stereotyping inaccurate. While patterns and values may seem common even in largely uniform cultures, individual identities are formed through experiences that might deviate from the cultural norms.

A subconsciously held stereotype is difficult to modify or discard even after we collect real information about a person. If it is also judgmental we may hold an inappropriate, ineffective, and harmful guide to reality.

Though we may find it difficult not to stereotype, we can use the ideas wisely as hints of how to act appropriately in new situations. Thus it is important to ensure we are conscious about our stereotypes rather than seeing all people the same; that we describe behavior rather than judging it; that we modify ideas based on experiences; and treat each person as an individual and if possible build relationships that transcend initial stereotypes.

## Applying Cultural Sensitivity in Humanitarian Practice

### – Some Case Studies

#### Case Study 1:

Despite providing the authorities with all the necessary paperwork you are unable to get the permits for staff to travel to project area and cannot see a reason for this based on the regulations and what you are submitting. A local staff member quietly points out that your organisation is not paying the usual 'editing fees' (about \$10) that are normal practice to ensure permits are granted by the authorities. You feel paying the money would be corrupt and against the policies of your organization. Without paying the money your work you will not reach those people in need.

- What are the key challenges in this situation?
- How will you respond to the situation in a culturally sensitive manner?

#### Case study 2:

You are invited by a local colleague to attend a celebration in their village for the wedding of some of their friends. It's a good opportunity to strengthen relationships with local people and to spend time with your colleague who you work intensively with. When you arrive you realise the wedding is between a man in his 50s and a girl of about 14. Child brides are common in this area and your own organisation and government has a child safe policy that promotes an end to this practice.

- What are the main challenges for you in this situation?
- How can you respond to the situation in a culturally sensitive manner?

#### Case study 3:

You have been in country for 1 month and recognise that punctuality is not common practice even for important meetings. Your field officer is consistently late to work making it hard for you to communicate with people and as she is also your translator. This morning you have had to cancel a meeting with the Local Authorities responsible for security in your project area because the field officer was 2 hours late to work. You have been waiting 3 weeks for this appointment.

- What are the key challenges in this situation?
- How can you manage this situation in a culturally sensitive manner?

#### Case study 4:

You badly need some very specific anti-malarial medications that are usually not available in this area. The local health authority says they have some in stock and assure you they will be sent through in the next convoy. The convoy arrives after a few days and you discover they have sent a box of paracetamol. You have now lost precious time.

- What are the key challenges in this situation?
- How can you manage this situation in a culturally sensitive manner?

### Principles for navigating culture in emergencies

The case studies above and other examples discussed have no absolute correct response. However they illustrate some key principles for working effectively. Consider your own experiences of when cross cultural communication and interaction worked well – what was going on at that time? The following is a list of some principles or guidelines for navigating culture in emergencies – they will vary of course and we also encourage you to consider different issues for team leaders and team members:

- Understand your own culture
- Be aware of power dynamics in situations (such as authority, age, ie. rank, status)
- Be non-judgemental / don't make assumptions (actively challenge own stereotypes)
- Be patient, tolerant and flexible
- Language - learn some, especially greetings
- Socialise - locally, not just with expatriates
- Be aware that a 'yes' might mean a 'no'
- Practice empathy and active listening
- Consider carefully how local staff are affected, particularly in complex emergencies when they may have family and friends impacted.
- Consider the way national staff may have multiple pressures to juggle – to please you, their organisation, family, government, etc.
- While many people in developing country settings have been exposed to outside values and may dispute some local customs, it is very hard to live outside of the bounds of culture without paying a price. Be sensitive to this tightrope
- Be aware of how your culture is perceived and the actions of those before you.
- Consider how your stereotyping affects your judgments
- Be particularly aware of hierarchies, gender dynamics and management styles that you take for granted.
- Keep asking yourself "Who is the expert?" in an emergency? The answer is not always clear cut – while people bring a range of technical skills these are useless without cultural expertise owned by insiders.
- Remember you are a guest in someone's country and community and behave accordingly
- When Working with locals:

- Consider different ways of managing time
- Be aware of Gender roles, be clear and confident in your own attitudes to gender and explain these to others respectfully. Act appropriately at all times to members of both genders.
- Consider and adapt your language – explain technical concepts in plain language and beware of your use of idiom
- Consider the person's capacity and have realistic expectations.
- Ensure there is clear accountability so people know where they stand
- Remember they are the local expert.

**REMEMBER: YOUR KEY GOAL IN AN EMERGENCY IS TO COMMUNICATE RESPECT, ENSURE YOUR MANDATE IS PROTECTED AND MAXIMISE THE EFFECTIVENESS OF YOUR ACTIONS.**

### Cultural Adjustment

This refers to the process people go through in moving into (and out of) a different cultural context. This includes general, work and social adjustment. For humanitarian workers it can be critical to our effectiveness, and has team, organisational, cluster and personal family / impacts. While often portrayed as a 'u-curve' (see below) it is not necessarily linear but can involve those stages to a greater or lesser extent. . Everyone reacts differently to this process. Some common types of reactions are:

#### Withdrawal:

- No interest in the new culture
- Little or no social contact - sticking with people similar to you

#### Aggression:

- Reacting with hostility to the new culture
- Resentment of the new culture
- Feelings of superiority – culture deficit attitude.

### Over-identification:

- Abandoning one's own cultural identity
- Trying to adopt the local culture completely

### Adaptation and acculturation:

- Cautiously adopting some behaviours that seem appropriate
- Balance of respect for own culture and sensitivity to new culture.

Culture shock is an extreme reaction to finding things are not as you expected and some common signs may include: Excessive concern for cleanliness; seeing everything as 'strange'; blanket mistrust of local people; feelings of hopelessness / confusion; Dependence on own nationals; disproportional irritation over minor delays; paranoia; Hypochondria, insomnia, psychosomatic illness.

Consider the strategies you have used to adapt to new situation in the past: what has been effective and what has ensured you make the transition there and back healthily – particularly in short, rapid deployments? Share strategies with others in the group and your team. Cultural adjustment is managed best by people with strong support networks on mission.

## Cultural specifics? No hard and fast answers – just good questions.

It is difficult, if not impossible to learn all the potential cultural differences. While culturally specific information found on websites and guidebooks is somewhat limited it can be helpful to know what we don't know and what questions to be asking. The following list provides some ideas on things to consider ahead of deployment and questions to ask, things to learn about in the local and organisational cultures you have to interact with. Some of these might be helpful for just-in-time training and refreshers.

### Time:

Different concepts of time can create misunderstandings, particularly in the work context.

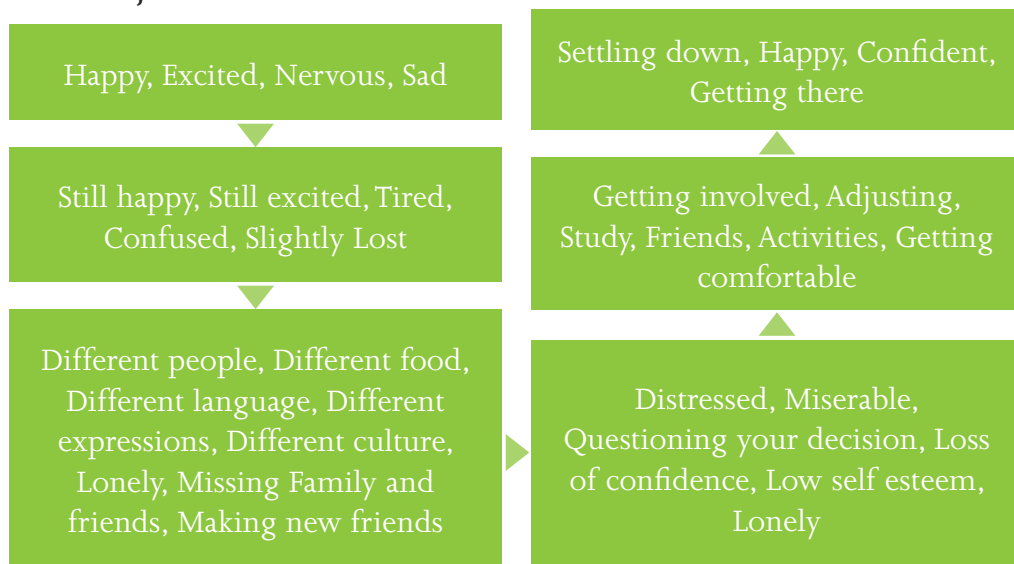
- How important is 'time'?
- What is the primary 'time focus' (ie. past, present, future)?

### Space:

Attitudes to physical space and distance can often cause misunderstandings, discomfort or offence.

- What is the 'comfortable' distance between people – is it important?
- What space is 'private' or 'public'? (Eg. Is the office private, are meetings held in public, what does a closed door mean?)

### Cultural Adjustments:



### Physical Contact:

- Is physical contact acceptable? What, how, where, when and how much? (ie, kissing, shaking hands, holding hands; in public or in private)
- Are there any taboos for certain parts of the body?

### Communication:

Apart from the obvious barrier of language, attitudes towards communication and transferring information can often cause difficulty or frustration.

- Is the importance of open and frequent communication valued?
- Is secrecy emphasised strongly?
- What should or should not be discussed in public?
- How is communication carried out? (Eg. Is it acceptable to ask direct questions?)

### Body Language:

It is very easy to send (or receive) the wrong message, or to cause offence.

- What are the normal gestures? Are they similar in meaning to your own?
- What is the attitude to eye contact?
- How should one stand or sit? (Ie. Is it acceptable to cross your legs? Should you stand when others are seated?)
- How does one show respect non-verbally?
- How does one greet another? Who does one greet? (Eg. shaking hands, or with a particular hand may cause offence, or it may be 'bad form' to greet servants or cleaners.)

### Dress/Presentation:

Wearing inappropriate clothing in public often causes offence and will certainly increase disrespect. Certain cultures dictate the clothes you can wear.

- What is the appropriate dress code for work and for relaxation?
- Are there any parts of the body which should be covered?
- What is the attitude to wearing clothing in different situations? (Eg. do you need to wear a hat/veil in public?)
- How will your clothing affect the people you meet? (Eg. wearing jewellery or very smart clothes in a poor rural area?)

### Gender:

Attitudes to men and women, particularly in the work place can vary significantly.

- Who normally does that type of work?
- How will your gender affect the people that you are working with, and your work? (Eg. if you are a woman, you may be treated as an 'honorary male'.)
- Should you behave in different ways when you are with men and women?

### Age:

Attitudes towards age and seniority vary. This is not something that you can do much about, but it can explain why you have more or less respect in different cultures.

- Is age seen as important for status and seniority?
- Are there different ways of behaving with different ages?

### Emotions:

- What emotions can be shown and when?
- How do people react to emotive situations?
- What feelings can be discussed openly?

### Relationships:

- What does 'friendship' mean?
- How important are good relationships at work?
- Are there any rules for socialising after work?
- What are the attitudes towards sexual relationships?

### Respect and Politeness:

- Who should be shown respect and how?
- What are the basic rules of politeness and decency?

### Religion:

- Is religion important during day-to-day life? What religions?
- How does religion affect working practices?
- If you are not religious, how will this affect your standing?
- If you are religious, how will this affect your work?

**Authority and Status:**

Attitudes to authority and status will affect who you work with and the way that you work with them.

- How is authority and status derived?
- How is the 'boss' viewed in the culture? (eg. approachable or distant)
- How are 'foreigners' viewed in the culture? (eg. experts or interference)
- Are the systems clearly defined in the work place? (eg. rigid, adherence to protocol)
- Who should/shouldn't be consulted?

**Decision Making:**

This will related to attitudes toward authority and hierarchy.

- How are decisions taken?
- What importance is given to consultation before decisions are taken?
- How is responsibility viewed?

**Loyalty and Trust:**

Cultures differ in the importance they give to loyalty and unity. Attitudes towards the nature of people will vary, and this will affect the level of trust.

- Does the culture tolerate non-conformity?
- What emphasis is placed on loyalty and to whom?
- Are people at work valued for their competence or for their loyalty?
- Who can you trust and how far?

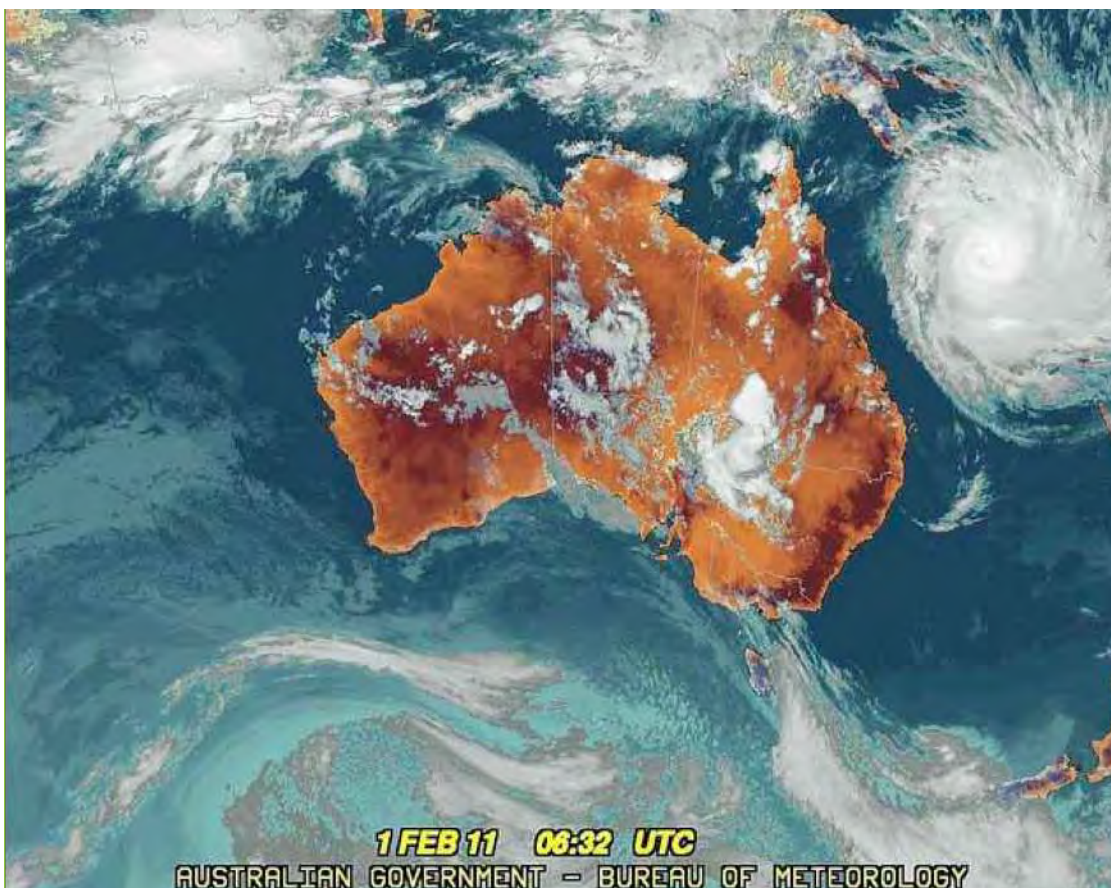
**Attitude to Nature and Work:**

- What is the relationship between human beings, nature and the world? Are human beings dominant? Is nature dominant?
- What respect is given to natural resources or places? (Is anywhere sacred?)
- What importance is placed on work? What is the relationship between work and play?
- Can human beings influence their own lives?
- Can people take 'risks' or 'chances'?

**Law:**

- What is the law and what importance is attached to it?
- Is the rule of law strong?
- What laws are relevant to me as a humanitarian? As a resident?

# Aboriginal Culture and Major Incidents



There are no hard and fast rules when interacting with Indigenous Australian peoples. Every community is unique. The approach you will take will be different depending on the community's location.

## Aboriginal Culture and Major Incidents

There are no hard and fast rules when interacting with Indigenous Australian peoples. Every community is unique. The approach you will take will be different depending on the community's location. There are remote communities, rural communities, communities in provincial towns and major cities each to be recognised as culturally distinct. So, as with any culture, Indigenous Australian cultures are very diverse and cannot be adequately described in one document. The information provided here is as a general guide only. While time constraints in a major incident may prevent the following, where possible:

- Before visiting a community, finding out 'about the historical development, family and political structure of a community will enrich personal knowledge to assist develop relations to engage and deliver services in a respectful way.'
- When working with a particular community try to identify and follow any existing community access protocols. 'Showing respect and developing an open and transparent relationship with community stakeholders will demonstrate respect to the people of the community and contribute to the delivery of more effective services and outcomes.'

NT Department of Health and Families 'Aboriginal Cultural Security: A Guide for Managers and Staff' 1999. Retrieved 07/01/10 from <http://internal.health.nt.gov.au/aboriginal/>

## Kinship

Kinship is the basis of Indigenous Australian society creating social identity within a group and dictating how relationships between members of that group will interact.

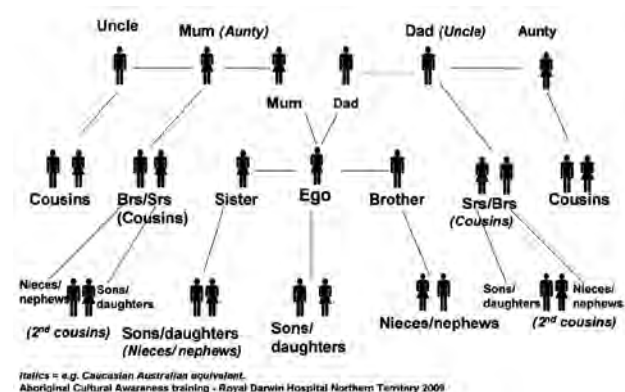
To be culturally aware within an Indigenous Australian society requires some understanding of the significance of kinship and the role it plays in every day life. Within the kinship system a person knows exactly how to behave towards everyone he or she meets and what type of behaviour is appropriate as a series of obligations must be followed when relating to others. The kinship system determines who marries who, ceremonial relationships, funeral roles and behaviour patterns with other kin.

The basic principle of this system in traditional societies is the equivalence of same-sex siblings. A kinship system of classification is used with all members of the larger group classified under the relationship terms. People who are of the same sex belong to the same sibling line and are viewed as essentially the same.

Therefore two brothers are considered to be equivalent. If one brother has a child, that child views not only his biological father as father but applies the same term to his father's brother. The same principle applies to sisters, with both mothers to any child either one bares. A mother's brother, being on the same sibling line but of the other sex, is identified as an uncle, a father's sister is an Aunt.

The children born of siblings will not be cousins but will consider themselves as brothers and sisters. Therefore it is not uncommon to have several mothers or fathers, and many brothers and sisters who all have equal importance within the community, (C Bourke & B Edwards. 2004. Family and Kinship, 2ndEd , pp104)

### The basic kinship family



Despite aspects of social organisation differing between regions, most language groups also use a further classification system with each section or subsection with either four to eight 'skin names'. An individual gains a 'skin name' upon birth based on the skin names of his parents, to indicate the section/subsection that he/she belongs to. This is a method of subdividing the society into named categories which are related to one another through the kinship system.

When speaking to, or about, another person, personal names are used with discretion as they are seen as essentially part of that person. A person is usually addressed by the appropriate relationship term – father, aunt, or older brother or if unrelated they are referred to as 'so and so's' son or mother.

Other kinship rules include 'avoidance relationships' prohibiting that individual from approaching and talking to some relatives to maintain respect between certain classes such as mother-in-law and a son-in-law, requiring a third person to be engaged if information between the two persons is to be exchanged. ? reference.

In summary then, many Indigenous Australian people will be related in some way either by birth and/or through the classificatory relationship of 'skin grouping'. Being very relationship focused, and most interactions being based on relationship, even people from areas far apart will usually find a relationship through 'skin grouping' and/or associated moieties, totems etc. in order to interact correctly. Many communities and kinship systems are collectivism based systems and therefore value is placed on a high degree of communal/family consensus decision-making processes. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.

Indigenous Australian people born and raised in cities and regional towns, may or may not follow these kinship systems but will still usually have close family networks in the area as well as knowing and interacting socially with many of the other Indigenous Australian people in their urban region. Many may still maintain their links to rural and remote Indigenous communities, families and kinship systems. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.

### Relevance to Practice:

Observing appropriate protocols when working with Indigenous Australian people and their communities is critical to establishing positive and respectful relationships.

- Introductory protocols are important. Be prepared to spend time sharing personal background information about yourself and the purpose of your visit.

Find out how a person wishes to be addressed – it could be by: a name they use for government agency interactions; a name they are known by in community; a 'skin name', or a relationship term e.g. 'Aunty' etc. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.

- Unnecessary, unfamiliar body contact – sitting too close and close touching may offend unless you have already established a good rapport with the person.
- If time permits, find out if there are any official protocols for visiting a particular community. These are usually available from local Indigenous community groups, councils, land councils or government departments involved in the area. Protocols will provide guidance about who to contact, who can accompany you around a community and any areas of cultural significance which you cannot visit. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- Children and the kinship system: It is not necessarily the biological parents sole responsibility to rear children, but the responsibility of others in the kinship system. Therefore it is not uncommon for the children of the community to be cared for by aunts, uncles, grandparents or some other relatives. Recognise and accept that children may present with 'designated' family members to care for them and that it may not be appropriate for the parents to attend.
- Many factors may be seen as requiring consideration, including the cause of the illness, the patient's role in the community, the possibility of blame, and even who has the right to know the story. An uncle may have more authority with a child than either mother or father, (emJA Issues in palliative care for Indigenous communities, Retrieved 31/12/09 from [http://www.mja.com.au/public/issues/179\\_06\\_150903/mad10362\\_fm.html](http://www.mja.com.au/public/issues/179_06_150903/mad10362_fm.html))
- This can cause difficulties in obtaining consent for treatment for a child where the biological parents are alive but not participating directly in the child's health care. If concerned regarding consent, check with other community members for the legitimacy of the guardian present.
- Ensure informed consent. For many Indigenous Australian people 'informed consent' for medical procedures must come from the 'right' persons within the network of kinship and community relationships, not necessarily solely the patient [5]. Disrespect for such a process might lead to payback for the ill person;

- There are “right persons” for the patient to confide in and to advise in decision making. Sometimes the carer or escort sent with a patient is a nephew or niece chosen because they have a good command of English. Such an individual may, however, be quite inappropriate in cultural terms: if, in reaching a decision, the patient’s “story” needs to be told (clinical history, examination and investigations), the nephew or niece may simply disappear, because they know they do not have the right to such information. (emJA Issues in palliative care for Indigenous communities, Retrieved 31/12/09 from [http://www.mja.com.au/public/issues/179\\_06\\_150903/mad10362\\_fm.html](http://www.mja.com.au/public/issues/179_06_150903/mad10362_fm.html))
- The avoidance relationships require social distance, such that they may not be able to be in the same room or car. Be sensitive to the signals that alert you to this situation, for example being told that there is ‘no room’ in a car or a building when there appears to be sufficient space.
- The use of silence should not be misunderstood. It may mean people do not want to express an opinion at that point in time, or they are listening and reflecting about what has been said. It is important that this silence is respected and not interrupted unnecessarily. In many areas it is considered impolite to answer questions immediately and these ‘pause intervals’ are a normal conversational style.
- Be prepared to accept that some questions may remain unanswered, for example sacred/secret knowledge or knowledge from people who have not grown up with their cultural ties, (European Network for Indigenous Australian Rights. (2009). Indigenous Protocols for Journalists. Retrieved December 30, from <http://www.eniar.org/info/journalists.html>).
- Gender issues are important, with “women’s business” and “men’s business” being defined and held separate. This can prevent a practitioner from examining an Indigenous person of the opposite sex. It may be considered more appropriate to talk to individuals other than the patient when discussing that patient’s situation, (emJA Issues in palliative care for Indigenous communities, Retrieved 31/12/09 from [http://www.mja.com.au/public/issues/179\\_06\\_150903/mad10362\\_fm.html](http://www.mja.com.au/public/issues/179_06_150903/mad10362_fm.html))
- If dealing with a major incident on an Indigenous Australian community, and using community members to assist you either with tasks, interactions or as a ‘cultural broker’, keep in mind the fact that they are related in some way to everyone else on the community, including injured patients and deceased persons. Therefore their level of trauma and distress will be even higher than is usually the case in major incidents. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- Seeking assistance in identification of deceased persons where necessary will need careful, respectful negotiation and ongoing support for those involved. Kinship rules also dictate who can and cannot view a deceased person and be involved in planning and discussions around care/storage/transport of the body, management of funerals and ‘sorry business’. It may be possible to use non-Indigenous community members to assist with identification although some are likely to have established relationship with various community members. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- Evacuating ill/injured persons to a regional hospital: Where possible they should be accompanied by a relative who can provide social and emotional support and language support if necessary, as the sense of isolation and loneliness away from family and familiar surroundings, can be acute. This may be difficult in a major incident and so would increase the patient’s level of distress if having to go alone and leave other injured or deceased relatives at such a time. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- Some people assume that a trip to hospital may mean they will not return home alive as this may have happened to relatives in the past, and therefore may be reluctant to leave. To most Indigenous Australian people it is important to die at home ‘on country’ with the correct cultural processes followed (albeit as much as possible in a major incident situation) and surrounded by family. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- When labelling deceased persons on a community, use as many identifiers as possible. People sometimes use a particular name for ‘officialdom’, forms, hospital etc. They may or may not be known by this name among family/community and may be known by a ‘community’, family, clan, or Indigenous personal name. It may be very stressful and difficult culturally for family members to ‘view’ a deceased or to say or hear the name of a deceased person when required for identification. In many areas the deceased name is not used, or is modified, or a

relationship term is used. This will often require careful, respectful negotiation with family/community members. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010. This also must be considered when providing information to the community or to media during a major incident. [https://www.indigenous.gov.au/cultural\\_protocol.htm](https://www.indigenous.gov.au/cultural_protocol.htm) accessed on 29/01/2010

- When recording dates of birth as part of identifiers, keep in mind that, for many people birth dates were not culturally significant and if not born in a hospital/clinic, birth dates were not always recorded. However they are likely to have had a date (and possibly more than one) guessed and 'conferred' by various agency personnel at some stage in the past and use this when needed officially. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- Belongings, finances etc. are often shared within the kinship system. With higher rates of socioeconomic disadvantage (SCRGSP (Steering Committee for the Review of Government Service Provision) 2009, Overcoming Indigenous Disadvantage: Key Indicators 2009, Productivity Commission, Canberra) including low income, many people needing to be evacuated from an area of a major incident, may need extra assistance from some social or disaster support services, for the costs associated with living away from home and living or deceased family who may normally have provided for them in daily life.

### Pay Back

In some areas, Indigenous Australian customary law is heavily influenced by the need to avenge the victim and to an outsider, punishments can at times appear arbitrary and harsh. Serious transgressions, such as murder, may result in some form of physical punishment, such as a payback spearing. However, it is also important to note that physical punishment is only one way, and not the only way, for Aboriginal disputes to be settled.

There are also numerous offences which are recognised by Aboriginal law, such as insulting an elder, singing sacred songs in public, showing sacred objects to women and neglect of kinship obligations, (Lawlink NSW. (2000). Aboriginal Customary law. Retrieved December 30, from <http://www.lawlink.nsw.gov.au/lrc.nsf/pages/r96chp3>.

The processes, if used, of determining cause, or apportioning blame or deciding retribution for someone having broken a traditional law, or caused illness or a killing, can vary from place to place. An example from one author is:

#### Traditional View of Payback

1. Wrong doing occurs
2. Meeting of elders from each skin group
3. Decision regarding appropriate punishment including who must administer it.
4. Punishment occurs with individual of skin group or representative.

#### The current or contemporary slant on payback

1. Conflict occurs between individuals
2. Individuals engage friends and cousins in conflict
3. Friends / cousins involve family and extended family in conflict
4. Feud erupts – retribution or 'payback' is carried out in accordance with Family alignments.

(T Westerman, Director Indigenous Psychological Services children and domestic violence, an analysis of the nature of violence in aboriginal communities and the psychological effects on aboriginal children and communities. Retrieved December 31, from <http://www.gtp.com.au/ips/inewsfiles/P17.ppt#256,1,Children and Domestic Violence>).

#### Relevance to Practice:

- Many people have longstanding cultural explanations (which may or may not correlate well with 'biomedical' explanations), for the cause of accidents, natural disasters and illnesses and in many areas, people still access a traditional healer. (Why Warriors lie down and die. Trudgen, R. ARDS Open Book Publishers, Adelaide, SA, 2000). Even where the 'biomedical' explanation is accepted and treatment desired, often cultural cause explanations sit comfortably beside this.
- In some communities, research has shown that, because of a history of health education and health related information not often being delivered in people's languages and with reference to cultural world views, information about 'Western' biomedical explanations for organ function, disease processes, etc. are not necessarily well understood or accepted. Many people have expressed a clear desire to have access to full and valid explanations and health information. 'Sharing True Stories' accessed 04/01/10 ref <http://www.cdu.edu.au/centres/sts/>

- Achieving informed consent for treatment or surgery with individuals and families, or explaining a cause of death, will require good communication skills. Good quality, well understood, and accepted information will contribute to reducing some of the distress (“They don’t Tell us the full story” Attitudes to Hospitalisation Amongst Yolngu People of North-East Arnhem Land – A comparative Study. 1999 Amery, H. THS) and presumably also some of the issues around ‘payback’.
- Many Indigenous Australian people, suffer a higher rate of socioeconomic disadvantage (SCRGSP (Steering Committee for the Review of Government Service Provision) 2009, Overcoming Indigenous Disadvantage: Key Indicators 2009, Productivity Commission, Canberra) and chronic disease than the rest of the population and may be on treatment for pre-existing conditions such as renal disease, diabetes, cardiac conditions including rheumatic heart disease, and hypertension at the time of an incident occurring. Also, those who may not have been given meaningful information about diagnosis, treatment and medication, may therefore not be able to give a full medical history. ‘Sharing True Stories’ accessed 04/01/10 ref <http://www.cdu.edu.au/centres/stts/>
- In many communities modest dress, particularly for women, is common practice – often with clothing that does not expose the thighs, especially when sitting. Uniform clothing, such as overalls, usually worn by major incident staff, is suitable. However, if wearing ‘civvies’ this requirement for modesty should be observed. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.

## Sorry Business

This is the ceremonial ritual, commonly practiced, of grieving. It releases the spirit of the Indigenous persons, creating a passage for the spirits to depart and cleanses the community. It is imperative to understand that not all Indigenous communities will refer to a funeral ceremony as Sorry Business and will have their own term of reference for the ritual. Predominately this is practised in traditional settings; however the contemporary Indigenous community reflects the importance of family and kinship, and the social obligatory interaction during this period. (Chapter 6, Kinship and Culture The Review of Policy Directive 9 Permit for Absence, may 2003 prepared by the Aboriginal Services Directorate of the then Department of Justice).

**Sorry Camp** (An expression often used in various areas, for example in central Australia, but may be known by other expressions elsewhere):

This is a practice of ceremony where the family is required to attend, it is a ceremony before or after the burial where the family attend to pay their respects. It is not unusual for family to self abuse (suggest - inflict minor injuries on themselves) when other family members don’t attend the sorry camp, as this ceremony is about respect. It is considered disrespectful when family members do not attend and the other family members may beat themselves. There are consequences for Indigenous people who do not attend funerals, even for reasons beyond their control. In some communities there could be punishment given to the family of the person who cannot attend. (Chapter 6, Kinship and Culture The Review of Policy Directive 9 Permit for Absence, may 2003 prepared by the Aboriginal Services Directorate of the then Department of Justice).

### Relevance to Practice:

- If a family member does not attend Sorry Camp it is likely that they or their family will face punishment under customary law.
- Family members may self mutilate for either Sorry Business or sorry camp.
- Sorry Business in the traditional setting results in wounds that are rarely life threatening. The purpose is to demonstrate grief not to cause injury that maims.
- Sorry Business in the contemporary setting may be carried out after consumption of alcohol, resulting in life threatening wounds.

- In the contemporary setting Sorry Business often is used to demonstrate grief for a variety of issues, and may be used to reduce the likelihood of payback.
- In the contemporary setting Sorry Business is sometimes inflicted with a variety of instruments that are unlikely to be sanitised. This results in a high likelihood of secondary infection. Ref. Darwin Royal Hospital.
- Given the cultural obligation to be involved in Sorry Business people may be reluctant to leave a community for treatment or accommodation elsewhere. They may themselves still be grieving over the loss of a relative prior to the major incident as they are often faced with illness and early deaths within family and kinship networks. (SCRGSP (Steering Committee for the Review of Government Service Provision) 2009, Overcoming Indigenous Disadvantage: Key Indicators 2009, Productivity Commission, Canberra)
- If death occurs in a regional centre or in another area away from a person's 'country', the family will usually want the deceased returned to the correct area for funeral and burial. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- Transport of deceased bodies in to or out of the community must involve, where possible, consultation with family. Often a family member may be required to 'escort' a body as their role and as respect. When transporting people out of a community for any reason (e.g. for treatment or for accommodation) do not transport a deceased person in the same plane/boat/truck unless specifically requested due to relationship. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- Clothing: If possible in a major incident - check with the person or family as the following applies in some areas: For cultural reasons, clothing (and other personal effects) that may have been removed when an Aboriginal patient is treated, may not be able to be discarded irrespective of the state it is in or whether or not there is blood or body fluids on it. It should be bagged appropriately, labelled and kept with the patient or given to the correct close family member if the patient is deceased. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- If dealing with amputated limbs etc. consult with the patient/relevant family if possible, as to their wishes for burial, storage or disposal as, in many communities, it is usually required that the part be buried 'on country' where that person's intended final burial place will be in the future. Royal Darwin Hospital (RDH) Aboriginal Services

Support Unit; RDH Cultural Awareness training information – January 2010.

## Language and communication

- There are many Indigenous communities in Australia of varying population sizes. For example in the Northern Territory, communities in rural, remote and regional areas vary from about 200 to 2500 persons. In addition, there are many separate smaller outstations formed from established communities for various cultural or clan reasons. An outstation (or 'homeland') may comprise as few as 15–20 people. Many communities have a clinic staffed by Indigenous Health Workers, non-Indigenous nurses and either resident or visiting medical officers. Telephone and fax services usually connect communities to bigger centres. Each community has unique cultural characteristics and often its own languages. Some Aboriginal people have fluency in several Indigenous languages, with English only a fourth or fifth language. (emJA Issues in palliative care for Indigenous communities, Retrieved 31/12/09 from [http://www.mja.com.au/public/issues/179\\_06\\_150903/mad10362\\_fm.html](http://www.mja.com.au/public/issues/179_06_150903/mad10362_fm.html)).

### Language Families

There are a number of language families that span over considerable areas. For example, languages that span the desert region of Central Australia, extending through the NT, Western Australia and South Australia. Within a language family, overlapping dialects/languages share common vocabulary and grammatical features, and the distinction between the dialects may be quite minimal. Ref. Darwin Royal Hospital.

Language	Location
Pitjantjara	The main language spoken in the Pitjantjatjara Lands (commonly referred to as the 'Pit Lands') in the north west of SA in communities including Ernabella, Fregon, Amata in SA, Wingellina in WA and around Docker River, Mutitjulu and Areyonga in the NT.
Yankunytjatjara	The dialect spoken more to the east of Pitjantjatjara. Speakers can also be found in communities in the north of SA at Mimili and Indulkana and the south of NT in areas around Finke and Mutitjulu.
Luritja	Spoken to the east of the Pit Lands from Oodnadatta in SA through Finke, Maryvale, Kings Canyon area, Areyonga, Jay Creek, Imanpa and Jutitjulu in the NT. It has often been used as the lingua franca between Western Desert and Arandic and Warlpiri speakers. There are various ideas about the origin of the term Luritja, one being that it comes from the Arrernte word for non-Arrernte people, Ulerenye. At Hermannsburg Mission all the Western Desert speaking people were called Lurinya/Luritja and this label remains today. (Heffernan & Heffernan 1999).
Pintupi Luritja	Is the name given to the Western Desert dialect as spoken from around Papunya to the WA border. It exhibits features of neighbouring languages such as Warlpiri and Arrernte, since one Pintupi came out of the bush, relatively recently, they have often lived in close proximity at Hermannsburg Mission and Papunya and Haasts Bluff ration stations
Kukatja	Speakers can be found around Kintore in the NT through to Kiwirrkura in WA and north as far as the Balgo region. This label is confusing as it also refers to the original landowners around Haasts Bluff (Heffernan and Heffernan 1999:5), as well as to dialects that were spoken in SA and QLD.
Ngaanyatjarra	A dialect spoken by only a few families around the WA border communities of Tjukurla, Warakurna, Blackstone and Docker River.

Arandic	A family of closely related languages includes a number of varieties of Arrernte, Anmatyerr and Alyawarr which comprise a network of mutually intelligible dialects, and Kaytetye which is a separate language. There are probably around 4500-6000 speakers in all (Hederson and Dobson 1994).
Eastern and Central Arrernte	These languages are spoken mainly at Harts Range, Bonya, Santa Teresa, Amoonguna and Alice Springs.
Western Arrernte	This dialect is spoken mainly around Hermannsburg, Wallace Rockhole, Jay Creek and Alice Springs.
Southern Arrernte and Pertame	There are few speakers left. Traditionally these dialects were spoken south of Alice Springs
Central and Eastern Anmatyerr	Anmatyerr is spoken to the north of Alice Springs around the communities of Mt. Allan, Napperby and TiTree. Eastern Anmatyerr is spoken at Stirling. It overlaps with Alyawarr to the north.
Alyawarr	Spoken further to the north and includes the communities in the Utopia homelands, Ammaroo, Epenarra, Murray Downs, Alekarenge, Canteen Creek, Lake Nash and also Tennant Creek.
Kaytetye	Spoken approximately 300 kilometers to the north of Alice Springs. The main communities where Kaytetye is spoken are Neutral Junction, Stirling, Ankweyelyengkwé and Barrow Creek. Kaytetye is spoken to a lesser degree at Murray Downs and Ali Curung. The neighbouring languages are Anmatyerr to the south, Alyawarr to the east and north-east, Warlpiri to the west and north west and Warumugu to the north

## Languages of the Katherine and ‘Top End’ regions of the Northern Territory:

(From: [www.dlgh.nt.gov.au/ais](http://www.dlgh.nt.gov.au/ais) retrieved 15/01/10)

Region	Language
Borroloola	Yanyuwa
North East Arnhem	Yolngu Languages: Dhay’ya - Djarrwark, Dhalwangu Dhangu - Golumala, Rirratjinu, Galpu, Wangurri Dhuwala - Gupapuyngu, Gumatj, Manggalili, Wubulkarra, Madarrpa Dhuwal - Djambarrpuynu, Liyagalawumirr, Datiwuy, Marrangu, Djapu Djangu - Warramirri, Mandatja Djinang - Murrungun, Mildjingi, Wulagi
Darwin	Larrakia
Groote Eylandt	Alawa, Anindilyakwa, Kriol, Nunggubuyu
Katherine	Gurrindji, Jawoyn, Kriol, Mayali, Ngarinman, Nunggubuyu, Warlpiri
Kunbarllanjanja (Oenpelli) Jabiru	Kunwinkju, Burarra
Litchfield (Batchelor)	Madinarl, Mariamu
Naiyu Nambiyu (Daly River) Peppimenarti	Ngangkurrungurr, Kriol, Ngangiwumirri, Marithiel
Maningrida	Burarra, Djambarrpuynu, Djinang, Guningu, Gurrongi, Kriol, Nakkara, Ndjebbana, Rembarnga, Yanyangu
Ngukurr	Kriol, Marra
Tiwi Islands	Tiwi
Wadeye (Port Keats)	Murrinh-Patha, Mari-Jarran, Nungu Jamidi
Waruwi (Goulburn Island)	Maung, Walang

Language is also part of the diversity of Australian Indigenous culture. Many grow up using English as a first language. Others speak Indigenous languages and English as a second or subsequent language, with varying degrees of English proficiency. In many areas people may use Kriol, Pidgin, or Aboriginal English. These all have distinctive features and structure.

While there has been language loss in many areas, there are areas where work on reviving language and the teaching of language is occurring. <http://www.une.edu.au/langnet/definitions/aboriginal.html> <http://www.fatsil.org.au/>

Speaking English as a second or more language requires the person to work much harder than the English speaker in a conversation. This can be very tiring and at times overwhelming. (Why Warriors lie down and die. Trudgen, R. ARDS Open Book Publishers, Adelaide, SA, 2000)

Some Australian Indigenous communication styles differ from Caucasian Australian styles. Many often take time to ‘size people up’, are good at observing body language and behaviour and can see when there is a genuine, caring approach and the speaker wants to communicate properly and have a good working relationship. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.

For many people, the desire to please and have a good relationship means that they may use gratuitous concurrence – agreeing/giving you the answer you appear to want. They may also do this in the hope that further in the conversation they may find more clues to understanding what the speaker is saying. ‘Sharing True Stories’ accessed 04/01/10 ref <http://www.cdu.edu.au/centres/stts/>

### Relevance to Practice:

- It is best to check if particular languages are spoken in the area you are working. Some web based resources listed below can help with this as can the local people.
- It is not appropriate for non-Indigenous people, who are not fluent in Kriol, Pidgin, or Aboriginal English, to attempt to speak these languages in interacting Australian Indigenous people – can be both demeaning and unintelligible. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- Use plain Standard English when working directly with people who do not speak English as a first language, or when working with an interpreter. Do not use system jargon, medical jargon, or Australian colloquialisms. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- Prolonged eye contact during conversation can make some Australian Indigenous people feel uncomfortable. It is generally not a polite thing to do in their own communication with each other. This can vary as some are more used to this in interacting with non-Indigenous people than others. Take your cues from the person. They may be not be looking at you but are listening. So you can be beside them looking to the front or if opposite – just glance and glance away. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- Be an active listener. Remember the ‘pause intervals’, if that is the style of the person you are speaking with, and try not to fill the gap. Give the person time to work across languages. **Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.**

**Questioning:** A lot of direct questioning can be intimidating to many Indigenous people (as well as difficult if having to listen/think in another language), so it is best to reduce this where possible or explain why you need to ask so many questions. Asking “Do you understand?” is not effective. Ask the person to tell you what they think you have said in their own words. Summarise what you think the person has said – check if your understanding is accurate.

<http://www.dlgh.nt.gov.au/ais> retrieved 15/01/10

- Bear in mind that at times of high stress it is common for people anywhere who speak English as a second or more language, to lose some of these second-language skills and to function more in their main or first language. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH

Cultural Awareness training information – January 2010.

- Also, traumatic stress can impair people’s ability to remember instructions or retain new information quite apart from language issues. This is compounded by cultural and communication issues. Royal Darwin Hospital (RDH) Aboriginal Services Support Unit; RDH Cultural Awareness training information – January 2010.
- The Northern Territory has an Aboriginal Interpreter Service (AIS) and there are registered interpreters in most communities and regional centres. To arrange to use an interpreter – phone AIS on 08 89998353 all hours.
- In Western Australia, The Kimberley Interpreter Service (KIS) is available on 08 91923981 all hours.
- In other states and territories enquire with the community as to the availability of people who can act as interpreters for you or if there are official interpreter services available.

### Further information:

Explore sources from Australian Indigenous organisations in a particular area you may serve. There are numerous websites with information about culture, health and welfare. The following may be useful:

- <http://www.clc.org.au/index.html>
- [www.nlc.org.au/](http://www.nlc.org.au/)
- <http://www.tsra.gov.au/>
- [www.glc.com.au](http://www.glc.com.au)
- [www.alc.org.au](http://www.alc.org.au)
- <http://lms.cucr.uwa.edu.au/moodle/> Online Aboriginal cultural training program.
- <http://www.aiatsis.gov.au/> (Australian Institute of Aboriginal and Torres Strait Islander Studies)
- Australian Indigenous Health Infonet: <http://www.healthinfonet.ecu.edu.au/>
- <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-about>
- <https://www.indigenous.gov.au/>
- <http://www.menzies.edu.au> (Menzies School of Health <http://www.crcah.org.au/> (Cooperative Research Centre for Aboriginal Health, RDH Campus).

Some Language information, history, maps etc:

- <http://www.fatsil.org.au/>
- [http://www.dfat.gov.au/facts/Indigenous\\_languages.html](http://www.dfat.gov.au/facts/Indigenous_languages.html)
- [http://www.ausanthrop.net/resources/ausanthrop\\_db/](http://www.ausanthrop.net/resources/ausanthrop_db/)
- <http://www.dnathan.com/VL/austLang.htm>

# Vietnam

[www.health.qld.gov.au/multicultural/health\\_workers/Vietnamese-preg-prof.pdf](http://www.health.qld.gov.au/multicultural/health_workers/Vietnamese-preg-prof.pdf)

<b>Location</b>	South Eastern Asia, Borders Gulf of Thailand, Tonkin and South China sea, alongside China, Laos and Cambodia
<b>Capital</b>	Hanoi
<b>Climate</b>	Tropical in South, Monsoonal in North. Temperature range from 5 C – 35C.
<b>Population</b>	86 210 781
<b>Area</b>	331 690km <sup>2</sup>
<b>Official Language</b>	Vietnamese
<b>Government</b>	Socialist Republic single party communist.
<b>Legislature</b>	National Assembly of Vietnam
<b>Formation</b>	Dai Viet 1054 French annexation 1853 to 1883 Independence from France 2 September 1945 Reunification 30 April 1975 Current constitution 19 December 1980
<b>GDP (ppp)</b>	2008 Estimate, \$240 757billion
<b>Religion</b>	Buddhist 85% Christianity 8% Caodaism 3% Others 4%
<b>Currency</b>	dong (VND)
<b>Time Zone</b>	UTC +7
<b>Drives on the</b>	Right
<b>Internet TLD</b>	.vn
<b>Calling Code</b>	84

## Culture

Confucius teachings are central to Vietnamese culture, describing their position in Vietnamese society. Confucianism stresses duty, loyalty, honour, piety, respect, sincerity for age and seniority.

The basic tenets are based upon five different relationships:

- Ruler and subject
- Husband and wife
- Parents and children
- Brothers and sisters
- Friend and friend

The concept of 'Face' is very important in Vietnamese culture.

## Relevance to Practice:

You 'take face' from a person by publicly yelling or being critical of them, or failing to acknowledge the most senior person either age or rank in the room.

You 'give face' by praising and complimenting a person and generally being respectful.

Avoid public displays of affection with a member of the opposite sex.

It is considered rude to touch someone on the head, shoulder or to point with your finger, use your hand instead.

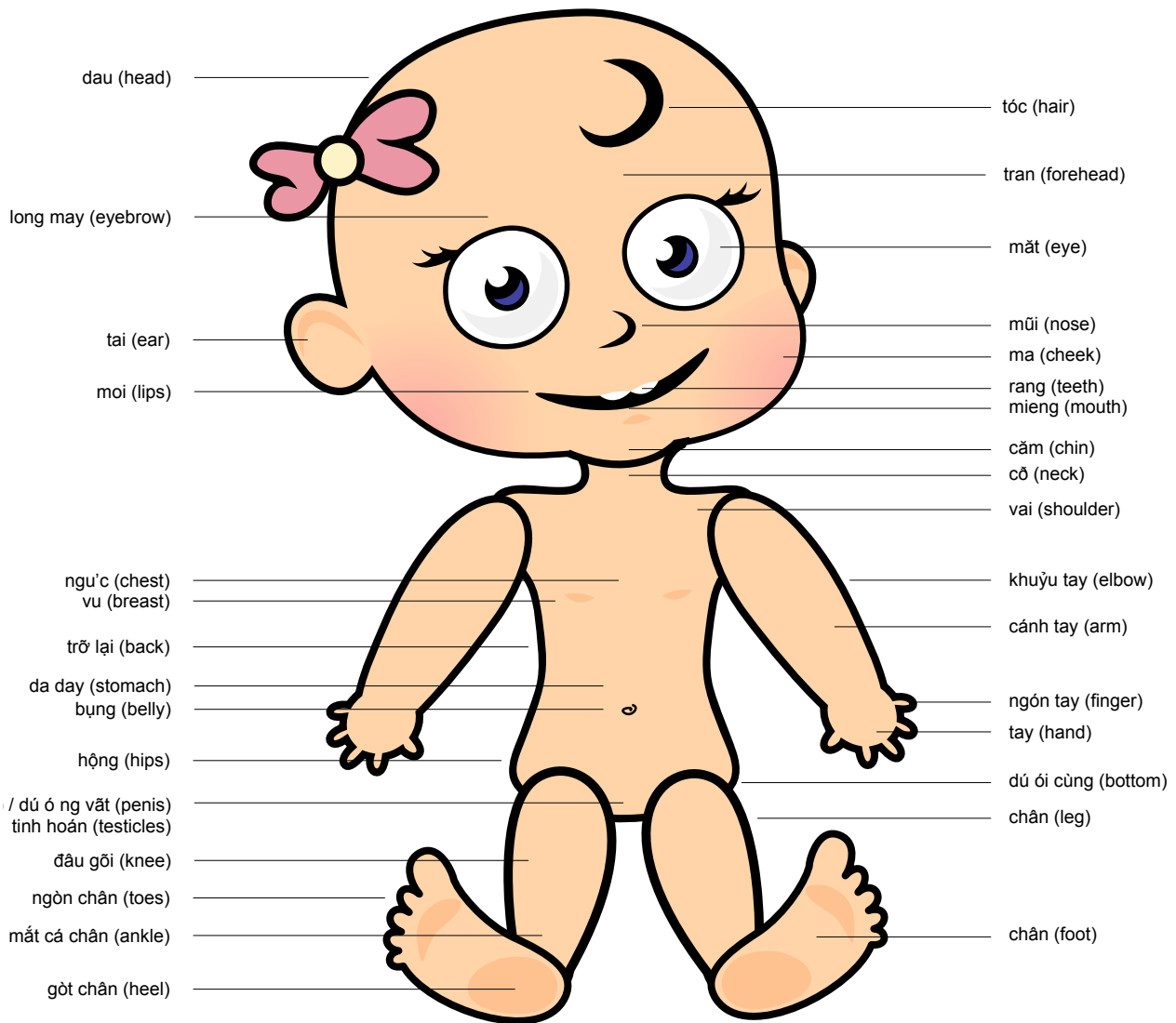
Standing with your hands on your hips or to cross your arms on your chest. This is considered rude and will cause a loss of face if directed toward another person.

Vietnamese dress conservatively, women should cover their legs and ensure their tops are not low cut.

The body is seen as operating in a delicate balance between these elements. Before seeking or complying with treatment, Vietnamese people may consider the effect the treatment will have on this balance.

People from a Vietnamese background may use traditional methods of healing in parallel with biomedical health care.

## Female Body in Vietnamese



# Cambodia

[www.health.qld.gov.au/multicultural/health\\_workers/cambodia.pdf](http://www.health.qld.gov.au/multicultural/health_workers/cambodia.pdf)

<b>Location</b>	South east Asia
<b>Capital</b>	Phnom Penh
<b>Climate</b>	Tropical to monsoonal
<b>Population</b>	13,388,910 (2008)
<b>Area</b>	181 035 km <sup>2</sup>
<b>Official Language</b>	Khmer
<b>Government</b>	Constitutional Monarch, parliamentary representative democracy
<b>Legislature</b>	Parliament Senate & National Assembly
<b>Formation</b>	Khmer empire 802 French colonization 1863 Independence from France November 9, 1953 Monarchy abolished March 18, 1970 Monarchy restored September 24, 1993
<b>GDP (PPP)</b>	28.461 billion \$2,082 per capita
<b>Religion</b>	Theravada Buddhist 95% Christianity Islam Hinduism Tribal
<b>Currency</b>	Riel (banknotes and coins)
<b>Time Zone</b>	UTC +7
<b>Drives on the</b>	Right
<b>Internet TLD</b>	.kh
<b>Calling Code</b>	855

## Culture

The concept of 'Face' is very important in Cambodian culture.

Cambodia is a collective society and is hierarchical. The greater a person's age, the greater the level of respect that must be granted to them. Cambodians are addressed with a hierarchical title corresponding to their seniority before the name.

Customary Cambodian teachings include: that if a person does not wake up before sunrise he is lazy; close doors gently, otherwise you have a bad temper; sit with your legs straight down and not crossed (crossing your legs shows that you are an impolite person); and always let other people talk more than you.

## Relevance to Practice:

When greeting people or to show respect in Cambodia people do the "sampeah" gesture, identical to the Indian namaste and Thai wai

In Khmer culture a person's head is believed to contain the person's soul--therefore making it taboo to touch or point your feet at it.

It is also considered to be extremely disrespectful to point or sleep with your feet pointing at a person, as the feet are the lowest part of the body and are considered to be impure.

Showing emotions is considered a negative behavior. Anger, impatience or frustration should be hidden as it would lead to loss of face.

Avoid prolonged eye contact. Modesty and humility are emphasized in the culture.

Many Cambodians have no knowledge of physiology or disease processes. Explain things carefully to your patient.

Cambodians rarely appear desperate or distressed, even when experiencing significant anxiety or pain.

Health care providers may find that patients explain their illnesses in terms of both the natural and supernatural.

Many Cambodians expect to receive medications for every illness, and injections are often seen as better treatment than oral medication.

Blood tests may be feared. Blood is thought to be replenished slowly, if at all, with consequent weakening of the body.

# Solomon Islands

[www.health.qld.gov.au/multicultural/health\\_workers/samoan-preg-prof.pdf](http://www.health.qld.gov.au/multicultural/health_workers/samoan-preg-prof.pdf)

<b>Location</b>	South Pacific, East of Papua New Guinea. Made up by many islands
<b>Capital</b>	Honiara
<b>Climate</b>	Ocean equatorial
<b>Population</b>	523,000 (2009)
<b>Area</b>	28,896 km <sup>2</sup>
<b>Official Language</b>	English, but only 1% speak it. Pijin is the main conversant language from multiple languages.
<b>Government</b>	Constitutional Monarchy and Parliamentary System.
<b>Legislature</b>	Democratic Parliament
<b>GDP (PPP)</b>	\$1.525 billion (2009)
<b>Religion</b>	Christianity 97%
<b>Currency</b>	Solomon Islands dollar
<b>Time Zone</b>	(UTC+11)
<b>Drives on the</b>	left
<b>Internet TLD</b>	.sb
<b>Calling Code</b>	677

## Culture

In the traditional culture of the Solomon Islands, age-old customs are handed down from one generation to the next, allegedly from the ancestral spirits themselves, to form the cultural values to Solomon Islands.

In the contemporary Solomon Islands, as elsewhere in Melanesia, kastom is the core of the assertion of traditional values and cultural practices in a modern context. Kastom advocates growing and eating traditional foods.

## Relevance to Practice:

Some Samoans believe that illness is caused by spirits, or retribution.

If western medicine is perceived as ineffective, then Samoans may use traditional healers.

Traditionally, Samoans have believed that the more they eat, the higher their status. This has had major health implications.

Women from Samoa may be reluctant to discuss health issues openly with a health practitioner.

Pacific Islanders in general may be reluctant to discuss personal issues with strangers. This should be kept in mind in health interactions.

# Papua New Guinea

[www.health.qld.gov.au/multicultural/health\\_workers/png-preg-prof.pdf](http://www.health.qld.gov.au/multicultural/health_workers/png-preg-prof.pdf)

[http://www.health.qld.gov.au/multicultural/health\\_workers/png-preg-prof.pdf](http://www.health.qld.gov.au/multicultural/health_workers/png-preg-prof.pdf)

<b>Location</b>	Pacific ring of fire
<b>Capital</b>	Port Moresby
<b>Climate</b>	Tropical
<b>Population</b>	6,732,000 (2009)
<b>Area</b>	462,840 km <sup>2</sup>
<b>Official Language</b>	English, Tok Pisin, Hiri Motu[3]
<b>Government</b>	Federal Constitutional Monarchy and Parliamentary Democracy. Monarch – Queen Elizabeth II Governor-General – Sir Paulias Matane Prime Minister – Sir Michael Somare
<b>Legislature</b>	Self governing democracy
<b>Formation</b>	1975 independence from Australia
<b>GDP (PPP)</b>	\$13.064 billion (2008)
<b>Religion</b>	Roman Catholic 27% Evangelical Church 19.5% United Church 11% Other various 43%
<b>Currency</b>	Papua New Guinean kina
<b>Time Zone</b>	AEST (UTC+10)
<b>Drives on the</b>	Left
<b>Internet TLD</b>	.pg
<b>Calling Code</b>	+675

## Culture

It is estimated that more than a thousand different cultural groups exist in Papua New Guinea. Each with their cultural expressions.

The language Tok Pisin, once called Neo-Melanesian (or Pidgin English) has evolved as the medium through which diverse language groups are able to communicate with one another in Parliament, in the news media, and elsewhere.

The people of Papua New Guinea are subsistence farmers with their main food the pig.

Sport is very important, with most following all forms of football.

## Relevance to Practice:

Papua New Guinea has the highest incident of HIV and AIDS in the Pacific region.

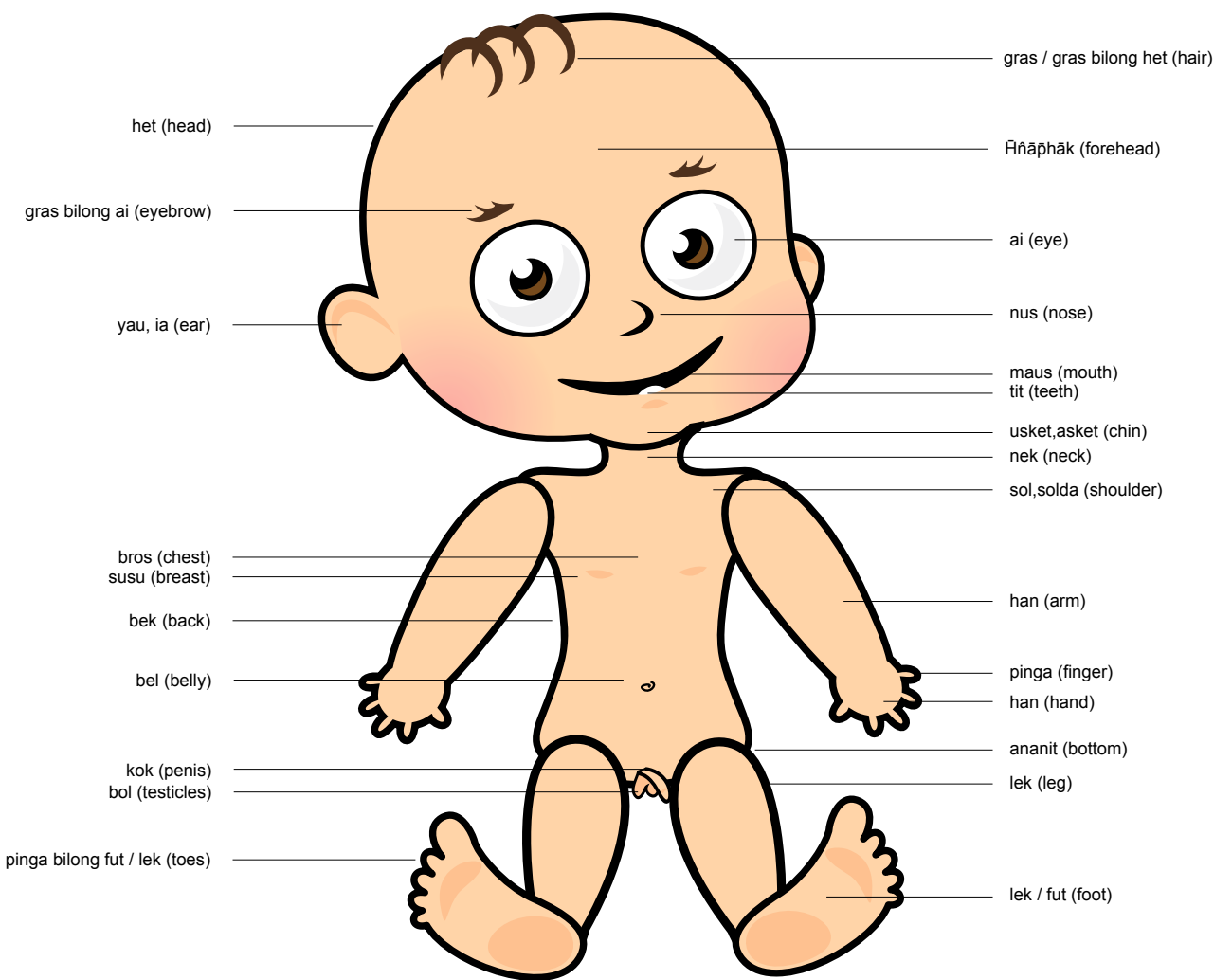
Since the introduction of Christianity, traditional healing through ancestors and spirits has often been replaced by church healing prayers and group gatherings to pray for health. Some people may believe in the power of spirits, sorcery and black magic as causes of illness and death.

Women may not be allowed to communicate with people of the opposite gender. Therefore, most women will prefer health practitioners of the same gender.

Women from some tribes may become disoriented after birth. This disorientation is a culturally influenced state by which labouring women are able to express the severity of pain.

There is a strong belief that a woman may die if the umbilical cord is cut before the delivery of the placenta. Some women may wish to take the placenta with them, or to take a section of the umbilical cord.

# Male Body in Tok Pisin



# Fiji

[www.health.qld.gov.au/multicultural/health\\_workers/Fijian-preg-prof.pdf](http://www.health.qld.gov.au/multicultural/health_workers/Fijian-preg-prof.pdf)

<b>Location</b>	South West Pacific
<b>Capital</b>	Suva
<b>Climate</b>	Tropical
<b>Population</b>	849,000 (2009)
<b>Area</b>	18,274 km <sup>2</sup>
<b>Official Language</b>	English, Bau Fijian, and Hindi
<b>Government</b>	Military Junta and Parliamentary Republic
<b>Legislature</b>	parliamentary representative democratic republic
<b>Formation</b>	1970
<b>GDP (PPP)</b>	\$3.678 billion (2008)
<b>Religion</b>	Christian 97%
<b>Currency</b>	Fijian dollar
<b>Time Zone</b>	(UTC+12)
<b>Drives on the</b>	left
<b>Internet TLD</b>	.fj
<b>Calling Code</b>	679

## Culture

Fiji's culture is a tapestry of indigenous Fijian, Indian, European, Chinese, and other nationalities

Fijian indigenous society is very communal, with great importance attached to the family unit, the village, and the land

A hierarchy of chiefs presides over villages, clans, and tribes

Etiquette in Indigenous Fijian ceremony is rather intricate depending on the function as various formalities and presentations which do several things; firstly it shows respect between two communal groups, strengthen tribal and family ties and reinforce social, tribal and family ties.

## Relevance to Practice:

It is important not to touch a Fiji-born person on the head as to do so is considered an insult. If you do need to touch a Fijian's head it is vital you explain why and excuse yourself for having to touch.

It is inappropriate to walk in front of someone (especially if you are standing and they are sitting down), but if you accidentally do so, it is important you lower yourself to their height and say tu lou (excuse me).

Motherhood elevates the status of a married woman; infertile women may be seen as wasting family resources.

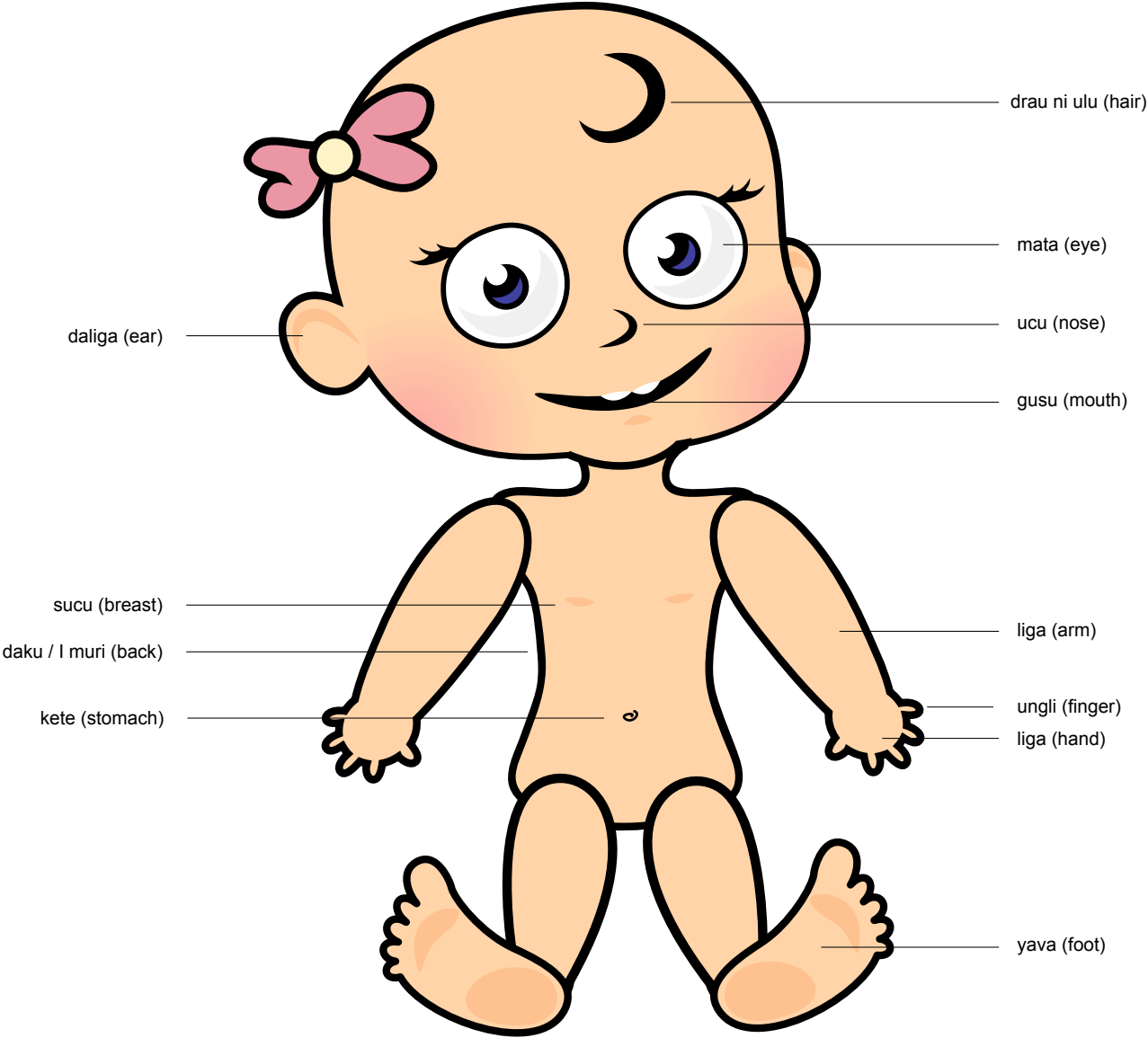
It is common for Fiji-born people to tell good friends or family if they are in pain, but not if a stranger is present.

Fiji-born people will accept medication and pain relief, if the health professional clearly tells the person the benefits.

Instructions of health professionals will be followed if the health professional has developed a trusting relationship with the person.

Fijian people are often less likely to participate in traditional healings due to Christian beliefs.

Female Body in Bau Fijian



# Democratic Republic of Timor leste

[www.easttimorgovernment.com/culture.htm](http://www.easttimorgovernment.com/culture.htm)

<b>Location</b>	South East Asia
<b>Capital</b>	Dilli
<b>Climate</b>	Tropical
<b>Population</b>	1 134 000 (2009)
<b>Area</b>	14,874 km <sup>2</sup>
<b>Official Language</b>	Tetum and Portuguese, Indonesian and English
<b>Government</b>	Parliamentary Republic
<b>Religion</b>	Roman Catholic 97%
<b>Formation</b>	From Portugal Indonesia 1702 Declared November 28 1975 Recognised May 20 2002
<b>GDP (PPP)</b>	\$2.522 billion
<b>Time Zone</b>	UTC+9
<b>Drives on the</b>	left
<b>Internet TLD</b>	.tl4
<b>Calling Code</b>	+670

## Culture

The culture of East Timor reflects numerous influences, including Portuguese, Roman Catholic, and Malaysia, on the indigenous Austronesian and Melanesian cultures of Timor.

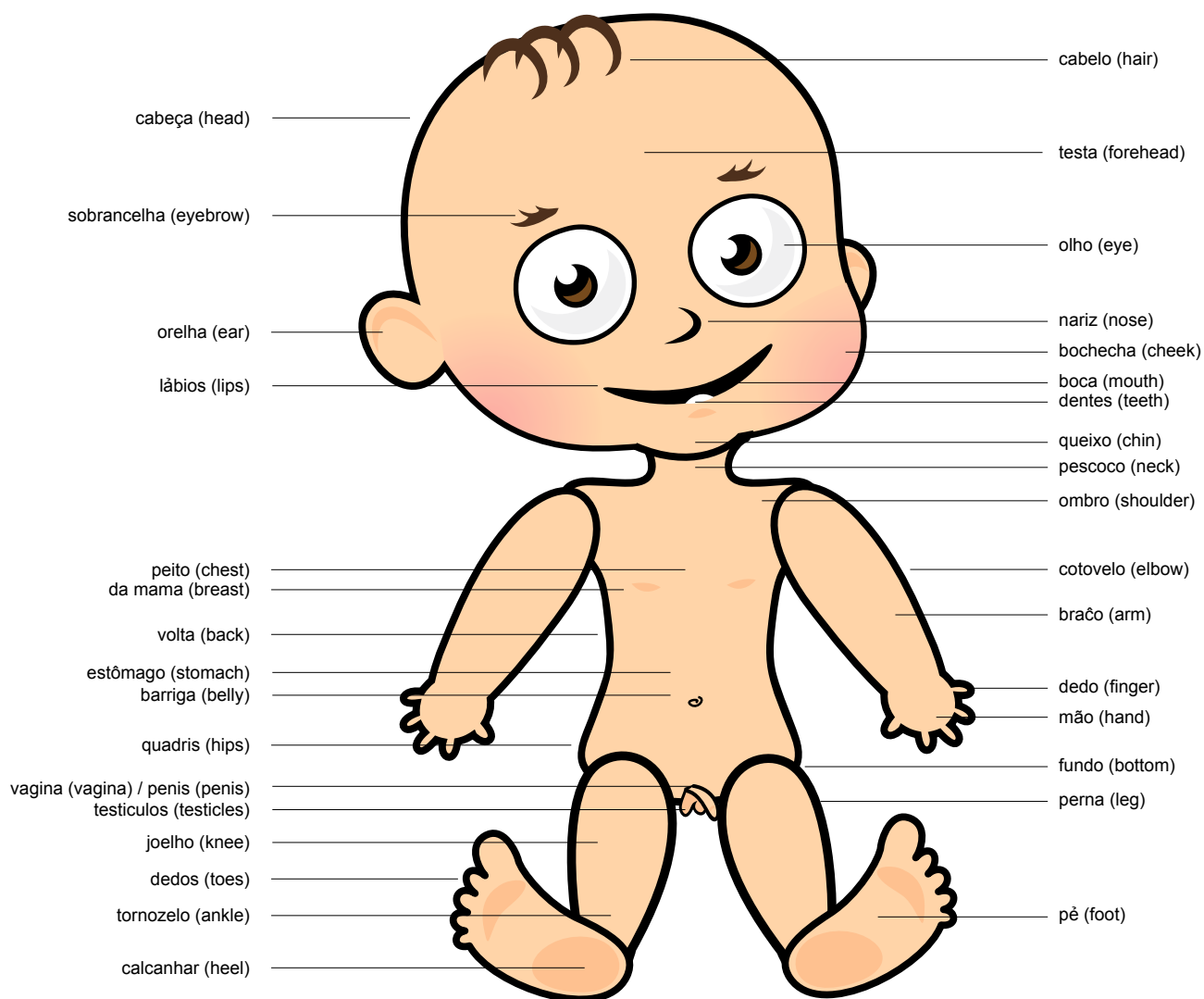
Another interesting point of culture is that it is duty for adult women (from the age of 15) in East Timor to remove all body hair (besides their head).

The culture of East Timor has been heavily influenced by Austronesian legends,

## Relevance to Practice

Reluctant to discuss personal issues with strangers.

## Male Body in Tetum



# | Thailand

<b>Location</b>	South East Asia
<b>Capital</b>	Bangkok
<b>Climate</b>	tropical
<b>Population</b>	63,723,953 (2010)
<b>Area</b>	513,115 km <sup>2</sup>
<b>Official Language</b>	Thai
<b>Government</b>	Parliamentary democracy and Constitutional monarchy. Monarchy of Thailand: Bhumibol Aduladej
<b>Formation</b>	Sukhothai Kingdom 1238-1448 Ayutthaya Kingdom 1768 – 1782 Thomburi Kingdom 06 April 1782 Constitutional Monarchy 24 June 1932 Later Constitution 24 August 2007
<b>GDP (PPP)</b>	\$547.060 Billion est (2008)
<b>Religion</b>	Buddhist 94.7%
<b>Muslim 4.6%</b>	
<b>Currency</b>	Baht
<b>Time Zone</b>	(UTC+7)
<b>Drives on the</b>	left
<b>Internet TLD</b>	.th
<b>Calling Code</b>	+66
<b>Country</b>	Thailand

## Culture

The wai (holding hands in prayer like pose) is the common form of greeting and adheres to strict rules of protocol.

Respect and courtesy are demonstrated by the height at which the hands are held and how low the head comes down to meet the thumbs of both hands.

The family is the cornerstone Thai society.

Great value placed on politeness, respect, genial demeanour and self control in order to maintain harmonious relations.

Loss of 'face' is significant in Thai culture.

## Relevance to Practice:

Showing emotions is considered a negative behavior. Anger, impatience or frustration should be hidden as it would lead to loss of face.

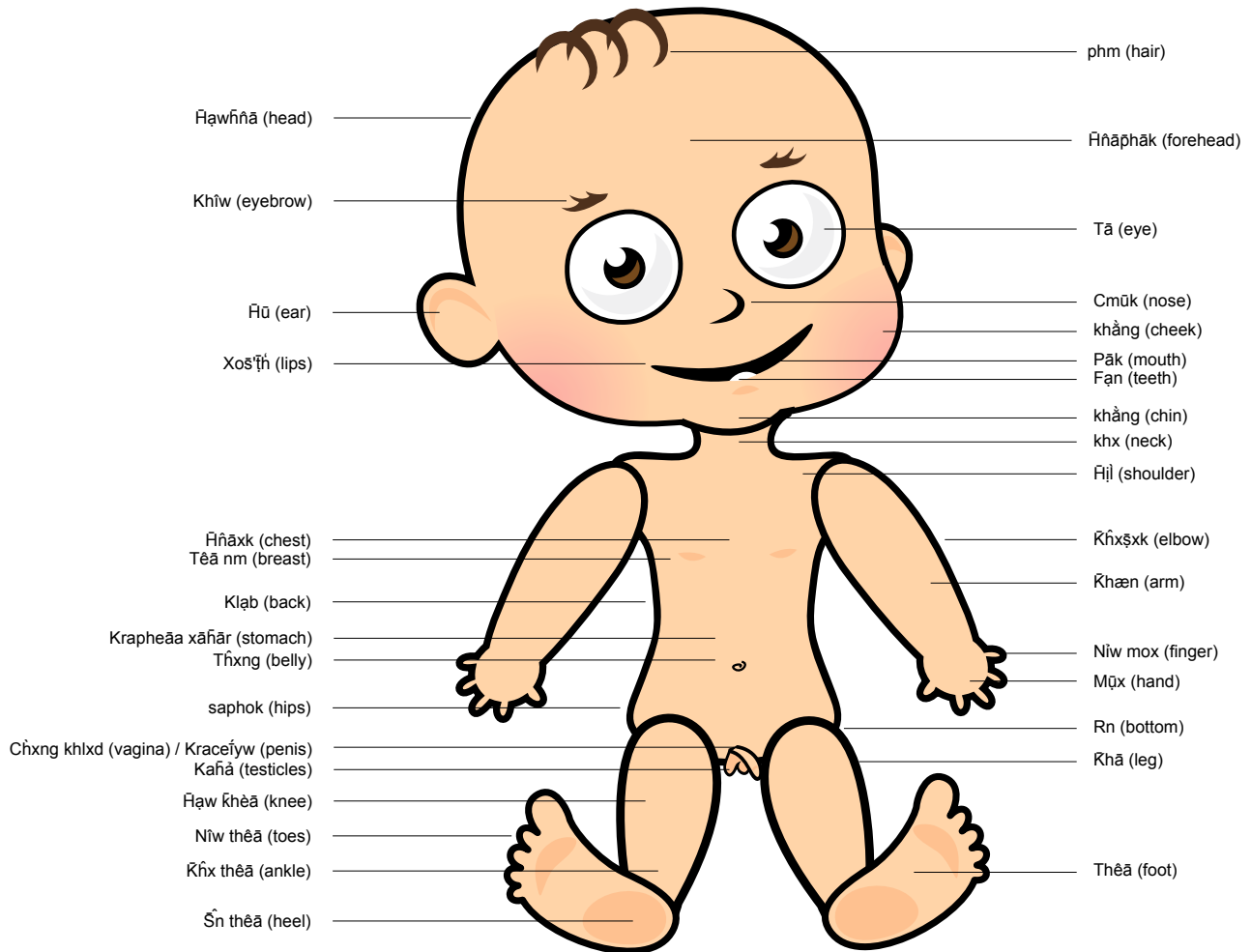
This is a non confrontational society, in which public dispute or criticism is to be avoided at all costs.

Avoid prolonged eye contact. Modesty and humility are emphasized in the culture.

Malays, Chinese and Indians in Malaysia share beliefs based on humoral medical theory.

Illnesses, body states, foods and medicines are regarded as 'hot' or 'cold' depending on the effect on the body.

## Male Body in Thai



# | Indonesia

<b>Location</b>	South East Asia
<b>Capital</b>	Jakarta
<b>Climate</b>	Tropical Climate
<b>Population</b>	240,271,522 (2009)
<b>Area</b>	1,919,440 km <sup>2</sup>
<b>Official Language</b>	Indonesian
<b>Government</b>	Presidential Republic President – Susilo Bambang Yudhoyono Vice President - Boediono
<b>GDP (PPP)</b>	\$909.729 billion (2009)
<b>Religion</b>	Muslim 86.1% Christian 8% Hindu 3% Buddhist 1.8%
<b>Currency</b>	Rupiah
<b>Time Zone</b>	various (UTC+7 to +9)
<b>Drives on the</b>	Left
<b>Internet TLD</b>	.id
<b>Calling Code</b>	+62

## Culture

Indonesia has a complex cultural mix of around 300 ethnic groups.

The concept of 'face' is very important.

Indonesians communicate quite indirectly to avoid causing shame. Negative answers are often avoided.

Greetings are formal often with a slight bow or place their hands on their heart after shaking your hand.

## Relevance to Practice:

Always start at the most senior person first when being introduced to groups.

When sitting with Indonesians it is best to keep both feet on the ground. It is considered rude to show the soles of your feet.

Use your right hand for giving and receiving things and food. The left hand is considered unclean.

To attract someone's attention, wave your hand with the palm down and clap your hands.

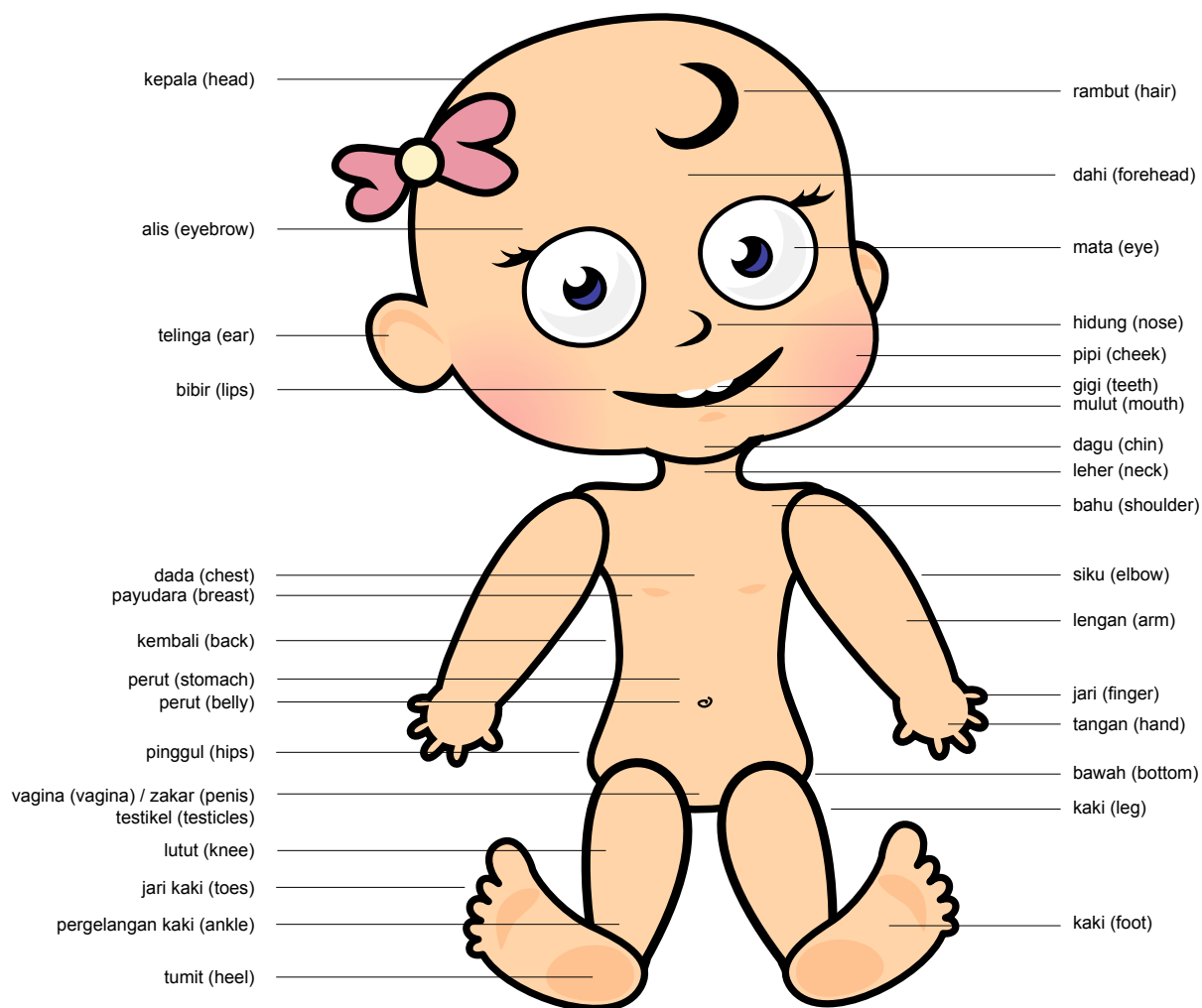
The head and hair are considered sacred, so avoid patting an adult's or child's head.

Public displays of affection between opposite sexes are unacceptable.

Raising your voice or yelling is considered inappropriate and a 'loss of face'.

Do not call out a person's name from a distance.

## Female Body in Indonesian



Pain	sakit
Headache	sakit kepala
Fever	demam
Sweating	berkeringat
Shakes / Rigor	getar
Cough	batuk
Diarrhoea	diare
Constipation	sembelit
Urine Burning / Pain	Pembakaran urin
Bleeding	perdarahan
Vaccinated / Immunized	divaksinasi

# New Zealand

<b>Location</b>	Oceania
<b>Capital</b>	Wellington
<b>Climate</b>	Temperate/Maritime
<b>Population</b>	4,353,731 (2010)
<b>Area</b>	268,021 km <sup>2</sup>
<b>Official Language</b>	English (98%) <sup>3</sup> Maori (4.2%) <sup>3</sup> NZ Sign Language (0.6%)
<b>Government</b>	Parliamentary Democracy and Constitutional Monarchy
<b>Legislature</b>	Democratic Republic
<b>GDP (PPP)</b>	\$115.809 billion (2008)
<b>Religion</b>	Anglican 24% Presbyterian 18% Roman Catholic 15% Methodist 5% Baptist 2% Protestant 3% Unspecified or none 33%
<b>Currency</b>	New Zealand dollar
<b>Time Zone</b>	NZST (UTC+12)
<b>Summer NZDT (UTC+13)</b>	
<b>Drives on the</b>	left
<b>Internet TLD</b>	.nz
<b>Calling Code</b>	+64

## Culture

Developed country egalitarian society, friendly outgoing.

New Zealand has no formal class structures. Wealth and social status is not considered important to Kiwis.

There can be a marked difference between Maori and NZ European societies and culture.

Maori are generally friendly and reserved placing great value on hospitality often at the point of going without.

Maori believe all things have a life force 'mauri'. Damage or domination of this life force results in a loss of energy and vitality.

Maori stand on ceremony and have distinct protocols regarding how visitors should be welcomed or seen off.

## Relevance to Practice:

New Zealand provides a western health care system and uses a range of tools when evaluating patients that will be similar to Australian medical systems.

Cultural safety can be achieved through respectful communications and considered approaches.

In addition the following should also be considered.

Extended family are very important to Maori life and may be involved in health decision making.

To strengthen the wairua (spiritual wellbeing) of the individual and their whānau or hapū (under where tapa whā – the four cornerstones of Māori health)

# Singapore

<b>Location</b>	South East Asia
<b>Capital</b>	City of Singapore
<b>Climate</b>	Tropical
<b>Population</b>	4,987,600 (2009)
<b>Area</b>	710710.2 km <sup>2</sup>
<b>Official Language</b>	English (main) Malay (national) Mandarin Chinese Tamil
<b>Government</b>	Parliamentary Republic
<b>Legislature</b>	Parliament
<b>Formation</b>	Founding 29 January 1819[2] Self-government 3 June 1959[3] Independence from the United Kingdom 31 August 1963 Merger with Malaysia 31 August 1963 Separation from Malaysia 9 August 1965
<b>GDP (PPP)</b>	\$239.146 billion (2008)
<b>Religion</b>	
<b>Currency</b>	Singapore dollar
<b>Time Zone</b>	SST (UTC+8)
<b>Drives on the</b>	left
<b>Internet TLD</b>	.sg
<b>Calling Code</b>	+65

## Culture

The concepts of group harmony and mutual security are more important than that of the individual.

The family is central to social structure.

Elderly are revered and the term family includes extended to family and close friends.

Having face indicates personal dignity. This can be greater than the person and extends to family, school, company and even the nation.

Confucianism directs and emphasizes respect and social harmony.

Singaporeans shake hands, this includes women, but they must extend their hands first.

## Relevance to Practice:

The elderly may be followed blindly and it is expected even if you do not know the person you will give special consideration.

A calm demeanour is respected and considered superior to a more aggressive style.

Observe your body language and facial expressions.

Singaporeans give pauses before answering a question, allow the answer to occur before speaking.

Singaporeans are non confrontational. They will not say 'no' overtly, likewise 'yes' does not always signify agreement.

# Malaysia

[www.health.qld.gov.au/multicultural/health\\_workers/Malaysian-preg-prof.pdf](http://www.health.qld.gov.au/multicultural/health_workers/Malaysian-preg-prof.pdf)

<b>Location</b>	South East Asia
<b>Capital</b>	Kuala Lumpur
<b>Climate</b>	Tropical
<b>Population</b>	28,310,000 (2009)
<b>Area</b>	329,845 km <sup>2</sup>
<b>Official Language</b>	Malay
<b>Government</b>	Federal Constitutional elective monarchy and Parliamentary democracy
<b>Formation</b>	Federation (with Sabah, Sarawak and Singapore) 16 September 1963.
<b>GDP (PPP)</b>	\$384.388 billion (2008)
<b>Religion</b>	Muslim 60.4% Buddhism 19.2% Christianity 9.1% Hinduism 6.3% Confucianism 2.6%
<b>Currency</b>	Ringgit
<b>Time Zone</b>	MST (UTC+8)
<b>Drives on the</b>	Left
<b>Internet TLD</b>	.my
<b>Calling Code</b>	+60

## Culture

In Malay culture, social interaction is concerned with the maintenance of harmonious relations between individuals.

Unobtrusive communication is the ideal sort of social interaction. Subscription to this style of communication is desired to avoid the discomfort associated with shame.

Some Malay women may not wish to shake hands with men.

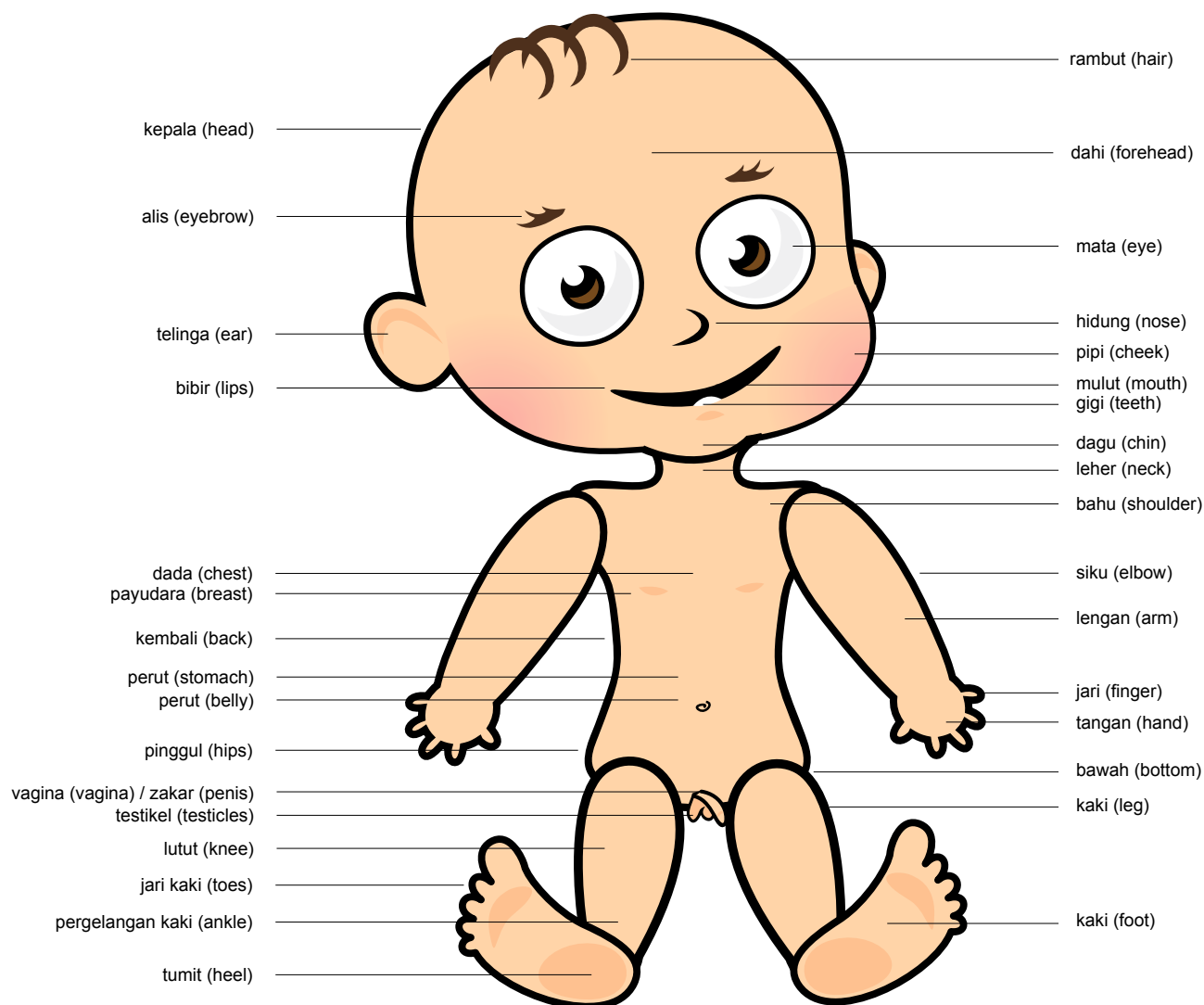
## Relevance to Practice:

Malays, Chinese and Indians in Malaysia share beliefs based on humoral medical theory. Illnesses, body states, foods and medicines are regarded as 'hot' or 'cold' depending on the effect on the body.

In general, women prefer to be examined by female doctors, and women who adhere strictly to Islamic precepts

Avoid direct eye contact for any prolonged period it is considered disrespectful.

## Male Body in Malay



# Republic of the Philippines

[www.health.qld.gov.au/multicultural/health\\_workers/philippn.pdf](http://www.health.qld.gov.au/multicultural/health_workers/philippn.pdf)

<b>Location</b>	South East Asia
<b>Capital</b>	Manila
<b>Climate</b>	Monsoonal
<b>Population</b>	91,983,000 (2009)
<b>Area</b>	299,764 km <sup>2</sup>
<b>Official Language</b>	Filipino (based on Tagalog) , English
<b>Government</b>	Unitary Presidential Constitutional republic President – Gloria Macapagal-Arroyo Vice President – Noli de Castro Senate President – Juan Ponce Enrile House Speaker – Prospero C. Nograles Supreme Court Chief Justice – Reynato Puno
<b>GDP (PPP)</b>	\$166.909 billion (2009)
<b>Religion</b>	Roman Catholic 83% Protestant 9% Muslim 5% Buddhist & Other 3%
<b>Currency</b>	Peso
<b>Time Zone</b>	PST (UTC+8)
<b>Drives on the</b>	right
<b>Internet TLD</b>	.ph
<b>Calling Code</b>	+63

## Culture

An important cultural value of Filipinos is *hiya*, which could be roughly translated as “embarrassment”, “shame” or “face”.

Traditionally, parents sleep with their children or have their children sleep with another relative, and do not separate them when they are ill.

A traditional belief is that a baby may be hexed by an admiring glance

## Relevance to Practice:

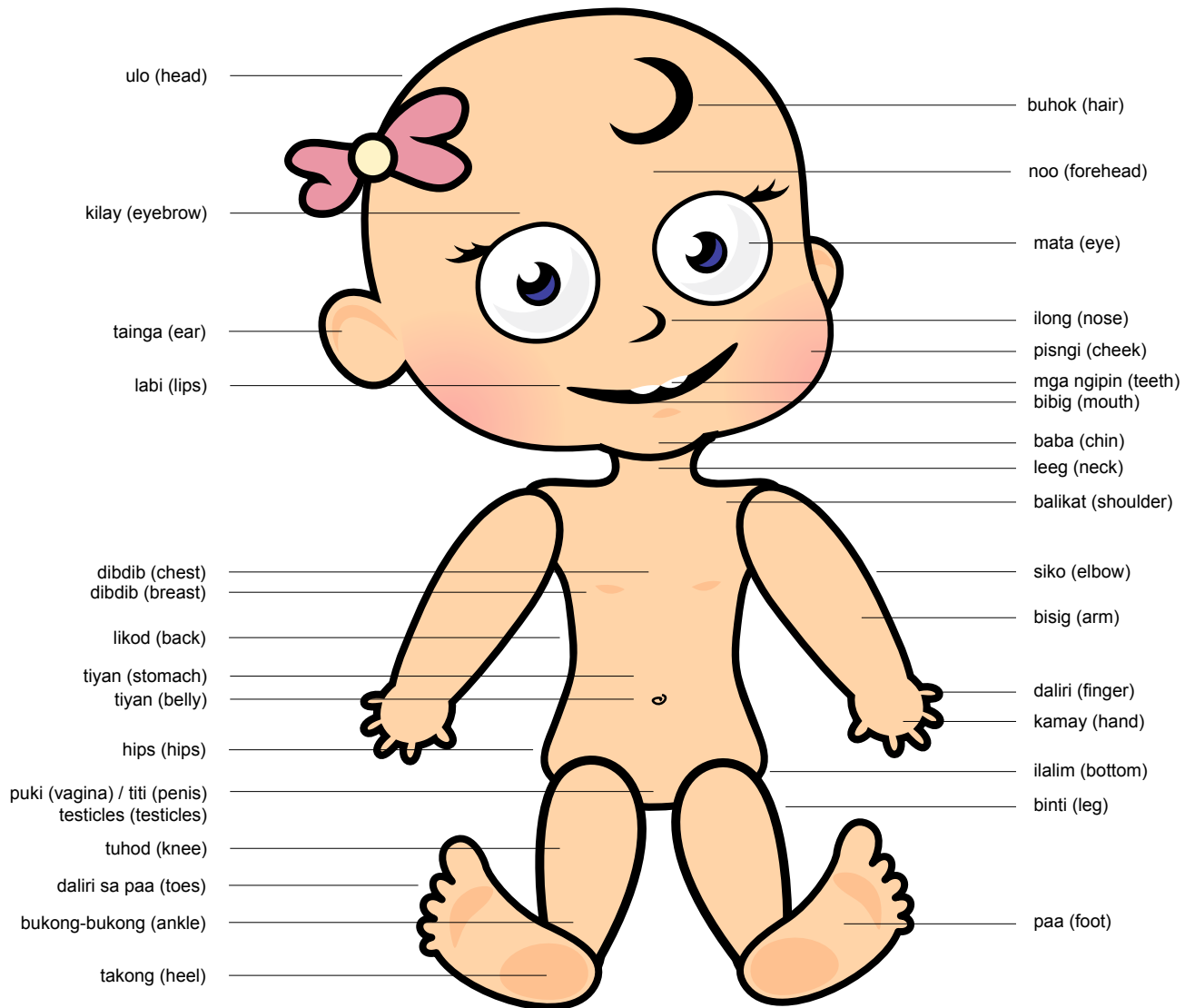
Filipinos generally consider it impolite to stare or look directly at people with whom they are talking. This should not be mistaken for mistrust or lack of confidence.

Filipinos, especially from rural areas, may not like to voice their concerns to health professionals.

People may use concepts of “hot” and “cold” to classify and explain illnesses.

In the Philippines, biomedical services are supplemented by herbalists and other healers who specialise in herbal remedies, massage or healing by spiritual means, through power derived from devotion to Christian saints.

## Female Body in Tagalog



# Samoa

[www.health.qld.gov.au/multicultural/health\\_workers/sam\\_tong.pdf](http://www.health.qld.gov.au/multicultural/health_workers/sam_tong.pdf)

<b>Location</b>	Polynesian region of the pacific
<b>Capital</b>	Pago Pago (American) Apia (independent)
<b>Climate</b>	Equatorial monsoonal
<b>Population</b>	65,628 (196) (2009)
<b>Area</b>	199 km <sup>2</sup> (American) 2,831 km <sup>2</sup> (Independent)
<b>Official Language</b>	English, Samoan
<b>Government</b>	American Samoa – US President Samoa – Parliamentary Republic
<b>Legislature</b>	Govenor – American Constitution (American) Parliamentary Democracy (independent)
<b>Formation</b>	1 January 1962 New Zealand
<b>GDP (PPP)</b>	\$1.088 billion[3] (Independent)
<b>Religion</b>	Christian 98%
<b>Currency</b>	US Dollars
<b>Time Zone</b>	(UTC-11)
<b>Drives on the</b>	Left
<b>Internet TLD</b>	.as (American) .ws (Independent)
<b>Calling Code</b>	+1-684 685

## Culture

The fa'a Samoa, or traditional Samoan way, remains a strong force in Samoan life and politics. Despite centuries of European influence, Samoa maintains its historical customs, social and political systems, and language.

Samoans are deeply spiritual and religious people, and have subtly adapted the dominant religion of Christianity to 'fit in' with fa'a Samoa and vice versa.

As such, ancient beliefs continue to co-exist side-by-side with Christianity, particularly in regard to the traditional customs and rituals of fa'a Samoa.

Samoan mythology include many gods with creation stories and figures of legend

## Relevance to Practice:

It is appropriate to address Tongans by their first name; "Mr" and "Mrs" are not used in their culture. This does not apply to Samoans.

Samoans and Tongans tend to be shy, and tend not to ask questions or question a health professional's authority.

They tend to say they understand even if they don't, so you may need to check a patient's understanding.

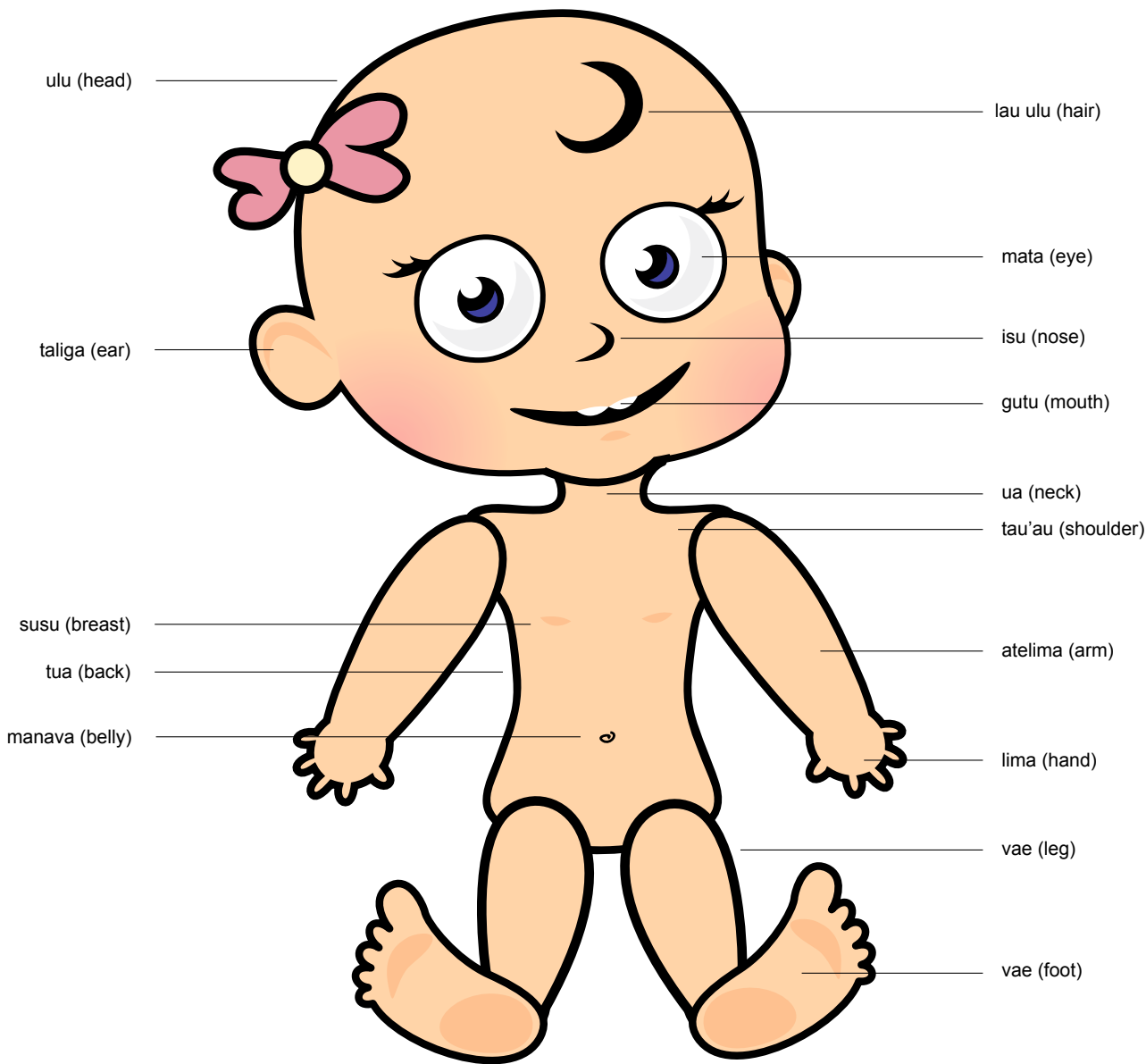
Among both men and women, a high level of body contact is natural and normal.

Samoans and Tongans are very respectful of health workers, however, they may feel uncomfortable and need reassurance.

The gender of the health provider may be an issue for Samoans, particularly the younger generation, and women may appreciate being asked if they mind being seen by a male doctor.

For many Samoans, prayer is a very important element of the healing process.

Female Body in Samoan



# | Brunei

<b>Location</b>	South East Asia
<b>Capital</b>	Bandar Seri Begawan
<b>Climate</b>	Tropical
<b>Population</b>	388,190 (2009)
<b>Area</b>	5,765 km <sup>2</sup>
<b>Official Language</b>	Malay
<b>Government</b>	Islamic Absolute Monarchy Sultan – Hassanal Bolkiah Crown Prince – Al-Muhtadee Billah
<b>Legislature</b>	
<b>Formation</b>	Sultanate – 14th Century End of British protectorate – January 1, 1984
<b>GDP (PPP)</b>	\$19.716 billion (2008)
<b>Religion</b>	Muslim 67% Buddhism 13% Christianity 11%
<b>Currency</b>	Brunei dollar
<b>Time Zone</b>	(UTC+8)
<b>Drives on the</b>	left
<b>Internet TLD</b>	.bn
<b>Calling Code</b>	+673

## Culture

Hierarchical culture, age and position are revered.

The role of shame and 'face' are crucial to Bruneians.

Maintaining face is of utmost importance and they do their best to not cause issues or problems which could jeopardize this.

Communication style is indirect and may translate as ambiguous.

Emotions such as anger, impatience or irritation is embarrassing and to be avoided.

Prayer is 5 times a day for the majority of the population.

Gender relations are governed by Islamic principles.

Nodding your head is appropriate in greeting between sexes.

Left hand is considered unclean

## Relevance to Practice:

Formal and respectful communication is the norm.

Hierarchy must be revered in all forms of communication.

Tone of voice, body language, eye contact and facial expression can often be more important than what is actually said. Observe the person as they speak.

If they disagree with treatment they will most likely remain silent as to not offend – but offer phrases such as 'it is inconvenient or we shall see'.

Nodding of the head does not imply agreement but rather acknowledges you have spoken.

Avoid direct eye contact for any prolonged period it is considered disrespectful.

A photograph of a person in a red jacket and helmet aiming a rifle in a field. The image is overlaid with a semi-transparent red filter. The person is wearing a red jacket, a red helmet, and a red bandolier. They are holding a rifle and aiming it towards the right. The background is a field of tall grass.

# Security

The following are excerpts from a variety of sources, published by the UN and other NGO agencies, whose breadth and experience in training personnel for deployment in insecure regions is extensive.

While AusMAT teams are intended to be deployed once security has been guaranteed, the training of personnel in security awareness is considered a minimum standard. For this purpose AusMAT teams will be exposed to security awareness and are strongly encouraged to read the selected material and additional reading text.

“By definition, the people who are working trying to tackle humanitarian need are working in places which are often remote, usually difficult, and very often dangerous as well, because that’s where the conflicts are and that’s where the natural disasters happen.”

John Holmes - Under-Secretary-General for Humanitarian Affairs

The worsening of the security situation for aid staff is reflected in the statistics of reported incidents. The ICRC has reported a significant increase in the number of so-called “security incidents” per year.

### Introduction

Since the beginning of the nineties, humanitarian aid and development organisations have been confronted with armed conflicts to an ever-increasing degree. In past years, the International Committee of the Red Cross (ICRC) was the only organisation maintaining a presence with expatriate staff to carry on with humanitarian activities during an acute armed conflict. This was possible because the Red Cross emblem was known throughout the world and, thanks to its unique status in international law, the ICRC was accepted and respected by the conflict parties as a neutral body. To day, a multitude of actors are present in large-scale crises and disasters. In addition to the wide variety of governmental organisations, hundreds of non-governmental organisations are often working at local level as well.

The United Nations refers to similar developments. From January 1992 to August 1998, 153 staff working for the UN lost their lives, and 43 were abducted. By May 2002, this figure had grown to 214 dead and 258 abducted persons. In 1992, the UN statistics referred to one fatality a month among their staff, one fatality every two weeks in 1993 and more than one a week in 1994.<sup>5</sup> In spite of a number of improvements in the meantime, violence prevails, and there are indications that the fatalities among the staff of non-governmental organisations have risen in particular. According to the ICRC targeting of its staff currently represents the greatest threat the organisation faces.

What are the reasons for these developments? Various aspects have to be mentioned here that relate on the one hand to the environment of humanitarian aid and on the other to humanitarian aid itself or the aid organisations involved:

The number of violent, almost always inner-state, conflicts has constantly been growing, and therefore, so has the number of aid missions. The UN has recorded a dramatic increase in the number of its peace missions, which are almost always accompanied by humanitarian aid. In parallel to the UN activities, a large number of humanitarian organisations always commence activities to support the population in crisis-shaken countries as well. This coincides with an increase in the number of aid workers in action.

A second reason is that non-compliance of the civil war parties with international humanitarian law is on the increase. They do not observe the internationally agreed rules on the protection of the civilian population in wars. On the contrary, the civilian population become a target of attacks and destabilisation policies. Whereas 90 per cent of the fatalities in the First World War were still soldiers, today, 90 percent are civilians. Some observers even claim that a soldier has a better chance of survival in many wars nowadays.

A growing culture of impunity is coinciding with non-compliance with international law. Aid organisations are seen as simple targets that can be attacked without this having major consequences for those responsible. The UN reports that people responsible for staff being killed on missions have been held to account in just 7 per cent of these cases.

In parallel to the attacks on the civilian population, aid organisations are also being attacked. As supporters of the victims of wars and disasters, they are no longer regarded as neutral parties to the conflict. Moreover, since they transfer resources that are important for the warring parties, their aid to the suffering population gains a strategic role in warring.

At the beginning of the 21st century, new problems are arising for aid organisations in several countries. On the one hand, there are more and more so-called »failed states«, i.e. states in which a generally accepted central government with a monopoly of power no longer exists. There, the above-mentioned developments have a particularly grave impact. On the other hand, international terrorism and attempts to fight it bear risks that also affect the options for the deployment of aid organisations .

But in addition to the environment aid measures are being carried out in, aid itself is changing. The international discussion focuses on two aspects:

Politicisation of humanitarian aid and its being used as a substitute for unsuccessful political action or as a means of covering up or justifying military incursions in crisis areas. It is observed that what used to be a clear demarcation line between humanitarian and military missions is now becoming blurred, which in turn is making it more difficult for aid organisations to maintain their neutrality.

Nowadays, there is stiff competition among the aid organisations for financial support for humanitarian missions and the attention of the media that these missions attract. This can result in security interests being subordinated to the marketing strategies of organisations, with humanitarian aid also being provided in countries or situations in which the wellbeing and lives of staff are put at considerable risk.

If one examines the fatalities in humanitarian missions between 1985 and 1998, one arrives at the following results. Contrary to widespread opinion, accidents and diseases no longer constitute the chief reasons for these fatalities. In 68 per cent of the cases examined, intentional violence against members of aid organisations was the cause of deaths. This tallies with the figures of the ICRC, which reports of 77 per cent of fatalities resulting from violence. In contrast, car accidents accounted for just 17 per cent of fatalities, and non-intentional violence for 7 per cent. More accurate analyses of targeted murders of aid workers show that in 47 per cent of incidents, they were victims of raids on cars or convoys. While the statistics point in the same direction in assigning the murders to the origin of the victims, the overall picture tends to be less coherent. The various surveys report that between 58 per cent and 74 per cent of the victims were local staff.

It has already been mentioned that these statistics do bear weaknesses. They nevertheless demonstrate very clearly that the threat to staff of aid organisations is a problem that humanitarian organisations really need to address.

## Improving security management in an organisation

Improving security management within an organisation involves a number of aspects. It is important that the topic is main streamed throughout the organisation. A coherent security policy has to be in place as well as detailed regulations on implementation at the level of local operations and straightforward statements of the organisation on what it expects of its staff. The organisation's obligations towards its staff should be clearly set out in writing, too. Last but not least, a management approach of this kind also addresses the issue of financing security measures.

## Main streaming the topic within an organisation

There are different reasons for the discrepancy in organisations between being aware that the issue of security is important and insufficiently integrating this aspect into their activities. The arguments most frequently referred to are a lack of time and money and a general attitude of resignation that one has to reckon with such threats in project work and that not much can be done about it. Often, an increase in security management is also confused with less freedom of action at local level. In contrast, a holistic view of the subject stresses that it is precisely appropriate security management that enables operations to be carried out in dangerous areas in the first place.

In order to be able to establish these issues in an organisation, the following management instruments ought to be in place at the head office, tailored to the existing scope an organisation has and to its size:

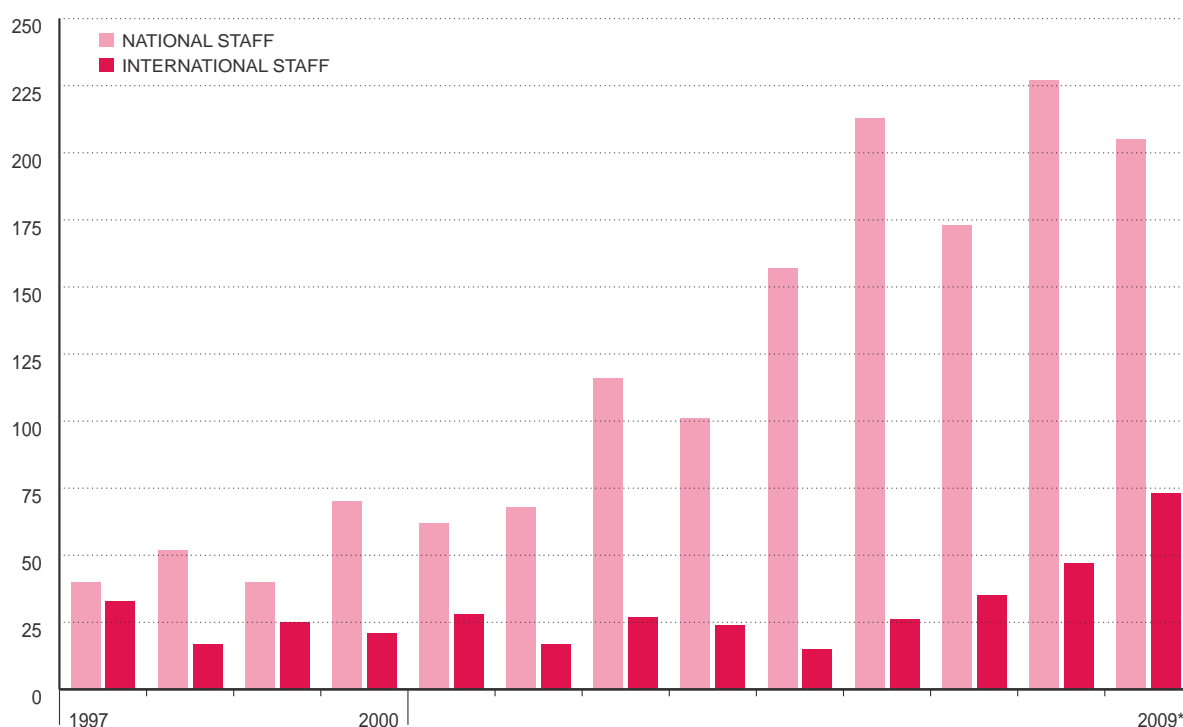
- A forum that corresponding steps can be discussed and planned in
- A review of the procedures and regulations within the organisation from the angle of staff security (project planning, staff recruitment and secondment, finance administration, reporting and information processing)
- Active involvement of and support by the organisation's management staff
- Straightforward division of labour, definition of responsibilities and decision-making powers, schedules
- Provision of human resources, labour time and operational means to support the main streaming process.

## Statistics Humanitarian Casualties

### Victims

**278** humanitarian workers were victims of 139 serious security incidents in 2009, compared with 1999 when 65 humanitarian workers were involved in 34 such incidents. In 2009, 205 of these victims were national staff members of humanitarian organizations, while 73 were international. In 1999, 40 victims were national staff and 25 were internationals.

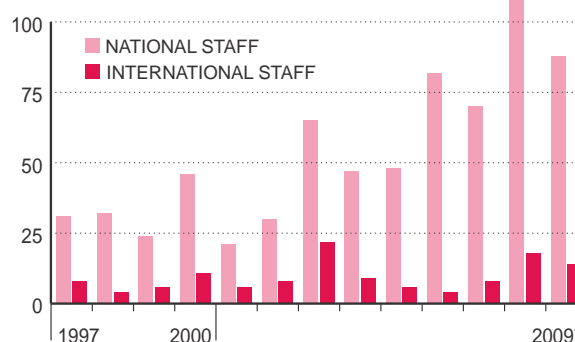
#### Humanitarian workers as victims of security incidents



### Killed

**102** humanitarian workers were killed in 2009 (88 national staff and 14 international staff), compared with 1999 when 30 humanitarian workers were killed (24 nationals and 6 internationals).

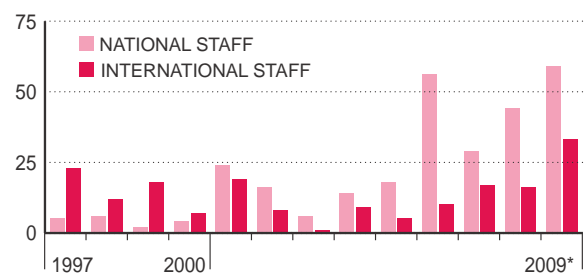
#### Humanitarian workers killed



## Kidnapped

**92** humanitarian workers were kidnapped in 2009 (59 national staff and 33 international staff), compared with 1999 when 20 humanitarians were kidnapped (2 nationals and 18 internationals).

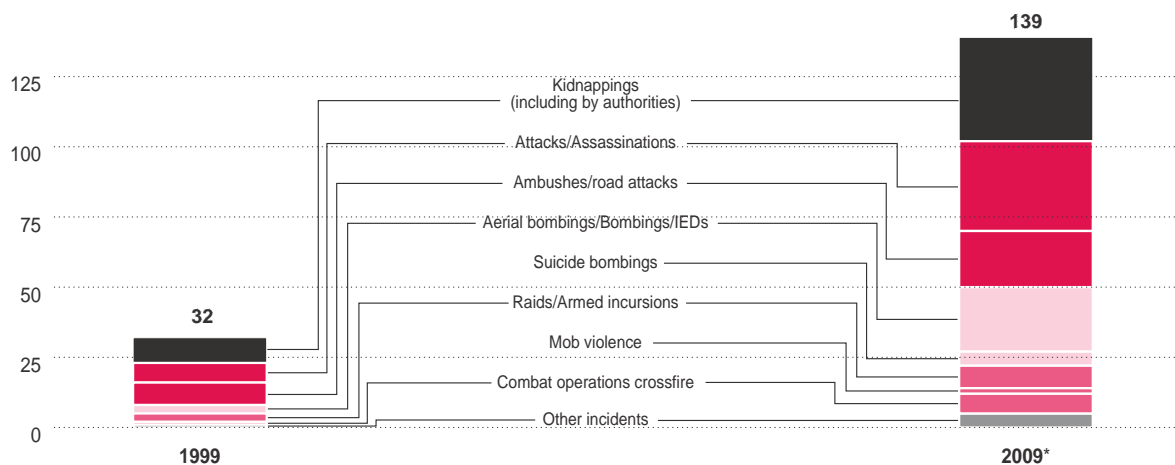
### Humanitarian workers kidnapped



## Victims

**139** security incidents occurred in 2009, compared with 34 in 1999. Kidnappings, the most common incident, increased from 9 to 37 over this period. Attacks and assassinations rose from 7 to 32. Bombing incidents increased from 3 to 23. Ambush/road attacks increased from 8 to 20.

### Security incidents by type 1999-2009



**Whenever possible, the following steps ought to be taken or conditions be created at local level:**

- Conducting a risk analysis for the field of deployment
- Drawing up a security plan
- Regulating the distribution of activities, responsibilities and decision-making powers
- Guidelines for incident reporting and analysis
- Further training programmes
- Enough financial means to remedy identified weaknesses.
- Working out a security policy tailored to a specific organisation

Every organisation ought to define a general security policy for itself in which fundamental values and principles are represented.

**One statement here could be e.g. that the lives of the staff always take precedence over the protection of material values.**

This policy serves the purpose of arriving at a common understanding of the topic, defining a uniform practice of action and actively involving the staff in implementing the objectives. Examples of this are the chapter on 'Werte und Prinzipien' (values and principles) in the guidelines of German Agro Action or the section on »Mandate« (mandates) in the MSF guidelines.

Since the size, mandate, working context, activities, etc. Of the various aid organisations differ considerably, no generalised recommendation can be given here on the contents a policy of this kind should have. However, it is advisable to cover the following topics:

### **The organisation's values regarding staff security and risk management**

What is our mission and vision for activities in the context of violent conflicts? What is our mandate and remit, and from what do we deduce the legitimacy of our assignment? What has priority in all circumstances and in every situation? What is our position on political and ethical or moral challenges that working in such a context entails?

### **Striking a balance between the possible risks for the staff and the desired benefit for the population**

The decision whether an assignment is justified and legitimate has to be taken anew in each individual situation. Here the issue that is always at stake is how a balance can be achieved between the possible risk for the staff and the desired benefit for the target group. In this context, the following questions can be helpful, and should be discussed in a participatory process whenever possible:

- The risks the concrete assignment entails and the organisation's general readiness to take risks
- The need of the population and the organisation's mandate and portfolio
- The benefit and the positive impact of an assignment and the existence of a humanitarian space options to reduce vulnerability to existing risks and improve security management in general.
- Aid organisations are in a position to reduce their vulnerability by pursuing an appropriate security strategy.

### **The preferable security strategy**

The security of aid organisations must not be conceived and treated in purely military terms, which are frequently mainly oriented on equipment, tactics and rules of behavior. Since the work of aid organisations differs considerably from that of the military, its problems and options for action in the field of security are more complex. Generally, it can dispose of three strategies for action. The first one aims at deterrence, the second at protection and the third at acceptance and recognition.

A deterrence strategy aims at raising the risk of an attacker by threatening with counter violence and inhibiting potential enemies. This includes political or economic sanctions as well as the exercising of diplomatic pressure. Armed escorts for aid shipments are also an element of this category. While this deterrence strategy is not particularly suitable for aid organisations, it does appear to be indispensable in some cases.

The second strategy is aimed at one's own protection and serves the purpose of making a potential attack more difficult.

The possible protective measures fall into three categories.

- First of all there is protective equipment,
- Second organisational rules and provisions and
- Third co-ordination with other actors.

Examples are burglar bars, bullet-proof vests, controlled access to offices and housing and other measures making attacks more difficult. Aid organisations almost always use this strategy too, especially as a protection against attacks by criminals.

While such a response is understandable, it can result in a reactive »bunker mentality«. Dug in behind walls and barbed wire, one perceives the surroundings as a threat and loses contact with the people to the wellbeing of whom one really wishes to contribute.

This is why aid organisations primarily opt for the approach to gain protection by acceptance and recognition among the civilian population in project activities and in working with the target groups. This strategy is also referred to as an anthropological approach to security issues, or it is termed as software-oriented, as opposed to focusing on equipment and technology (hardware). Involving the people and the local authorities in the planning and implementation of measures is to help achieve their feeling responsible for the protection of the aid workers. Fear among the population of the aid organisations being withdrawn and a loss of international support is an important protective element.

## The civilian population remains an aid organisation's most important ally.

However, recognition of the organisation's activities on the part of the population cannot simply be presumed but has to be earned. It is recommendable to again and again explicitly check the local »rate of acceptance« when a project commences and at regular intervals during its implementation. Here, local staff can contribute valuable services as a mediating and communicating body.

Often, there is a considerable discrepancy between how an organisation sees itself and how it is perceived by the local population in terms of how well it is known, its mandate, its work and, in particular, to what degree it is accepted.

Transparency in the criteria for the allocation of aid, continuous communication, how the staff behave and correct project planning are important elements.

This is why all approaches towards conflict sensitive project planning are immediately relevant to security. An existing source of tension in society may be heated up by the way that aid is distributed or by implicit ethical messages, e.g. by giving preference to an ethnic group in recruiting local staff. Thanks to failed project planning, they will be perceived as biased, or their operations may interfere with the activities of the warring parties. Thus they get into the field of fire and become targets of attacks.

## Security planning at local level

An organisation's security policy, which has been worked out at its headquarters, is put into concrete terms and regulations at local level.

Staff require clear orientations as to how they are to respond to crisis situations and who can or has to make what decisions. Reporting on and analysis of incidents are also important issues that require guidelines. In addition to instructions for action, the imparting of methods with which the security situation can be assessed and adequate responses to it can be initiated is also recommended. In order to avoid disagreement and misunderstandings, it is helpful if the headquarters makes binding statements in a document for its staff on what its expectations of behavior are in the country of assignment and what sanctions will be taken if these rules are not complied with.

Security planning at local level includes a risk analysis, working out or drafting a security plan (which also makes provisions for reporting on incidents), a code of conduct for the staff in everyday project activities and guidelines for co-operation with other actors.

## Risk analysis

Before a security plan is compiled at local level, a risk analysis ought to be conducted in a similar way to the assessment of the needs a target group of a planned project has. Here, potential threats are analyzed on the one hand, and on the other, the vulnerability of the individuals working in the project is assessed.

A risk analysis of this kind follows the equation  $\text{risk} = \text{threat} \times \text{vulnerability}$ . Although the threat itself can only be influenced minimally in most cases, aid organisations can reduce their vulnerability by opting for an appropriate security strategy.

Local or international staff are vulnerable to certain threats to a varying extent. Age plays a role, as do nationality and, in several countries, ethnicity as well as, for example, one's status within an organisation or the profile of the organisation it-self.

Particular attention ought to be given to differences in vulnerability between men and women. Sexually motivated assaults almost exclusively affect women, which is why special precautions ought to be taken to protect female staff in countries in which such threats are very likely to occur.

On the other hand, the situation should not be used as an excuse not to employ any women right from the start. In some countries and situations, men are in more jeopardy than women, especially if the attackers' main aim is to demonstrate their power and strength. And if media coverage is of special importance, for example in the case of an abduction, woman hostages and children are frequently released at an early stage to gain a better public image.

### The following questions are asked in analysing threats:

- Who represents a threat?
- Why?
- What are the possible targets for attacks?
- How and where could attacks be launched?

Checklists can be drawn up for these considerations, and security levels can be defined to classify certain situations.

The UN has a five-phase model, while various aid organisations work with four-phase models (e.g. MSF, WVI, Care International, Caritas International Afghanistan).

Phasing offers the advantage of a certain degree of standardisation of responses and a guarantee that certain provisional measures are taken without having to spend much time on planning and co-ordinating in an acute situation.

Moreover, the events or threat scenarios resulting in a certain phase are defined right from the onset. This prevents staff from gradually getting used to a deterioration of their situation and only becoming aware of this when it would have been better to leave the region or the country when it is already too late.

The disadvantage of phasing is that the system is rather rigid. Often, the local situation changes very quickly, and there is not enough time to determine the transition from phase x to phase y. Furthermore, there is a danger that staff may have a false sense of security if the country of assignment has been graded as relatively unproblematic.

In these countries too, security problems can arise almost overnight, or individual persons or organisations can become a target for certain reasons, even if the general situation appears to be relatively stable.

So an ongoing monitoring of the surroundings with regard to security issues is always recommendable. As an alternative to the security levels, risk analysis can be adopted as an integral element of day-to-day project management.

Gathering information from different sources and continuous dialogue with as many people involved as possible are important ways of always ensuring an optimum up-to-date assessment of the situation.

Information can be processed with the aid of a matrix on the horizontal axis of which the probability of the occurrence of a threat is entered while the vertical axis shows the impact. This matrix can be used to determine how serious a risk is. Consideration should subsequently be given to how the risk can be reduced.

- Is it possible to lower the probability of its occurrence?
- Is it possible to reduce the impact on individual project staff or the programme as a whole?
- Can the predictability of the risk be improved?
- Are there opportunities for the organisation or the staff to reduce the level of exposure to the risk?

On the basis of such a risk analysis, the security strategy is chosen that is most suited to the concrete situation in the project area. As already explained, it should be a mix of the different approaches. Depending on the organisation and the country of assignment, this strategy will assume different forms, but it will be formulated in concrete terms in the security plan for the respective country and translated into instructions for action to be taken for the staff.

The central element of an organisation's »security architecture« is the definition of responsibilities and (decision-making) powers.

## What a security plan should contain

On the one hand, they ought to be included in the job descriptions for the staff, and on the other, the security plan should contain clear statements on the employees' authority to give directions and the duty to comply with instructions.

### Typical table of contents of a security plan:

- **Introduction:**
  - Date and author
  - Objective Elaboration process Intended users
- **Background information**
  - Mission Statement
  - Context analysis
  - Mandate of the organisation
  - Risk analysis
  - Security strategy
- **Standard Operating Procedures**
  - Transport of personnel and material
  - Site security
  - Communications
  - Handling money
  - Incident reporting
  - Land mines (if applicable)
- **Contingency Plans**
  - Evacuation Medical evacuation
  - Kidnapping
  - Death of staff
  - Natural disasters (if applicable)
- **Supporting Documents**
  - List of staff, addresses, telephone numbers, passport details, blood group, family contact details
  - List of international organisations, contact persons, contact details including radio frequencies
  - Resource people (medical personnel, UN security Officer, immigration and travel agencies)
  - Maps indicating assembly points, evacuation routes and preferred route

## Transporting staff and materials

### The following is of special importance

- **Vehicle choice** (4-wheel drive: yes or no, label and model, new or second-hand cars, own fleet or rental cars)
- **Vehicle safety** (Equipment, maintenance, training the person- nel in repairs)
- **Style of driving and behaviour** (Speed limits, seat belts, recruitment and train- ing of drivers, policy regarding driving at night, behaviour if causing an accident)
- **Approaches to passengers** (Policy regarding lifts for armed personnel and the police)
- **Journey planning** (Team briefing and debriefing, collection of in- formation, maintaining contact with the base station)
- **Checkpoints** (Preparations before reaching the checkpoint, behaviour at the checkpoint, policy regarding handling over documents)
- **Convoys** (Planning, constituting and leading a convoy, behaviour and discipline)

## Communication

### The following is of special importance

- **Choosing telecommunications** (HF-radio, VHF-radio, mobile telephones, satel- lite telephones and email)
- **Setting up the equipment** (Operational requirements, vulnerability for failure and sabotage, prices, maintenance, net- work compatibility, administrative permissions and licensing)
- **Operating the equipment** (Installation of the base station and mobile units, power supply, safety)
- **Training the users** (Technical details, rules and regulations for calls, discipline, distress and security calls)
- **Regulations on communication** (Tasks and competence, frequency, regulation in case of an incident, operating hours)

## Protection of Site

### The following is of special importance

- **Site selection** (Neighbourhood, proximity to strategic infra- structure, compound, landlord)
- **Physical criteria** (Site, access and ways out, parking, illumination, burgler bars, power supply)
- **Managing access** (Visitors, keys)
- **Guarding** (Own guards or security firms, police patrolling, equipment of the guards, management of shifts and duty)

# Principles of Security

Personal security is a term which encompasses all the principles of everyday security and the application of these in everyday procedures whether operating in the field or off duty in the town



Personal security is an individual responsibility. The security risk can be reduced by using common sense and precautionary actions. You the individual play the most important role in maintaining your personal security.

## Introduction

Personal security is an individual responsibility. The security risk can be reduced by using common sense and precautionary actions. You the individual play the most important role in maintaining your personal security. These guidelines are provided to assist you in developing good security practices. They are not all-inclusive and staff members who have further concerns should contact the Security Officer or Designated Official at their duty station. You should adapt these guidelines to your own duty station, situation and abilities and use them to assist you in security planning. Although locally recruited staff members are generally well-versed in dealing with the security and safety aspects of life in their homeland and city, some of the measures outlined herein may also be of interest to them. (UNHCR ESS & eCentre48 29 August– 3 September, 2004 Pranburi, Thailand))

## Principles

- Observe the rules.
- Assist functionaries.
- Use personal discretion.
- Limit exposure to danger.
- Adopt careful habits.

## Education:

- Do not take valuables into the field.
- Lock up personal effects in a tin box.
- Lock living accommodation.
- Let colleagues know where you are going and your time of return.
- Never go off alone.
- Always move in pairs between compounds after dark.
- Wear sensible clothing and footwear.
- Take mobile communications on long trips.
- Always be aware of surroundings and mood.
- Be methodical in your planning.
- Avoid routine.
- Do not carry confidential documents around with you.

- Clean your baggage and personal folders before moving to a new location / area.
- Always have your quick-move kits packed and on hand.
- A minimum team of two staff when re-locating / opening up a new area / location.

## Vehicles

These SOP's should be applied whether undertaking long or short journeys and at field locations.

- Always check communication and vehicle.
- Book in time of departure
- Destination
- Estimated time of return.
- Keep doors locked.
- Vehicle full of fuel.
- Vehicle emergency tools
- Food
- Water
- Extra fuel.
- Travel in pairs.
- When moving through remote tribal areas have small selection of goodies available as presents if stopped
- Soap
- Salt
- Cigarettes.
- Windows, maximum of 2" open especially when moving through towns and populated areas. In field locations use discretion and act accordingly.

## Considerations

- The threat to you and your team.
- Special details with regard to country, area, and location.
- What do you need to know.
- The Security and Local Ground Rules, know how best to apply them.
- Be aware of and consider the consequences for yourself, your colleagues if you ignore the rules.

### General

The best way to be safe is to avoid trouble in the first place, rather than try to extract yourself later. This means that you should develop a strong sense of security awareness and adjust your behaviour to take into account the environment in which you find yourself and the possible risks related to it. Consideration of the following points will increase your own personal security awareness:

#### Do:

- Follow your instincts. If you feel uncomfortable about a location or a situation, leave immediately-;
- Learn to notice details about people. In the event of an incident, this will help in giving a good description;
- Always know where you are going. Always behave as though you know where you are going. Demonstrate a confidence that you may not necessarily feel;
- Become knowledgeable about your neighborhood. Where is the nearest police station? Which stores, restaurants, businesses are open late at night? Is there a telephone nearby?
- Keep a low profile;
- Establish several routes to work and vary your selection of them and the time you depart for work and return home. Most incidents take place as the individual either leaves or returns home;
- Identify routines, such as the regular game of tennis, jogging, social events, etc., and change the time at which they occur. Also, beware of routines that cannot be avoided such as picking up children at school;
- Be alert to any evidence of surveillance of your house, office or travel route between the two, serious attacks are usually preceded by a period of surveillance;
- Know your own ability. Be honest with yourself and be aware of your capabilities. You should always try to maintain yourself in good physical condition;
- Call attention to yourself if you are in danger; shout, blow the horn of your vehicle;
- Be sure that you know what specific security arrangements are in place at your duty station; know how the walkie-talkie system operates;
- At a new duty station find out about customs, how to behave, potential threats and areas to avoid;
- Learn a few phrases in the local language so that you can signal your need for help; also, learn a few phrases in the local language about the United Nations and its role in the country;
- Rehearse what actions you would take if you were to be confronted. There is no right or wrong way to respond to an attack. Each situation will be different. Whether to resist an attacker or not can only be your decision. Generally, the following options will be open to you: talk your way out of it; give in to the demands made of you; shout for help or yell "fire"; flee; fight. Remember, your life is not worth losing for material possessions; and
- Make sure your level of security is balanced by the level of threat at your duty station.

#### Do not:

- Place yourself in situations which may be expected to attract threats, e.g., political rallies;
- Ignore unusual or strange circumstances;
- Display cash, keys or other valuables, as this may attract potential robbers;
- Establish routines, as they make your movements easy to predict for any observer.

### Traveling

Travelers are often exposed to particular risk, as they are known to be carrying money, passports and valuables. They are vulnerable because they are often disoriented and unsure of the safety of their surroundings. Consideration of the following points will improve your security while travelling:

#### Do:

- Always check the security phase of the country to which you are travelling and ensure that you have the proper security clearances, as required;
- Always inform the United Nations office of your arrival and local contact numbers. Remain in touch with the office; ensure you have the telephone number of the Designated Official and his/her Deputy;
- Before you leave home, let someone know your plans. Leave contact numbers. If you change plans, let someone know;

- Stay alert - watch your luggage and briefcase. Keep your passport, laissez-passer, airline tickets, money and traveler's cheques safe; it is preferable to keep them on your person;
- Photocopy airline tickets, passport identification page and relevant visa page, driver's license and credit cards you plan to take. Leave one set at home and keep another with you in a separate place from the valuables. Leave a copy of traveler cheque serial numbers at home and take a copy with you;
- If possible, schedule direct flights. Try to minimize time spent in unsecured airport public areas. Move quickly from the check-in counter to the secured area;
- At the airport be calm, do not allow people to rush you, keep your possessions under control,
- Know exactly how you will travel from the airport to the hotel or first business appointment. If you
- Are being met at the airport, does the person waiting for you have proper identification?
- Stay in larger hotels which have more elaborate security;
- Choose a room near the elevator to avoid having to walk down a long, empty corridor. If you feel uncomfortable, ask a hotel employee to escort you to your room;
- Keep the balcony door or window locked and draw the curtains,
- Use a rubber doorstop for added safety (recommended that you carry one as part of your luggage). If not available, use a chair to jam the door;
- Upon arrival in your room, find the nearest fire escape. Walk from your room counting the doors until the fire escape. Imagine how you would reach it if you were crawling in darkness and smoke. Read the hotel's fire instructions;
- Park in well-lit areas;
- If you are attending a conference, remove your name tag as soon as possible to avoid being Identified,
- When first entering your room, check the closets, bathroom and balcony to make sure they are not occupied;
- Be wary of con artists and people offering to exchange money for you at black market rates-;
- Beware of individuals posing as police or security officers who want you to accompany them to another location. Obtain proper identification and call the local police to verify. Ask the hotel desk to assist you in verifying identities. Before you accompany them, call the Designated Official and advise him/her of the situation.

#### **Do not:**

- If someone knocks on your door, assume the person is who he/she claims to be; call the desk to double check. Always use the dead bolt and chain,
- Enter your room if you find the door open or unlocked. Return to the desk and ask someone to accompany you to your room,
- Stay on the ground floor or in a room facing an outside corridor. If possible, book a room between the second and seventh floors - above ground level to prevent easy entrance from outside and low enough for fire equipment to reach in an emergency;
- Display your room key to strangers; and
- Leave the "Please clean my room" sign on your door. It tells people the room is empty. Call housekeeping instead.

## **Walking**

#### **Do:**

- By considering the following points, you will improve your security while walking:
- As you prepare to go out, check that all closures on your bags are shut. Put your wallet in a front pocket or under clothing. Carry only the cash you need and divide it;
- Always be aware and alert to your surroundings;
- Walk nearer to the curb to avoid passing too close to shrubbery, dark doorways and other places of concealment;
- If you must use a personal stereo, i.e., a Walkman, keep the volume down low enough so that you can hear your surroundings;
- Keep only those keys on your key chain that you use;
- If someone suspicious is behind you or ahead of you, cross and re-cross the street to the other side. If in doubt, use whatever means necessary to draw attention to yourself and remember that it is much better to suffer the embarrassment of being wrong than to fail to take action if you feel threatened;
- Mark your keys so they can be identified in the dark; this makes it easier to find the appropriate keys quickly;
- Carry identification, preferably with blood type indicated.

### Do not:

- Approach the vehicle if a driver pulls up next to you asking for directions, and beware of the suggestion to “look at this map”,
- Be afraid to yell and run in the opposite direction if a car approaches and the driver threatens you;
- Hitchhike or accept a ride from a stranger,
- Jiggle your keys in your hand unnecessarily, it announces that you are on your way home-,
- Take shortcuts through isolated areas;
- Walk alone at night;
- Talk to strangers;
- Have your name or address on your key chain.

## Driving

### Do:

- Being in a vehicle can give you a false sense of security and can possibly make you a target of hijackers. Following the tips below can improve your security:
- Whenever possible, travel on well-lit, populated streets. Keep windows rolled up, except for a small ventilation space. Keep doors locked;
- Be especially alert when you are at a red light or a stop sign. Develop the habit of adjusting driving speed to avoid stopping at traffic lights. Be prepared to drive away, sounding the horn, if you are threatened-,
- Keep your car in good working order. Make sure you have a full tank of gas, flashlight, inflated spare tire, jack, tire iron, basic tool kit, jumper cables, folding shovel, first-aid kit and a gallon of potable water. Know where you are going and how to get there. Carry a map with you-,
- When parking at night, select a place that will be lit when you return. Check for loiterers before leaving the car. Do not park your car on the street if you have access to a garage or a security parking area;
- Before getting into your car, look inside first to make sure no one is hiding in the back seat. Check underneath the car from a distance. When leaving your car, make sure it is locked-,
- Think twice before deciding to offer assistance to what may appear to be a stranded motorist, regardless of gender.

### Do not:

- Drive into your own driveway or park in a deserted area if you suspect that someone is following you.
- Make a few turns down active streets. If the car continues to follow you, drive to a location where you know you can get help, such as the nearest police station;
- Drive alone at night;
- Panic if someone attempts to force you off the road. Blow your horn constantly to attract attention. If you are forced over, as soon as you stop, put your car in reverse and back away. Blow your horn and keep the car in motion-,
- Pick up hitchhikers.
- Public transportation
- Considering the following points will improve your security while using public transportation:

### Do:

- Wait for your train in a designated waiting area during off-hours;
- Sit in the train car that is occupied by the conductor or driver;
- Know the hours of operation of the trains you are using so that you do not need to wait on deserted platforms.
- Avoid taking the last train to your destination;
- After getting off the bus or leaving a subway station, always look around to see whether you are being followed.

## Security concerns for women

### Introduction

In spite of all the security precautions which are taken, it is possible that you will become a victim. The following section outlines some specific concerns ranging from sexual harassment to rape. The purpose of this section is to increase your awareness and understanding of these issues and provide you with information which may be useful should you or anyone you know be affected by such incidents.

### Sexual harassment on the street

You are sitting on a bus. The man opposite is staring hard. His eyes follow you as you get off. You are waiting at a stoplight. A man brushes past, lets loose a mouthful of obscenities and melts into the crowd. You are walking home at night. You hear soft footsteps behind you, footsteps that quicken when yours do.



There probably isn't a woman alive who hasn't had one or more of these experiences. In crowded cities they are often a way of life. "Psychological rape" is the term one sociologist uses to describe these actions - the stares, leers, crude remarks and other behaviour with which men terrorize and intimidate women without laying a finger on them. Emotionally, it can be as destructive as its physical counterpart.

The reaction of women - fear, anger, humiliation, vulnerability - is common. Part of the distress springs from the impersonality of the attack. It is degrading.

How do you cope with stares, leers, muttered obscenities and the like? The only hard and fast rule is stay out of danger. If, however, you are reasonably safe, you may consider responding with the following:

- a) stop, Ignore the advance. If a man is just trying to get a reaction from you and finds he can't, he may
- b) If you are in a familiar environment, you may consider answering in kind. If a man is trying to shock you with his words, a response in a similar vein may stop him. However, ensure you are not within striking distance when you do this;
- c) Confront him. If you stop and politely ask, "Were you speaking to me?" the annoying party may feel embarrassed, especially if his acts were based on fear or insecurity; and
- d) Most important, release your feelings of anger and indignity fast so that you can put the incident out of your mind as soon as possible.

## Rape awareness

### Introduction

The information contained in this section was prepared with the assistance of St. Vincent's Hospital and Medical Centre Rape Crisis Programme, New York, New York, and exert from UN charter on Security for personnel. Its primary goal is to educate you about the issues associated with rape and sexual assault in order to reduce the possibilities of your becoming a victim. Rape is considered the second most violent crime. Homicide is number one. Rape is psychologically devastating, and it can take years for the victim to recover. Only recently has it become acceptable to openly discuss this problem. As a result, misconceptions concerning rape and sexual assault and its victims are being identified and dealt with.

The following terms are working definitions commonly used by professionals who deal with sexual assault. They are not legal definitions.

**Sexual assault: Any non-consensual sexual act which is forced by one or more persons upon another.**

**Rape: Sexual intercourse which is achieved without the victim's consent.**

Everyone is a potential victim of sexual assault. Sexual assault is a threat to all women. Rape and other sexual assaults have been documented against people as young as two months and as old as 97 years. No one can afford to believe that it could never happen to them. It can.

Sexual assault is a crime of violence. Sexual assault is any sexual act committed against the will of another person. This can include physical force and coercion. People who Force sex on others are not motivated by sex, they are acting out their desire to hurt and control another person.

Most sexual assaults are committed by an acquaintance of the victim. Sexual offenders are not always strangers. Many victims have had some prior contact with their attackers. Sex offenders may be casual acquaintances, neighbours, dates or family members. Knowing the attacker does not make it any less a violent crime.

Sexual assault is one of the most under-reported of all violent crimes. Sexual assault is not an infrequent crime. It is just infrequently reported.

### Tactics used by rapists

The sexual assault attack cycle is divided into five parts:

- Victim selection: Depending on his motivation, the would-be offender selects his victim. The individual is either pre- selected or the target of opportunity. In either case, the offender will wait until the potential victim is vulnerable or isolated;
- Approach the victim: The would-be offender approaches his victim by
  - (1) tricking the victim into accompanying the offender;
  - (2) overwhelming the victim;
  - (3) surprising and jumping the victim;
- Initiation of the assault: The offender maintains control of the victim through mere presence, threats, force;
- The assault;

- The push-off: It is here that the attacker decides whether to further physically punish or kill his victim.

### Common psychological motivations of the rapist

No single profile provides an answer to why rape occurs. Opportunity, emotional illness, lust - it happens for all of those reasons, yet often for none of them. Anger is a common thread among all the types of sexual assault. Broadly speaking, offenders fall into four types: anger, power, sadistic and opportunistic rapists.

The anger rapist is the most ruthless. Sexual assault becomes a means of expressing and discharging feelings of intense anger, rage, contempt, hatred and frustration, the assault is characterized by excessive brutality. Far more physical force is used in the commission of the offense than would be required simply to overpower and subdue the victim. Sexual assault for this type of offender appears impulsive more than premeditated. Quite often a precipitating stress can be identified which involves a significant woman in the offender's life his mother, wife, girlfriend. The resulting fury is released and discharged in a sexual assault against a victim who may not be the actual person towards whom the offender harbours such feelings. Sex becomes a weapon, and rape is the means by which he can hurt and degrade his victim and, through her, the significant other. Satisfaction and relief result from the discharge of anger rather than from sexual gratification.

The power rapist employs whatever force is necessary to overpower his victim and gain control over her. The offender places his victim in a situation through verbal threat, intimidation with a weapon and/or physical force where she cannot refuse him or resist him, and this provides the offender with a reassuring sense of power, security, strength, mastery and control. In this fashion, he compensates for underlying feelings of inadequacy, vulnerability and helplessness. Rapes committed under war conditions usually fall in this category (UNHCR ESS & eCentre).

The assault is usually premeditated and preceded by an obsessional fantasy in which, although the victim may initially resist him, once overpowered, she will submit gratefully. A power rapist may actually look for an easy victim.

The sadistic rapist eroticizes aggression through a sexual assault. The offender derives satisfaction in the abuse of his victim. This assault is deliberate, calculated and premeditated. For this offender, anger and control become sexualized in terms of the offender's finding intense gratification in controlling, hurting and degrading his victim.

Perhaps the most common reason for rape is opportunity. Frequently, the opportunistic rapist carries out the assault during the commission of another crime, e.g., a robbery or car-jacking.

### Options for the victim during an assault

A rape victim may choose to take any of a number of actions during an assault. In considering what action to take, the victim must take into consideration the type of rapist, the environment and the person's own capabilities. A victim may choose one or a combination of the following options:

- Submit: The victims are in fear of losing their lives. The objective here is to survive;
- Passive resistance: Do or say anything to ruin the attacker's desire to have sexual contact with you; and
- Active resistance: Any type of physical force used to fight off the attacker, includes shouting for help, running away or fighting back.

Pros/cons of self-defence and use of weapons. There are conflicting opinions regarding self-defence and the use of weapons. The following considerations must be borne in mind.

- Self-defence techniques: Require training and practice. It is a personal decision which each staff member must make. It gives you self-confidence and cannot be used against you. It is legal and always accessible.

### After an attack

After a woman is raped, she must make the decision whether to report the crime. If she chooses to do so, in most cases the police will question her very carefully on the circumstances of the event. Sometimes the police are very professional, treat the victim with dignity and respect and explain exactly why they must ask certain questions. In other instances, policemen have been known to be less sensitive to the victim.

After talking to the police, the individual will be taken to a hospital for an examination which may help to prove that a rape occurred. It is critical that she try to preserve any evidence of the rape, including clothing. A rape victim should not wash until after she has been examined. Following the examination, she will be provided with treatment for any injuries as well as for venereal disease. In some hospitals, she will be given an injection of penicillin as a preventive measure against venereal disease. She may be offered information about preventing pregnancy. In some

locations, information about AIDS may also be provided. Some hospitals may offer counselling; however, this is extremely rare. Counselling may be arranged through the United Nations Designated Official if on international deployment or the Department of Health and Families Northern Territory.

In most cases, if the rapist is caught, the victim can choose to prosecute. If she does, she is in for a long ordeal in the courts. Rape is a difficult crime to prove. During any eventual trial, every effort is made by the defence to exculpate its client regardless of the means. Often this includes delving into the woman's sexual past and bringing out anything to cast doubt on her story. Many victims feel that the trauma of a trial is more than they are willing to risk.

If a woman does not choose to report her rape to the police, one can only guess what happens to her. It is well-known that many women do not report the crime because of the difficulties with the police they have heard about or because they are feeling too guilty, upset, frightened or weak to talk about the rape. Sometimes these women seek help on their own, but they usually keep their experiences to themselves.

### Stages of recovery

The emotional impact of rape on its victims was first studied in the 1970s. It was found that most of the victims suffered from an acute stress reaction to a life threatening situation. While each victim's specific emotional and physical symptoms varied, they fell into a discernable pattern which became known as the Rape Trauma Syndrome. It is virtually identical to Critical Incident Stress. There are four stages the victim must go through to recover from the experience:

#### Acute phase: disorganization

The woman may experience an extremely wide range of emotions. The impact of the rape may be so severe that feelings of shock or disbelief are expressed. Feelings of fear, anger and anxiety may show through such behaviour as crying, sobbing, smiling, restlessness and tenseness. Alternatively, the woman may be controlled with her feelings masked or hidden and a calm, composed or subdued demeanour exhibited.

In many cases, the victim is in a state of shock, is simply unable to believe that the attack has happened. Some women experience a detached, super - alert state during or just after the attack. Even while it is occurring they may be memorizing their assailants' physical features or details about his clothing. While this may be a victim's way of distancing herself from the experience, it also has real survival benefits. Physical symptoms during the first several weeks following a sexual assault may be evident:

- Physical trauma from the physical attack;

- Skeletal muscle tension
- Tension headaches and fatigue;
- Disruption of sleep pattern;
- Irritability; and/or gastro-intestinal problems.

Emotional reactions will also be apparent. Women express a wide gamut of feelings as they begin to deal with the after-effects of rape. These feelings range from fear, humiliation and embarrassment to anger, revenge and self - blame. Fear of physical violence and death may also be manifested.

The victim should be encouraged to talk about the assault as much as possible to her friends and family or, if this would be embarrassing for her, to someone she trusts. As the victim turns from fantasy to handling the realistic problems, there may be a decline in non-specific anxiety.

### Outward adjustment

The victim appears to have dealt successfully with the experience, but this phase contains a heavy measure of denial and suppression. The victim begins to resume her normal activities, and this healthy response should be encouraged. This is perhaps the most problematic time and the stage most likely to last, because it is heavily dependent on the victim's state of mind prior to the assault and because she is extremely vulnerable to the opinions of those around her. She may feel guilty, blaming herself endlessly for walking down a certain street or acknowledging a greeting. In other words, she turns her anger at the assailant inward.

### Long-term process: reorganization

All victims will experience disorganization in their lifestyles following the sexual assault. Various factors will affect their coping behaviour regarding the trauma, e.g., ego strength, social network support and the way people treat them. This coping and reorganization process begins at different times for different women. The same symptoms are not experienced in the same sequence. This stage is characterized by:

A need to change residences; A need to change telephone numbers; Nightmares; Fear of indoors; Fear of outdoors (seclusion); Fear of crowds; Fear of people behind them; Sexual fears; Extreme depression; Anxiety; Insomnia; Apathy; and/or An almost total inability to function normally.

### Resolution

During this phase the victim is able to cope with her trauma and integrate the experience into her emotional make-up. The victim stops wondering "Why did this thing happen to me?" and instead says "Such things happen. It happened, it's over and now I'm going on." She also learns to direct her rage at the assailant and not at herself

# | Grab Bags



Grab bags are small, easily portable bags or back-packs with key survival equipment and essential documentation pre-prepared and carried with AusMAT members throughout their deployment. The bags should be small enough to allow unencumbered evacuation across rough terrain, and should be taken to places of work during shift, and remain close at hand at all other times. You should be prepared to leave all other equipment and belongings behind, with a focus on evacuation primarily, rather than protracted survival supplies.

Key items to consider on your list include;

- 30 L (roughly) back pack or similar
- Water and food for at least one day
- Simple first aid kit and small supply of vital medications
- Survival tools e.g. matches, whistle, torch, knife, map, compass GPS
- Travel documents e.g. passport, licence, spare cash and cards
- Communications e.g. mobile phone, radio, key contact lists and frequencies
- Consider a personal beacon/EPIRB for the group
- Clothing, climate appropriate, and enough to survive a night in the elements
- Sunscreen, mozzie repellent and a small tarpaulin

Team leaders should have a record of all personnel, and high level contact details for evacuation of team etc. They may also consider extra communications equipment and funds as backup.

Preparation and practice of the use of grab-bags should become routine during deployment, and form part of the regular exercising of evacuation drills, muster point roll calls/ buddy systems etc.



# | Field security



## NGO/IGO Field Security

Unfortunately, security is often conceptualised in terms of military or police models which appear (albeit superficially) to emphasise equipment and tactics. While there is much that we can learn from these models, NGO security is far more complex. Fancy communications gear, logistics capabilities and com- pound security have their place, but are only a small part of what constitutes security for aid workers.

At IRC, each field office must adapt a local security protocol which includes each of the three elements of the security triangle: acceptance, protection and deterrence. An effective local security protocol must balance all three elements. A strong acceptance strategy with supportive protection and deterrence elements is ideal. However, where local conditions limit the effectiveness of the acceptance strategies, it is necessary to build stronger protection and deterrence capabilities.

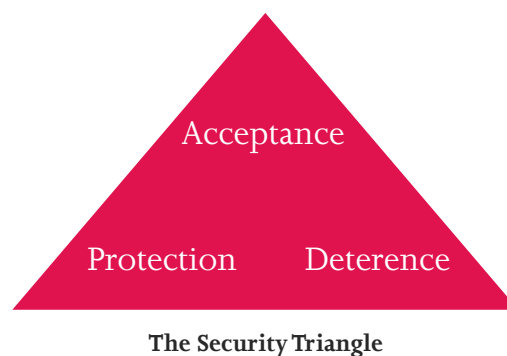
### 1. Acceptance - softening the threat

This is when the community in which an NGO/IGO is working accepts and supports the NGO/IGO's presence, and out of that acceptance grows security. Lest 'acceptance' appear too utopian, note that acceptance strategies include the security which may be provided by local law enforcement authorities. Some of the elements of acceptance are:

- The belligerent parties/combatants or the official or de facto authorities in the IGO's area of work give their consent to the NGO/IGO's activities.
- The community has a stake in the programme and participates actively.
- The community has been involved in the assessment and design of the programme.
- The community is involved in the evaluation of the programme.
- The NGO/IGO's mission is transparent and broadly communicated.
- The NGO/IGO's activities are perceived as impartial.
- The NGO/IGO's staff and presence are culturally and politically sensitive.
- The NGO/IGO's programme reflects local priorities.
- The NGO/IGO has developed good working relationships with local government authorities, including the police and military where appropriate.

- The NGO's/IGO's programmes reflect basic development concepts and a willingness to invest the time and effort to involve the community in every facet of project assessment, planning, implementation and evaluation

Acceptance is the cornerstone of security for NGOs/IGO's with a development mandate, but is often challenged under the timeframes and political circumstances in which NGO relief efforts take place. In war-time relief operations, acceptance by the beneficiary community may seem to be grossly overshadowed by the hostility of one or more of the combatants. For example, Bosnian acceptance of NGO operations in Sarajevo was overshadowed by Serb hostility, making it necessary for NGOs to build strong protection and deterrence strategies. In emergency operations, the pressure to get programmes moving may limit the ability of staff to thoroughly involve the local community. However, it is imperative that NGOs do not let a limited vision of mission obscure this critical element in the security triangle and core element in quality programming: the community's involvement.



### 2. Protection - “hardening the target”

This is the element that many people most readily associate with security, though it is by no means the

most important element in the triangle. Elements of ‘protection’ are presented under three main headings:

Protection devices:

- The materials and equipment needed to provide adequate security, such as:
- Communications equipment
- Reliable vehicles and maintenance facility
- Perimeter security devices including walls, barbed wire and alarm systems
- Flak jackets and helmets
- Use (or non-use) of the NGO/IGO emblem (or other symbols)

#### Operational policies & procedures:

The institutional mechanisms which enhance security, such as:

- Clear and equitable national staff personnel policies - including grievance procedures - which are communicated to staff and implemented consistently.
- Incidents involving disgruntled staff are one of the largest causes of security infractions for NGOs/IGO's.
- Clear financial policies and procedures including division of responsibility in accounting, and prudent cash transfer procedures
- Clear vehicle operations policies and strict discipline regarding vehicle operations
- Curfews and no-go zones where appropriate
- Development of and/or participation in a ‘warden system’ or communications pyramid for conveying emergency messages
- Communications protocol, training and disciplined radio usage
- Security orientation for incoming staff and routine security briefings for staff including personal security training
- Convoy operations protocol
- Visitor screening protocol
- Clear and consistent discipline for infractions of security policy, including the inclusion of security compliance in routine performance reviews

#### Coordinated operations:

The activities which NGOs/IGO's are able to carry out together, thereby creating a ‘strength in numbers’ strategy, such as:

- Active membership in NGO/IGO's coordinating bodies
- Active relationship and coordination with the United Nations
- Collaborative convoy operations
- Integrated communications
- Collaborative monitoring, community policing, etc

Some elements of protection are important in all situations, even in stable settings where acceptance is the primary strategy. Good communications, sound policy structures and inter-agency coordination are always the mark of quality operations.

Protection strategies need to be enhanced if conditions deteriorate and become less effective, but should never be viewed as an alter-native to strong community support.

### 3. Deterrence - posing a counter threat

Most NGOs/IGO's are not large enough, nor an appropriately suited actor, to pose a credible counter threat on their own. The focus of deterrence strategies is the relationships which we are able to build with larger regional or international institutions:

Diplomatic deterrence: This is the product of an NGO's/IGO's relationship to larger international actors who can exert diplomatic pressure on our behalf, influencing local authorities and actors who either pose security threats themselves or who are well placed to promote the security interests of the NGOs/IGO's, but are not adequately doing so. This is a very important element in the security strategy in any country of operations. Elements include:

- The quality of our relationship with key diplomatic missions
- The quality of our relationship with the United Nations
- The quality of our participation in NGO/IGO coordinating bodies which are capable of presenting a unified front

### Guards:

The use of guards is a common deterrent strategy at NGO/IGO facilities around the world. Oddly, there are very few instances where NGOs have developed strong professional guidelines for this very common deterrent force. Uniforms, basic training, incident debriefing and provision of basic equipment (ranging from a night stick and flashlight to VHF radios) are among the cornerstones. Coordinated interagency monitoring greatly strengthens the effect of guards.

**Military deterrence:** This is the least common form of deterrent strategy, usually appearing in conjunction with peace-keeping missions when NGOs/IGO's formally coordinate activities with external international military forces. We have witnessed this in northern Iraq, in Somalia and in Bosnia. In each case, NGOs have worked closely with international military coalitions who have provided a military security umbrella under which NGOs have been able to implement humanitarian assistance programmes. Needless-to-say, military deterrent strategies are less than ideal and should only be pursued when the other elements of the security triangle are clearly insufficient.

## Threat assessment and response

Threat assessment should accompany any initial programme assessment, and be carried on continually during programme operations. Like programme assessments, security threat assessments should include a wide variety of inputs from the United Nations, the embassies and national government, through to other NGOs, local government and community leaders and finally individuals in the community. In the simplest terms, it is a matter of identifying what security threats are of the highest probability and greatest consequence to an NGO's/IGO's operations and prioritising resources to these threats accordingly.

## The security triangle in practice

There is an appropriate place for each point of the security triangle under any type of security threat, from land-mines to burglary, even though the emphasis may shift between acceptance, protection and deterrence.

The acceptance strategy focusing on a local community may be of limited use when travelling between distant locations. In these situations, protection strategies such as sound vehicle protocols governing routes taken, times of travel, communications en route, use of convoys, etc, become much more important.

## Conclusion

These brief examples suggest rounded strategies for each threat. There are clearly advantages and disadvantages to any strategy, which must be weighed within the context of each local environment.

In Liberia, for example, the poor quality of rented cars and their drivers eventually posed a greater risk than car theft, and the policy was abandoned. Thus, flexibility and local control over security policies are an imperative. When developing security policies, field managers should first identify the key risks in the local environment based upon probability and consequence. Risks of high probability and/or high consequence should be the primary focus of agency attention and resources.

Secondly, for each of these key risks, the field manager needs to carefully and creatively consider each of the three strategies - acceptance, protection and deterrence - in devising an appropriate local response. Security for humanitarian staff operations is too often viewed in terms of military models or, worse yet, overlooked as an inevitable and inalterable aspect of working in humanitarian crises. In fact, there is a lot that can be done to enhance security in humanitarian operations. However, security in humanitarian operations calls for a new paradigm that weighs not only the familiar equipment and technology of security but also the dynamics of community support, inter-agency coordination and diplomatic influence.

Randolph Martin is Senior Director for Operations at the International Rescue Committee, New York.

1 Dan Smith with the International Peace Research Institute, The State of War and Peace Atlas, Myriad Editions Limited, 1997, p13.

2 UNHCR, State of the World's Refugees 1995, Oxford University Press, p26.

3 Smith, op cit p26.

4 Van Brabant K 'Cool ground for aid workers. Towards better security management in aid agencies', Disasters 22 (2), pp109-125, 1998.

# Preventing and Defusing Anger and Hostility

By Lisa Schirch and Dave Dyck; Eastern Mennonite University, Conflict Transformation Program,  
1200 Park Rd., Harrisonburg, VA 22802; 540/432-4497; fax: 540/432-4449; e-mail: [schirchl@emu.edu](mailto:schirchl@emu.edu) and  
[dyckd@aslan.emu.edu](mailto:dyckd@aslan.emu.edu). InterAction/OFDA NGO Security Training Preventing and Defusing Anger & Hostility



NGO/IGO personnel may find themselves in situations where they need to attempt to defuse aggressive, angry people. For example, if you are driving across an international border in late afternoon or evening, you may have to deal with drunken, angry border patrols in some regions.

## Goal

To learn how to prevent, defuse and de-escalate security incidents which involve dealing with angry, hostile people.

## Objectives

- To understand how respectful behaviors reduce vulnerability To explore how principles which work to redirect and de-escalate aggression
- To learn specific behavioral approaches and communication skills which de-escalate anger and hostility through nonverbal, listening, and speaking skills

## Key Learning Points

- Anger and aggression are often the product of frustration and a feeling of powerlessness.
- Respect is a key principle in de-escalating and defusing anger and aggression. The ability to communicate skillfully and appropriately so as to foster acceptance has a great impact on security.
- Cooperation is a key principle in all efforts to defuse anger unless cooperating causes harm to you or others. Efforts to resist physically or verbally are often counterproductive, putting the aggressor(s) in an even more defensive position. Use both nonverbal and verbal postures that reflect your calm and confident ability to respond and interact with the aggressor.
- Listening is an important skill in defusing anger. While it may seem easy, skillful listening is quite difficult. Close attention to non-verbal cues for listening, along with the skills of paraphrasing and questioning are important means of defusing anger.
- Learn to redirect and reframe anger and positional arguments into a discussion that involves an analysis of the real interests involved.

## Definition of Terms

- Frame: refers to the perspective from which one is looking at a given situation.
- Paraphrase: refers to restating what has just been said using different words positional arguments:
- Refers to arguments which insist on one specific solution to a problem empower:
- To give someone power, or a feeling of control over their environment

## The Importance of Respect as a Principle for Security

Demonstrating respect for others is a primary means for de-escalating hostility and aggression. When faced with anger and the threat of violence, it is of course difficult to respond with respect. When a person shows initial signs of hostility or begins to respond angrily to an incident, the following general principles which stem from the “acceptance”, or relationship focused dimension of the overall security paradigm are important to remember:

- Recognize that the aggressor is often feeling threatened, anxious and fearful, and will respond even more aggressively if s/he feels more threatened.
- Focus on communicating respect with appropriate listening skills and non-aggressive, non-challenging body language. The ability to show concern for the specific, personal needs of others while maintaining a non-anxious demeanor in the midst of an angry interpersonal encounter, may defuse the situation.
- More specifically, being a good listener of others, in interpersonal exchanges, is a far more powerful tool than speaking when trying to defuse hostility. (The components of good listening are detailed later in this module.)
- Cooperate with an armed aggressor’s commands, unless they are completely unacceptable. Unless the commands given would result in harm to yourself or another member of your team, a general attitude which communicates a desire to cooperate in solving the problem is almost always the most appropriate response.

- Attempt to establish some type of significance with the aggressor's humanity and personal dignity. When confronted with an unacceptable demand, an appeal to the aggressor's humanity has proven effective.
- Remain calm yourself; reduce physiological stress through some form of relaxation; talk calmly to yourself using strategies that you have practiced and found effective in the past. Holding an open and relaxed body posture communicates respect and attention to the aggressor.
- To whatever extent you are able, show an interest in resolving the issue or meeting the other's needs and concerns: -emphasize willingness to be cooperative and address the issue(s) being raised -acknowledge the importance of whatever concern they are expressing
- Help the other person maintain their dignity -reassure him/her that their concerns are legitimate -offer the option to pursue the issue/problem later if possible -refrain from openly judging his/her behaviour
- Individual NGO personnel who have strong skills in understanding power dynamics and who recognize and use their own power in ways that are assertive but do not threaten others are more able to defuse aggressive behaviour by giving recognition and respect, in a variety of ways, to these aggressive persons. (See Image, Acceptance, and Reciprocity by Koenraad Van Brabant and Power, Image, and Security by Schirch and Dyck for more information on this topic).

### Factors That Escalate Hostility and Aggression

- **Insecurity:** We all experience insecurity whenever we are fearful or feel a loss of control and predictability in our lives. When this basic degree of order and safety are threatened, people become increasingly volatile and unpredictable.
- **Lack of choices:** In general, humans respond with hostility and aggression when they perceive that their choices are limited. The sense of powerlessness that comes with feeling that one has little or no options often produces violent or hostile responses. Feeling powerful (that is, able to significantly influence situations affecting one's group or person), is a prerequisite to dealing positively with other people. Just as a cornered rat fights the dirtiest, so too do humans. When there is dirty fighting, someone

is usually feeling powerless. This is hard to remember. Cornered people are often intimidating and can inflict serious injury. Worse, they mask their powerlessness - from themselves as well as others. **Nothing suppresses a whimper better than a snarl!** This hostility is most likely to be directed at you if people feel that either you are responsible, directly or indirectly, for their predicament or that you have options that they do not.

- **Asymmetrical power:** When one person or group has or is perceived to have more power than another, the less powerful person may feel threatened.
- **Ostentatious use of symbols of power:** The tangible, concrete things that are associated with having a high degree of influence. e.g. hi-tech equipment, expensive vehicles, contextually extravagant lifestyles, uniforms, guns, association with Western culture and education, money, understanding of the local language, etc., may be seen as threatening to people without such resources. (See Module on Image, Acceptance and Reciprocity)
- **Disrespectful behaviour:** Any actions which are considered inappropriate in terms of a lack of deference to local customs, leadership, and ethical/moral norms. This behavior is often engaged in by those who lack a knowledge of their context and/or themselves and the way they are generally perceived by others.
- **Inconsistent Team Behaviour:** The lack of a systematic, consistent philosophy and approach to issues within the community on behalf of personnel associated with the same, and sometimes even different, NGOs. In other words, when there is a lack of sufficient communication within and between NGOs.
- **High Levels of Intra-Team Discord and Conflict:** The presence of highly conflicted relationships within the team can provoke animosity within the community towards certain individuals on the team.
- **Aggressive or Passive Responses:** Aggressive or passive responses on behalf of NGO personnel to concerns within the community or to the hostility can easily escalate that hostility to deadlier levels.



## The Aikido Principle for Defusing Anger

Aikido is a martial art which moves to dissipate the power of the attack by leading the attacker in a new direction so that the attack is neutralized. Rather than resisting or fighting against an opponent, aikido realigns the attacked with the direction of the opponent's attack. While extensive physical training is needed in order to use Aikido moves to defuse a physical attack, the principle is appropriate for understanding how to defuse verbal anger and aggression. Rather than opposing your opponents anger and/or needs in a security context, it may be helpful to re-direct their verbal aggression into a non-threatening form of discussion that can bring a cooperative, problem-solving approach. The following communication skills outline how to defuse anger with nonverbal, listening and speaking skills based on the principle of redirecting the energy of the attack.

## The Importance of Communication in Preventing and Responding to Hostility

NGO personnel use communication skills in every aspect of their work. Within their organization, NGO personnel need good communication to make sound decisions and build good working relationships with one another. With the local population, communication skills are helpful to get through government bureaucracy, to travel through check points, or to manage one's own perspectives and emotions.

When dealing with situations that involve the potential for violence, it is imperative that we think critically and carefully about the way that we communicate about our interests, needs, emotions, limitations, and purposes to others. Being able to communicate one's perspective is vital to effective negotiation and crisis management, and communication skills are of utmost importance when facing hostile or threatening people.

We often think we have two choices when threatened in a conflict: fight or flee from the situation. These responses may seem instinctual, but there is another option. Appealing to the other, gathering information without antagonizing, drawing out underlying needs, concerns and fears, and learning to make requests and communicate one's own limitations or needs without antagonizing can be very helpful in communicating with others in an insecure environment. Improving our ability to communicate and negotiate effectively results in better personal and group outcomes. These outcomes are not only related to the immediate task, they also contribute to overall improved relationships and a higher degree of acceptance of the NGO within the community in which it is active. The ability to communicate skillfully and appropriately so as to foster acceptance may have a greater impact on security than any other single factor. In addition, interpersonal skills are considered by some analysts to be the most neglected area of security training today.

## Encoding and Decoding

Communicating involves verbal, non-verbal and listening skills. Communication theorists talk about speaking as "encoding" and listening as "decoding." We all speak and listen, encode and decode, through a filter of our own experiences and beliefs. The encoding-decoding process can cause miscommunication - i.e. the message one person encodes in their speech is decoded with a different meaning by the person listening - even in the most stable and trusting environments. When working in a cultural and linguistic context different from your own, where tension and mistrust may already be fairly high, the encoding-decoding process can become extremely difficult and the chances of an angry, explosive reaction greatly enhanced.

A factor that often contributes to the breakdown of communication and leads to conflict and even crisis is the assumptions we all make. In our daily interactions we often misinterpret the behavior of others during the decoding process of communication. When people are under the stress associated with conflict or insecurity, the tendency to misinterpret each other is greatly increased. When the above mixture of ingredients is combined with cross-cultural dynamics, a particularly ripe setting for miscommunication and assumptions is created. These assumptions can have deadly consequences in settings of vulnerability.

## ACTION

(message)	words			(message)
INTENTION	encode	actions	decode	EFFECT
		expressions		

Expressions We have a tendency to assume the other's intention from the effect their action has on us. For example:

If I am offended, angered, or feel threatened by the actions of another person I will tend to assume s/he intended me to feel this way.

In the same way, the actor or sender of the message assumes that the other individual receiving it will correctly interpret the intent of the message or action. Do not let statements like "I thought that..." go unchecked. Such phrases may be indicators of assumptions that need to be clarified.

Similarly, if you are disturbed by the behaviour of another person or group, do not simply make assumptions about the intent underlying the action. Instead, take responsibility for both inquiring about their intent and informing them of the effect on you. To communicate effectively and reduce our vulnerability, we must make our intentions clear and check out our assumptions. By themselves, actions, tone and words can all mislead.

## Non-verbal Communication: Defusing Hostility Through Body Language

Communication research shows that at least 80% of communication is non-verbal (tone and visual). Of this total, most is communicated through the body. Human beings exchange meaning through eye movements, facial expressions, body posture, gestures, and proximity. Just as with verbal communication, there are many languages of nonverbal communication that vary greatly with culture.

Often NGO personnel work in countries where the local language is not their first language. If NGO personnel do have knowledge of the local languages, it is usually fairly limited. In these situations, to a great extent, local people rely on understanding the goals of NGOs and their expatriate workers largely by what they communicate non-verbally.

Because so much of our understanding of a situation and our ability to communicate in that context is dependent on nonverbal communication, it is particularly important to observe and learn from local people in the cultural context

where your NGO is located. It is usually extremely helpful to have a local person train new expatriate staff in cultural nonverbal communication. How NGO personnel behave, in terms of body language, in response to aggression can dramatically affect their ongoing relationship with the local population and can greatly heighten or downgrade the risk in a particular incident. The following list highlights several areas which should be given particular consideration.

### We increase our nonverbal communication skills by:

- Trying to pay extra attention to the nonverbal signals your body is giving when dealing with anger. Are you frowning or shaking your head while they talk? Are you receptive to the information being shared? Make sure your body posture is open rather than closed, inviting information rather than shutting yourself off from the speaker
- Being conscious of our facial expressions and our body posture in terms of the local, culturally appropriate customs;
- Learning what kind of eye contact (from direct to indirect) is appropriate in various settings;
- Paying particular attention to the physical distance between you and the person speaking. This varies widely according to culture;
- Being very sensitive about the kind of gestures you are using. A gesture which communicates warmth and acceptance in one culture may mean something highly offensive or communicate intense animosity in another;
- Being aware of standing eye to eye with a person. Communication specialists stress that standing at an angle (sideways) rather than directly across from someone can help keep a situation calm and non-adversarial;
- Heightening our awareness of all of the above whenever we are dealing with a hostile or potentially hostile person.

## The Key Defusing Strategy

Listening skills are crucial to security. The ability to listen well will assist NGO personnel in gathering information about their context, particularly in relationship to assessing threats and analysing the context as a whole. While many

Security handbooks advise keeping one's hands on the steering wheel and in plain sight when approaching border checkpoints. Why is this important? What does this communicate and how does it contribute to defusing a potentially dangerous situation? Would one attempt to communicate this message verbally? Why or why not?

People believe it is more important to speak well than to listen well, listening is a powerful and transformative tool in crisis situations. Everyone wants to be listened to and to be understood. People often become angry or aggressive only after a lengthy period of not being listened to or acknowledged both collectively and individually. By listening effectively, people can often defuse an angry or threatening situation.

Many people think listening is easy. In fact, it often requires years of practice to learn how to listen effectively. It is very difficult to not make assumptions, judgments, or responses when listening. Yet it is very important to let yourself focus on listening rather than thinking about your own concerns.

## How to listen effectively:

- Empathize - put yourself in the other person's shoes and try to understand how s/he feels.
- Listen - for the feelings or emotions of the speaker, the meaning of their message, and the specific content they are trying to communicate. Angry people often say aggressive, inappropriate, offensive, unfair, unfounded things. Nevertheless, do not lose control of your emotions and begin arguing. Do not give into the temptation to start interrupting, correcting, and arguing with the angry person. When people are escalating, rational arguments have little to no effect except to further provoke their hostility. Instead, focus on the deeper issues the person is so eager to communicate. (See discussion below on Aikido listening, reframing positions to interests)
- Validate - let the other person know that her/his experience is valid. This does not mean that you agree with them, only that you have listened to their experiences and can understand why they might be feeling the way they do.
- Paraphrase - Paraphrasing is restating in your own words the core of what the other has expressed in a message. A good paraphrase gets at content and emotions (see below)
- Clarify - ask questions to get more information about the problem (see below)
- Gather information - try to gain a better understanding about the situation without antagonizing
- Recognize your own prejudices- be aware of the way in which your feelings or reactions to a person influence your interpretation of what is being said. Change your judgment to curiosity, even when what the angry person is saying seems unfair or ridiculous.

- Draw out underlying interests - use open-ended, non-threatening questions (see below)
- Be Quiet! - Too many people talk too much when facing escalated situations. People usually do not want to be told how they should think, feel, or act in the midst of their anger. Often, people become angry because of a lack of a sense of control or influence over their own lives. Telling them what to do only exacerbates this tension.
- Use the other person's name respectfully (if you know it)
- Be prepared to patiently repeat yourself
- Match and lower intensity

## Questions as a key element to effective listening

### Questions which escalate hostility

There are many types of questions which we use reflexively which often prove unhelpful and can escalate the situation. Some of these questions may be divided into the following types:

- WHY - draws out information but, depending on tone, can have the impact of challenging, blaming or calling upon the other person to justify or defend his/her actions or position. Many "why" questions are intended to prove wrong-doing. For example, "Why would anyone do that?"
- LEADING - is really a disguised statement. The speaker attempts to express his or her opinion through a question. For example, "Don't you think, given the implications of not returning the radios, that you would be better off simply settling this quickly?"
- MULTIPLE - is when two or more questions are asked immediately following one another without adequate time for response. This is often confusing for respondents because they have trouble focusing on what is being asked. For example, "Is it true you're intentionally provoking animosity towards our organization and, if so, are you aware of the legal implications of this and what will happen should this go to a formal investigation?"
- CLOSE-ENDED - invites a one or two word answer, "Are you in a position to make that move?" The possible responses are often limited to "yes" or "no". Closed questions narrow the amount of information that is given and, while sometimes useful, often have the effect of creating an adversarial atmosphere.

- ASSUMPTIVE CLOSURE - gives the expected answer in the question. “Now I know you don’t want this project delayed any longer, right?” or “This is a pretty basic question isn’t it?”

### Questions that can defuse hostility

In effective conflict defusing, questioning can be used to probe for information. It is not used to prove a point, to demolish an argument, or to get compliance.

As with any technique, there are also helpful ways to use questions. When undertaken with care, questioning can help clarify assumptions and uncover vital information and effectively defuse a situation.

- OPEN-ENDED questions, ones which cannot be answered with a simple “yes” or “no”, move away from judgment towards curiosity. Open questions invite a longer response, giving a choice of how to respond and thereby moving the control from the questioner to the responder. This type of questioning may seem risky because the questioner cannot know exactly what direction the conversation will go. Although this may seem to be a disadvantage in a purely adversarial environment, open questioning often results in creation of a more open, co-operative forum. Open questions encourage answers which provide unanticipated information, reveal interests, and provide clarity for all involved. Open-ended questions are questions that require more than a “yes” or “no” answer and demonstrate an interest in the other’s concerns. However, in some cultural contexts, use extreme caution with open questions because they can be seen as intrusive, disrespectful and inappropriate. There are a number of different types of open questions:
- Probing questions ask for more information about concerns or emotions. “What is it you want to see happen in this situation?” “How did your group react to that news from our NGO?” “What are your concerns with the policy?” “What are some other possibilities to resolve this situation?” (Brainstorming)

- Clarifying statements or questions seek to understand particular aspects of the message. “What do you mean by \_\_\_\_\_?” , “Are you saying that \_\_\_\_\_?” “Could you help me understand how you came to \_\_\_\_\_?”
- Consequential questions are used to get the speaker to think about the consequences of what they are saying. It is a form of “reality testing.”

### Paraphrasing as a Key Approach to Effective Listening

Angry Statement: “You Australians are all the same...you’re here until some problem erupts and then you leave! I’m so sick of this happening again and again! Well, this time you can’t just take all your fancy stuff with you! This equipment was intended for us and this is where it’s staying or somebody is going to get hurt!”

- Paraphrase: “Sounds like you’re really fed up with our pattern of just taking off...”

**Paraphrasing is one way to make sure you have understood the intended message. It has a number of purposes:**

- It provides a climate in which the speaker is more likely to feel understood.
- It allows you to check to make sure you understand the speaker’s intent.
- It allows the speaker to correct you if you have misunderstood something, thereby preventing misunderstandings.
- It allows the speaker to correct themselves if they feel they inaccurately expressed what they were trying to communicate.
- It provides you the opportunity to focus on understanding the other person rather than thinking of your own response.
- It conveys to the speaker that you are interested in him or her and what s/he has to say. This often allows the person the freedom to continue talking

## Re-Framing Positions to Interests

REFRAMING, like paraphrasing, is another way to respond to a hostile speaker to let her/him know that you understand what they are saying. However, unlike paraphrasing, which simply repeats back what has been said, reframing is a way of changing directions. When faced with hostility, it is natural to push back. However, rather than opposing your opponent's anger in a security context, it may be helpful to re-direct aggression into a non-threatening discussion of their underlying needs. At its best, reframing can elicit a more cooperative, problem-solving approach to address the concerns and interests rather than the positions of an attacker.

**POSITION** - A position is one specific solution to a problem, usually stated as a demand in an attempt to resolve a conflict. Often the positions of people in conflict are mutually exclusive because each person is attempting to address only his or her own needs. Positions often arise out of impulses that seem to demand immediate reaction. Common motives for becoming positional are the desire to be taken seriously, fear, revenge and unmet expectations from the past.

**INTEREST** - Interests are often closely connected to an individual's values and priorities. These values and priorities can often be identified through an individual's expression of their underlying wants, needs, fears, hopes and/or concerns. In expressing their interests, parties in dispute often discover that they share many more values and concerns than they assumed while in their positional stance and they are subsequently much less likely to perceive one another in purely adversarial terms. Basic human interests, which often arise in disputes are the need for power, approval, justice, inclusion, identity and security.

While a judgmental reaction to another's position often leads to no movement and frustration, a curious attitude allows us to uncover the interest(s) from which the position of the other person stems. When NGO personnel learn to speak in terms of their underlying interests, they adopt a much more flexible approach to conflict and reduce the chances of misunderstanding. You can also defuse potential aggression by assertively articulating your own interests rather than aggressively pushing your position.

In reframing the listener takes a statement that is framed, or seen from a perspective of a position that makes it difficult to redirect anger, and reframes it, or looks at it from a new perspective which might allow the discussion to move forward. Reframing is a powerful tool. It can demonstrate that you understand the other person's interests and turn a potentially destructive comment into a constructive problem-solving comment.

When speaking to an angry, aggressive person, reframing hears the demanding and accusatory statements and then reframes by tentatively stating the underlying interests. Instead of stating what they say they don't want, the listener focuses on naming what it sounds like they need.

Reframing may also involve:

- Changing the emphasis from differences to common ground
- Changing the emphasis from negative to positive
- Changing the emphasis from the specific to the general or vice-versa

### Formula to begin:

It is important to you that.....

It sounds like ..... is important to you.

So you value.....

### Examples:

**Statement:** An angry person approaches an NGO/IGO worker preparing to evacuate and says: "If you leave here this time, there'll be trouble- that equipment was intended for us and we're not letting you take off with it."

**Interest:** Ongoing use of equipment; loyalty to local population

**Reframe:** "It sounds like you're really concerned about the loss of the equipment to get your work done. Maybe we could talk together about how to address your concerns."

.....  
.....

**Statement:** “Working here is so depressing. Nobody thanks me for my contributions. I have no way of knowing if I’m even doing an adequate job or not.”

**Interest:** Acknowledgment or being valued

**Reframe:** “So, receiving feedback and acknowledgment is important for you? In what ways would it be helpful to you to hear feedback?”

.....  
.....

**Statement:** “You’re always checking up on me. It bugs me that you don’t believe I’m working.”

**Interest:** Trust

**Reframe:** “So, you’d really like me to trust you...”

.....  
.....

Consider a story in which an NGO/IGO worker uses reframing skills to focus on interests rather than positions in a security situation:

- An NGO in Somalia has had two of its vehicles stolen in a short period of time. Knowing who is responsible, one of the NGO workers, “Stefan” approaches an elder member of the same clan as the two men who stole the vehicles. While the immediate concern of the NGO worker is that the cars are absolutely vital to the NGO’s work that and the theft of vehicles might lead to a decision, by administration, to pull out, posing his concern in the latter threatening manner would likely not be effective. Instead, Stefan defuses a potentially aggressive encounter by discussing the interest of the clan in protecting its reputation and the NGO’s interest in staying active and effective in the community.



### Questions for Reflection:

- 1) What would a positional approach, on Stefan’s part, have sounded like in this scenario?
- 2) How might a positional response have escalated the elder or the ongoing NGO-community conflict?

In crisis situations, the most important re-framing skills to remember are:

- Reframe a competitive attack into a more cooperative stance;
- Reframe demands or “positions” on issues into a discussion or focus on how to meet mutual needs.

### Assertive Communication: How to Communicate Your Interests

While listening is a powerful skill in defusing anger and aggression, there may be times when you will need to assert your own needs and interests in a security situation. NGO personnel can sometimes use speaking or disclosure skills to help defuse an angry person or group before they have escalated.

#### Be “hard on the issues, but soft on the person”

This implies that while it is important to communicate your viewpoint, it is important to do so in a way which refrains from personal attack on people who disagree with it. It is important for you to communicate your own perspectives and interests as early as possible (before a situation escalates to an angry encounter). Therefore, do not be overly cautious to say what you need or want from a situation, but speak thoughtfully, so that your words will not provoke the person you are speaking to. When you are actually facing a very angry person, you may need to be more cautious about what you say or divulge in that moment. It is often very important to look for a calm moment to talk/negotiate.

Through careful reflection on how you approach people, you can greatly increase your control over whether your message is received the way you want it to be and decrease the chances of a hostile response. Finally, non-aggressive modes of speaking about our perspective and/or needs encourages others to shift their behavior and do the same. It is important to remember that negotiation is most appropriate before a situation has grossly escalated.

## I/We Messages

When communicating your interests in a tense atmosphere, it is easier to hear a statement in which the speaker clearly states their perspective or needs (i.e. “I”) than it is to hear a statement which focuses on the other person or parties (“You!”). Speak from your own experience and needs, rather than what you’ve heard others say. Others are less likely to become defensive if you state your own beliefs and preferences rather than using language that focuses on what you dislike about others or attempt to speak for people beyond you or your jurisdiction.

Starting a sentence with “I or We” often lowers the level of escalation and tension. A “YOU” message usually raises the level of pressure and tension. These messages usually blame, accuse, threaten, order, put-down or make the other person feel guilty.

An “I/We” message has three parts:

When ..... happens, I/We feel/need .....  
because it has the effect of ..... on me/us.

- When (specific behavior) ....
- I or We feel/need (specific feeling or need) .....
- Because (tangible effect or rationale)

Each part plays an important role when we attempt to communicate our concerns and/or influence another person’s behavior.

- The “WHEN” element helps separate the person from the problem. This is extremely important for keeping the discussion in a problem-solving rather than attacking mode. It informs the other person of the specific behavior that is problematic for you.
- The “I FEEL” component is important because the speaker is taking responsibility for his/her feelings, indicating trust in the listener, and clarifying her/his feelings.
- The “BECAUSE” is most often missed but is crucial when trying to deal with a conflict. The “because” part of the message pushes the speaker to look beneath a position to clearly define what the situation is in terms of interests. It also allows the speaker to more easily understand and communicate that interest rather than position.

## Example:

**Instead of saying** - “The people in this community are constantly after our equipment and vehicles. We may simply have no choice but to withhold our services unless that radio is returned.”

**You Might Say** - “When our radios disappear, we/I feel concerned and frustrated because it becomes very difficult to carry out our work. We’re also aware that the radios are a big temptation for local people and I’m eager to hear your thoughts on what we can do to solve this problem.”

There are a number of additional principles that can empower you and your organization to share information more effectively and defuse potentially aggressive encounters before they evolve. They are as follows:

- Reflect - step back and think about the situation if possible. Clarify your concerns and feelings. Choose a place and time, when possible, that will facilitate good communication.
- State your intention to resolve the issues at hand positively. This can help motivate others.
- Before speaking, try to think of the easiest way it would be for you to hear the message you want to communicate.

## Making an Assertive Request

There are times when NGO/IGO personnel are facing an angry person who does not pose an immediate, lethal threat. In such situations it may be appropriate to respectfully but assertively request a specific change in behavior as a condition of continuing a discussion. It is important to remember, however, that when an individual does pose an immediate, potentially lethal threat because they have a weapon or the authority to use violence, making an assertive request may not be an appropriate or feasible option.

- PREFERENCE STATEMENTS: Clearly communicate your preferences or desires rather than stating them as demands or forcing others to guess what they are.

My preference is....

If it were up to us...

What I would like is...

From our perspective, it would be helpful if...

- **INTEREST STATEMENTS:** Clearly state your wants, needs, fears, and concerns.  
What concerns me is...  
What we really need is...  
Because...
- **PURPOSE STATEMENTS:** Disclosing your intentions enables others to understand what motivates you and minimizes the opportunity for misunderstanding. It also reduces the chance for others to unknowingly operate at cross-purposes.  
What I'm trying to accomplish with this policy is...  
We're out here today because we were hoping to...  
I am in the process of trying to locate...  
Our intention with this group of people is to...
- **DESCRIBING OBSERVATIONS:** Describe what you are currently observing between yourself and the other person in a non-positional way. In an unhelpful conversation with a community elder, one might say: "I'm noticing that we seem to be at an impasse in this conversation. It seems like we're all getting a little tired and frustrated. I'm not sure how to move on. What do you think?"
- **AGREEMENT STATEMENTS:** Acknowledge where you agree with the other party in the midst of a disagreement. This increases the amount you share in common and reduces the conflict field.  
I agree with you that...  
We definitely share your concern about...  
Your interest in..... makes a lot of sense to me.  
We share your hope that..
- **"YES AND ...." NOT "YES BUT..."** The word but has been called the "verbal eraser" because agreement statements lose their effectiveness if they are followed by a disclaimer such as but. It is better to make your agreement statement and then raise your other concerns.  
I share your concern about....  
and I am also concerned about...  
I agree that we should....  
and I also think that...

## Things to Avoid When Speaking to/ Defusing an Angry Person:

**Blaming** - Do not blame. Blaming leads people to become defensive and hostile rather than cooperative and understanding.

**Accusations or Counter-Accusations** - *Do not accuse. In general, be cautious about starting sentences with "You" or "You people" For example, it usually makes people defensive to begin a sentence with "You didn't...." or "Your people always..."*

**Making Assumptions** - Don't assume that your perceptions are correct and others are false. Acknowledge the assumptions that inevitably underlie all our beliefs. We are often unaware of the different ways people experience the world. Individuals perceive the world differently and so react differently. Again, change judgment to curiosity.

## Disengaging from an Angry Person

The goal of disengaging is to remove yourself or the other person from the threatening situation when it appears that all your other efforts to listen, make assertive requests and other methods of verbal aikido are failing or that you yourself have become so angry that the interaction is becoming more threatening. Ideally, disengaging from an angry person involves an explanation for your behavior, allowing a cooling off period, and/or scheduling a time more conducive to effective problem solving. It also allows one to deal constructively with safety issues, should they arise during an encounter. When an individual does pose an immediate, potentially lethal threat because they have a weapon or the authority to use violence, disengaging may not be an appropriate or feasible option.

### Disengage when:

- You are too angry yourself and you are having trouble self-managing.
- You feel too much discomfort with the situation, due to the rising level of emotion and/or the destructive direction of the discussion or exchange.
- You are nervous about the situation and fear for your safety.
- You both need time to compose yourselves.
- The time or location is not conducive to effective problem solving

**Misused when:**

- The angry person poses an immediate, potentially lethal threat and will see your disengaging as an affront or challenge to their authority
- You disengage to provoke or manipulate the other party

**A Sample Disengaging Script**

- Acknowledge: “I can see you are furious with me,
- Commit involvement: and we need to talk more about it.
- State your needs: Right now though, I feel like things are too intense. I need to be alone for a while...
- State your intention to return: I’ll be back.” or “We can work through this later.”
- Then leave immediately!

**When you feel yourself becoming angry in a situation which could have immediate, potentially life-threatening consequences.**

- Be extremely cautious about expressing your anger in any terms
- Place your emphasis on de-escalating yourself and avoiding getting provoked
- Consider and act on ways to disengage from the situation as soon as possible
- Place an immediate priority on defusing the situation (e.g. most often this entails listening to and acknowledging the other’s feelings and needs) rather than on expressing your own frustration or anger
- Remember that there will be other times, places, and means to express your anger and that timing is absolutely crucial when it comes to insecure environments and anger



# Negotiation

## Negotiation Theory

### Interdependence

Individuals willingly enter negotiations if they expect to gain more than their bottom line. For example, someone selling a car will only negotiate on prices above a certain value. This value depends on two elements. First, the subjective appraisal of the seller: his/her belief that the car has a certain market value. Second, the fallback options available to the seller.<sup>8</sup> For instance, if the seller must leave the country in a hurry and faces the alternative of abandoning the car, he/she will be ready to accept a price even lower than his/her initial appraisal.

Interdependence, therefore, means that two parties can find common ground, or that their bottom lines (made up of a subjective and a contextual component) are within a common range.



### Rejection, Resistance and Resentment

Interdependence often does not exist in humanitarian scenarios. In many instances, humanitarians are simply not wanted by warring parties that are determined to win their fight at all costs, harbor grave suspicions about interfering outsiders or feel that humanitarian obligations will compromise their political and military objectives. Recurrent killings of humanitarian workers make this shockingly evident.

### Humanitarians feel increasingly rejected by their counterparts:

*“The environments in which humanitarians operate are increasingly hostile and without concern for humanitarian values. With economic interests prevailing and governments or armed groupscaring less about their moral image ... humanitarians are often not even granted the space to start negotiations.”*

*(Aid worker talking about experiences in the Great Lakes region)*

Humanitarians lack power over the territory and people they want to assist and protect and whether negotiations take place often depends, therefore, on their counterparts' willingness to receive them. In situations where counterparts believe that they will be able to achieve their objectives more effectively without negotiating, humanitarians can only try to persuade them to come to the table. Persuasion involves many of the same activities as negotiation and good negotiators are usually also good persuaders.

### Concluding Only Second Best Agreements

The best agreement a negotiator could possibly aim for is a principle agreement. This means that both parties can achieve their objectives without having to make concessions. Although often impossible to achieve, many humanitarians and their counterparts favour principled agreements:

*“Ideally, humanitarian negotiation is a dialogue in a more or less conflictual situation where the opinions of both sides are considered and where finally, when leaving the discussions, each party has the impression that their point of view has been taken into account. It is a dialogue where there is neither a winner nor a loser.”*

*(Aid worker reflecting on experiences in West Africa)*

*“A successful humanitarian negotiation is a situation where one frankly and openly arrives at equilibrium. Each side has to recognise its responsibilities.”*

*(Military representative in West Africa)*

*“A good humanitarian negotiation is one that makes everyone smile. It is a negotiation that brings stability to our relations. Each party has to have the impression to have gained something.”*

*(Civil servant in West Africa)*

In many instances, humanitarians may feel, therefore, that they face a win–lose scenario, necessitating a hard-line approach and an all out effort to win and prevail over the other side.<sup>10</sup> But, unfortunately, humanitarians do not usually have the requisite power to adopt such an aggressive stance. Experience also shows that agreements reached through coercion seldom lead to durable arrangements on the ground as they are often contested. The use of hard-line tactics by an agency or individual can also be remembered with hostility for a long time to come and prevent good negotiations in future. As a result, it will often be the humanitarians who are the losers in a win–lose scenario.

Humanitarian workers often consider it impossible to achieve win-lose agreements:

***“In a win-lose scenario, we are going to be the losers. As humanitarians, we simply do not have the levers to win.”***

*(Aid worker sharing experiences in Southeast Europe)*

***“Going for a win-lose agreement rarely plays out in our favour.***

***In most cases, we are the losers. But even if we do win, our counterparts will always resent and impede the implementation of the agreement and we can be sure there will be security incidents.”***

*(Aid worker reflecting on experiences in South Asia)*

Humanitarians often find themselves between a rock and a hard place. On the one hand, they feel frustrated by apparently mutually satisfactory agreements for ethical reasons. On the other hand, they lack the means to conduct effective win-lose negotiations and risk spawning counterproductive outcomes if they play hard.

Tragically, this is why many humanitarian negotiations fail. Or, even if they succeed to some degree, they cannot be celebrated as an unambiguous success.

Negotiations fail or are protracted in many other professional areas too, but the consequences are not always as disastrous as they are when humanitarian negotiations do not succeed. Delayed agreements or partial achievements still mean death, suffering or lack of protection for many people whose needs were great before the agreement was reached or who still lie beyond the reach of the latest deal.

Humanitarian negotiators live, at most, with the reality of second best agreements and highly compromised notions of success. Nevertheless, though, second, third or fourth best results still save lives, offer protection to people who are not yet affected and leave the door open to incremental progress.

## Pre-Negotiation Strategy Check List

by Steven Roberts . The Negotiation Experts. [www.negotiation.com](http://www.negotiation.com)

This check list will help you prepare a successful negotiation strategy for any potential conflict and attain the best possible agreement.

Many naturally talented people abound on this orb of ours. They seem to float effortlessly through life, like a boat slices neatly across a crystal mountain lake. Other people have to scrape and claw their way competing against many other rivals, who vie for the rarefied air of the elite.

To perform well, we must learn to prepare before we can expect to succeed. Ask any athlete who spends countless and tedious hours preparing for a competition, or a lawyer about to step into a court room.

As negotiators, we also must learn the basics, and above all else, we have to follow some regimen to prepare for our negotiations. Simply ask yourself how well you did when you decided to skip the preparations and just ‘wing it.’ Your response might be that you didn’t fare too badly, but have you ever thought about how well you might have done, had you really prepared?

### 1) Assess the situation

Each negotiation is going to be different, no matter how often we’ve addressed similar situations. We will always be negotiating with people who have different styles, goals and objectives, and who are coming from different circumstances and have different standards. So, always take stock and gauge each negotiation as something unique.

### 2) What Kind of Negotiation?

There are basically 3 circumstances to consider.

- Is it a one time negotiation, where we will unlikely interact with the person or company again?
- Is it a negotiation that we are going to be repeating again?
- Is it a negotiation where we are going to form some kind of long term relationship?

Most of our business negotiations are likely going to fall in the last two categories. We will be handling a lot of repeat negotiations, where we negotiate with regular suppliers, or engage in labour negotiations with the same union reps for example. Or, we will be seeking a long term negotiated agreement such as a joint venture, where we will be mutually entwined over a long period of time.

### 3) What Type of Conflict Will We Face?

There are basically two types of conflict situations we may encounter in a negotiation. Conflicts can present themselves singularly, or may be a mixture of the two. It is vital that the negotiator carefully analyze the conflict issues, both individually and collectively, to fully appreciate the unique challenges they present.

The first form of conflict might simply be called **agreement conflict**, where one person's views or position are in conflict with another individual, or members of a group. This is a situation that takes into account their conflicting views relating to opinions, beliefs, values and ideology. For example, two executives may have different views about whether a policy should be implemented. Another example may consist of a trade dispute between two countries, and entail ideological or religious based differences. Or, the conservative viewpoints of management might conflict with the more left wing approach of union leaders.

The second form of conflict entails the **allocation of resources** like money, quantity, production or simply put - things. Any physical commodity will fall into this category of conflict. Other issues might entail the allocation of resources, as a separate segment of the trade dispute. Resource issues though, are more tangible as they comprise knowable items, or particular products.

One glaring example occurs when subsidized farmers of one country, 'dump' cheaper products onto the market of another country, at the expense of the indigenous farmers of that country.

By analyzing the types of conflict into categories, negotiators can have a better understanding of the real measure of the disputes, and frame or focus their strategies more effectively.

### 4) What Does This Negotiation Mean to Us?

There are only two reasons why we enter into a negotiation.

The first reason occurs when out of **necessity, we have to**. This could be due to either some immediate need, such as urgency to find a particular supplier, or it could be that we face severe cutbacks in personnel, if we can't increase our business.

The second reason occurs when we are seeking out an opportunity. This situation may arise simply because an opportunity has sprung up, where we can increase our overall business at an opportune time,

The reason for entering into a negotiation will affect both our approach and **strategy**, and also our relative negotiating power in comparison to our **counterpart**.

### 5) The Ripple Effect

We also need to ask ourselves whether the results of the negotiation we are conducting, will affect other negotiations or agreements later. Many companies today have international interests. An agreement with a company in one country, may affect how talks will impact or be influenced, with negotiations that will transpire later, with other countries. It's vital that we, as negotiators, consider the impact or consequences of an agreement in developing our strategy.

### 6) Do We Need to Make an Agreement?

We either enter into negotiations because we have to, or because we want to. Part of our strategy will involve a careful analysis of our BATNA (Best Alternative to a Negotiated Agreement). If an agreement is absolutely essential, and we have few alternative options, in the event of talks collapsing, this will affect our strategy. Or, if the negotiated agreement is not essential because we have a strong option, and can walk away with confidence, this also influences the approach to our strategy.

### 7) Do Other Parties Need to Formally Approve the Agreement?

Many agreements made during the negotiated process require formal approval, or ratification before an agreement is official. Union members may vote before they accept a tentative labour agreement, that was previously negotiated between management and the union. A Board of Directors, CEO, stakeholders, or other outside constituents, may need to review and ratify an agreement, before it comes into effect.

### 8) Is the Clock Ticking?

Time has an impact on the course of negotiations from two perspectives. First there are deadlines that might be imposed, to either make or break an agreement. Offers with expiry dates may be tendered.

Secondly, we all know that 'Time is money'. Negotiations use up time, and if a plant is shut down while the clock is ticking because of a strike, then this is costing money. Or, it could be due to some other resource issue, such as waiting for badly needed components, in order to resume production. The point to remember is that the longer the negotiations drag out, time will negatively affect the bottom line.

As illustrated in Part 1 of this article, there are many factors that negotiators have to take into account while considering a negotiating strategy, in how we are going to approach our talks with our negotiating counterparts. The rest of this article considers other factors, that may have to be factored into our strategy, to get the overall picture.

### 9) Your Place or Mine?

In much the same way as sports teams enjoy a 'home advantage', negotiators playing away from home need to adjust their game plan and strategies. There are 3 possibilities to consider when deciding where the talks will occur. We can either hold the talks in *their offices, our offices*, or at a neutral domain. We might choose the latter so no one has the psychological and resource advantage, of holding the negotiations on their premises. Sometimes, deciding upon where the negotiations take place, can open up a whole new can of worms, especially in the case of international disputes for example.

### 10) Will we be Under the Public Microscope?

Negotiations are often private affairs with little fanfare, until an agreement is signed. There are also agreements that are advertised afterwards, to maximize the mutual benefit both sides obtain. On other occasions, negotiations may be held in strict secrecy.

Then, there are the highly publicized occasions when the press becomes actively involved. It could be that one of the negotiating parties uses the powers of the press, to lever an advantage to sway and manipulate the outcome. We need only scan the daily newspapers, to understand the importance of how public involvement, can influence and add intense pressure to some negotiations. The press can be utilised as a public forum to embarrass our opponents into action, or to deflect their strategy. Press releases are another means to use as an effective strategy in the negotiation process.

### 11) Will We Need a Third Party?

Third parties have many different functions and roles to play in developing a negotiation strategy. They may act as agents, intermediaries, translators, consultants, or other specialists who have an expertise, that one or both parties require. There are occasions when a neutral third party will act as a facilitator or chairperson, to manage the negotiations such as in multiparty negotiations, inter organizational negotiations, or even international negotiations.

Then, there are the other occasions when we hit a roadblock, or impasse in our negotiation. During these times we may

use a neutral third party to act as a mediator or an **arbitrator**, to either facilitate an agreement or to impose an agreement, such as in a labour dispute for example.

### 12) Who is Going to Blink First?

There are situations when we have to decide how a proposal or offer is to be presented, or in deciding who is going to go first. Will we make an informal proposal before we start the negotiations, or wait until we meet face to face? Will we be prepared to make an offer after listening to their proposal, or do we need more information? Will we respond right away, or refer the matter to our constituencies? Will it be to our advantage to be first in making an offer or proposal, to set an anchor around which the talks revolve? Or will it be better to hold our cards tight to our chest and let the other side go first? Of course, this will all relate to the issues, positions, goals and objectives that will determine our approach. These are very serious questions that we need to intelligently address, before we begin our talks.

### 13) Who Are the Decision Makers?

Before we enter into the negotiations, we must establish who is going to make the decisions. What is our authority and who do we report to in our organization? Similarly, what are the authority levels of our counterparts? Finally, can we make an agreement in principle, or an unofficial agreement that will likely stand the test of scrutiny?

### 14) How Far Will We Push It?

Negotiations can be a one shot occurrence where one party comes right out and says 'This is a one time offer - take it or leave it.' There are some instances where haggling is not considered acceptable, and will not be tolerated by the other party. Other situations will drag out into the equivalent of a marathon ping-pong match, as each party bounces offers and counter offers, back and forth between them. We need to know who we are dealing with, before we get too cute and find ourselves cut out of the opportunity altogether. It also depends on the offer and proposal, in relation to the circumstances such as time considerations, need, and many other factors.

### 15) Are We Strong or Weak?

Two or more parties who are about to engage in a negotiation, seldom operate from an equal power base. If one party has something that we desperately need, for our company's survival and we have no alternatives, then we may find ourselves negotiating at a disadvantage. This all relates

to our **BATNA** and how we stack up against our potential counterpart. Size is not necessarily relevant, as we've all heard the old biblical account of 'David versus Goliath', and how that conflict turned out.

Weakness can be countered by strengthening our BATNA, or even by finding allies to support our position and add to our strength. Also, we should seek ways to diminish the power base of the opposing party where possible, before we begin our negotiations, or even during the negotiation process itself.

### Summary

Negotiation strategies need to be developed by considering a whole host of factors, that might have a powerful impact on our success. It is also wise to remember that our strategy has to be flexible and will need to be adjusted as the game plays itself out. We cannot know everything before we go into our first meeting, so we need to prepare to adjust our strategy and tactics, as the situations warps and changes shape. Flexibility is vital, but good preparation is essential.

1. Harvard Business Essentials 'Negotiation' Harvard Business School Press, (2003).
2. Leigh Thompson, 'The Heart and Mind of the Negotiator-2nd Edition', Prentice Hall Business Publishing, (2001).
3. J. Lewicki, A. Litterer, W.Minton, M. Saunders, 'Negotiation', 2nd Edition, Irwin, (1994).

## Detecting Lies in Negotiations

by Steve Jones.

Negotiators often don't say everything they're thinking. Sometimes they hold back or distort information to avoid being exploited by the other party. Disclosing your "walk away" or "must have" conditions can frequently be a risky strategy – particularly with aggressive negotiators on the other side.

How many times have you been fooled by the other party claiming to have decision making authority when in reality that wasn't the case? Or maybe they make commitments they have no intention of keeping?

### So how do you spot this?

The truth is that people are not as good as they think they are in picking up deception. Studies have shown that many people's gut feelings about when people are lying are not much more reliable than tossing a coin. When you are under pressure this is even worse. In phone negotiations this is

even more problematical because you have no opportunity to pick up the non-verbal clues or incongruities in others' behaviours.

Fortunately, those skilled in human observation-including psychologists, poker players, and actors-can teach us a number of strategies for distinguishing lie from truth.

### 1. Be completely aware of all behaviours

Professor Paul Ekman has pioneered the study of what he calls "micro-expressions". These are small facial movements that are extremely difficult to detect. People assume that failure to make eye contact is a sign of lying. Sometimes it is – but some people are just lacking in confidence or are shy – particularly in a high stress situation. Other studies have revealed that staring or eye-balling is used by many to conceal a lie, perhaps due to the popularly held belief that looking away shields a lie.

### 2. Listen, all the time

The verbal content of the conversation is frequently the best indicator of attempted deception. A few of the key behaviours are listed below:

1. Uses your words – allows them to get the answer out fast without processing the information
2. They won't stop talking – the nervousness means they continue to provide more and more information, or repeat themselves like a dog chasing its tail
3. They aggressively stonewall in an attempt to limit challenges
4. They don't answer the question directly
5. The reactions are disproportionate to the questions
6. The 3rd party view may be missing from the story
7. Answer your questions but don't ask any
8. Immediate relaxation when subject is changed
9. Not indignant or excessively indignant when accused
10. Humour or sarcasm
11. Answers a question with a question
12. Suddenly starts stammering, develops a nervous tick or twitch, or starts blinking excessively
13. Expresses extreme displeasure at another - on your team or their own

### 3. Look for anomalies

Some people are highly attuned to picking up nonverbal cues. One of the best ways for a layman to pick up half truths is to watch for inconsistencies or anomalies. Ask yourself: Was their behaviour consistent? So when considering the above list of behaviours, ensure that you compare their suspicious behaviour to how they behave normally. To do this you need to be tuned into their normal behaviour - which can be a challenge if you're negotiating with a team or haven't known the other party for very long. All the more reason to invest in the relationship first and not talk business too soon.

So if they normally listen attentively, answer your question promptly, use the language you've used in your question, and blink briefly before answering - be on alert if they pause for longer before answering, their eyes focus on a member of their team instead of just blinking, they neglect to use the language you've used in your question, and they lean back unconcerned instead of listening to your response. They may not be lying, the onus however is on you to probe further to uncover the reason for their behaviour change.

### 4. Ask the right questions

In negotiation, the question "Is that really your best offer?" almost always elicits a "Yes." No one is going to say, "Well, actually, it isn't. I was just hoping you'd think so." A better strategy is to give the other party an out. If someone says, "Take it or leave it." One option is to simply treat the statement as untrue for the moment, discuss further and make a counter-proposal. The truth of an ultimatum is tested by whether the person making it is willing to consider alternatives. It's up to you to float them.

Sources: The Negotiation Experts. [www.negotiation.com](http://www.negotiation.com)  
Michael Wheeler Professor of Management Practice at Harvard Business School co-author, of What's Fair? Ethics for Negotiators, Professor Paul Ekman author of Never be lied to again, Telling lies

## Use Clever Questions in Your Negotiations

Learn how to ask negotiation questions in the right way. The question you ask will either elicit information or will invoke an emotional or irrational response.

Do you use and can you tell the various types of negotiation questions apart? How often can you tell when your chain is being pulled, in order to get a "fight or flight" response?

'The pen is mightier than the sword.' This is only partially true. The power of the spoken word should be more powerful or impactful. The tone or volume we use in our voice can be as blunt as steel or as calming as a lullaby to a sleepy eyed child. We don't expect this is news to you. Yet, often we don't give particular thought to how we really effectively communicate. Language can be used and played like a melodious violin, or annoy our senses like itchy, irritating hives. Oft times, we neglect to use our communication skills in our **negotiation** to our best advantage.

### Good Questions vs. Bad Questions

Asking questions the right way is both an art and a science. Ask the question the wrong way and a person might act like a turtle, becoming defensive and withdrawing into their shell. Ask the questions another wrong way and a person might roar back at you like an enraged lion. Ask it the right way, and the person might 'spill the beans' like they use to say in those old black and white movies. During a negotiation, we need to learn how to ask questions to get vital information, and we need to think about how to ask questions to get our **counterparts** to talk.

These really are the only two types of questions. Good questions produce results while bad questions don't. Sounds simple enough, doesn't it? But what's the real difference between the two? Let's take a look and hone our communications skills.

### Effective and Useful Questions

The following are the most productive types of questions to ask in a negotiation. When you are attempting to elicit information, you need to phrase your question with the objective that you will obtain a beneficial and productive response that you can use to your advantage.

#### 1. Open-ended questions

These are the kinds of questions that require a detailed answer in a negotiation and cannot be simply replied to with a 'yes' or 'no' response. They consist of using who, what, where, when, why, and how. The respondent has no alternative but to provide some detail.

Example - 'How did you arrive at that particular price?'

## 2. Open opportunity question

This form of question invites the person to participate and offer their views.

Example - 'What do you think of this option as a solution?'

## 3. Leading Question

Just like it sounds, you try to guide the person to your point of view in a persuasive manner.

Example - 'With all these advantage I've pointed out, don't you think that this package benefits us both and is the best way to go for both of us?'

Or, another form of leading negotiation question simply tails off and invites the other person to fill in the blanks.

Example - 'And after we provide those documents that you just mentioned, you will....?'

## 4. Low key question

This is a gentle way to ask a question and not trigger an emotional or hostile response.

Example - 'How much more will this cost if we chose this additional feature?'

## 5. Sequential questions

Sometimes, it can be very good strategy to ask a series of questions to lead up and achieve a particular result conclusion. Generally, it might be a good idea to plan these in advance.

Example - 'And after you complete the first delivery, how long will it take for you to have the second shipment ready and sent to us?'

## 6. Flattery question

This is an effective means to be both complimentary to your counterpart while eliciting information from them, both at the same time. Everyone responds well to a friendly compliment.

Example - 'Could we draw upon your particular and specialized expertise to add some input into this particular issue?'

## 7. Probing deeper question

When you need to gain a better insight into a person's thought process to further illuminate their rationale or position.

Example - 'Could you provide us with more detail in how you analyzed the data that you just described and how you reached your conclusion?'

## 8. Emotional thermometer

There are occasions when you will sense that something might be starting to boil beneath the surface. This might be a good time to address a pending emotional response

that might de-rail the negotiation by simply checking out how the other person feels about certain issues. Example - 'How do you feel about that aspect of settlement package?'

## Landmine questions

These are the kinds of questions that can be very counter productive, confrontational and evoke negative emotional responses. When used in wrong stage of a negotiation, you might put your counterpart on the defensive or cause them to respond aggressively in return. Either way, your negotiation could end up being de-railed without your intending to self-destruct.

### 1. Aggressive

Certain kinds of question can result in being too pushy, especially when used at the wrong stage of your negotiation.

Example - 'You're not trying to pull a fast one on us are you?'

### 2. Loaded

This style of question puts the person on the hot seat regardless of they respond to the answer, and therefore in very defensive position. It is very aggressive.

Example - 'Do you expect me believe that this is the only acceptable solution that you will accept?'

### 3. Emotional Trigger

Certain questions will definitely result in triggering a powerful emotional response particularly when posed with a tint of arrogance or insulting scorn. You are definitely not going to add to your knowledge base by adopting this type of question because it's like shooting yourself in the foot in the process.

Example - 'Do you really think that this ridiculous proposal is worth wasting my time?'

### 4. Impulsive

This is the type of question that pops out of your mouth before you gave it any thought. Always think - then ask, not the other way around.

Any inappropriate question can serve as an example here.

### 5. Tricky

These are the questions that are loaded with innuendo, and may imply a threat or some similar action.

Example - 'Are you going to cede to the demands we've outlined, or take us to arbitration?'

This is not to say that occasionally the so-called bad questions aren't productive in prompting a necessary reaction or response in the right situation to move things along. However, they are not the kinds of question that will elicit badly needed information, or that can be positively used when you are trying to build a partnership or relationship with your opposite number.

### Summary

When you are asking questions to get information you need to evaluate the circumstances of your negotiation, you want your counterpart to work with you and not against you. It is important to think about how to best use your communication skills to get the best results. The manner in which you ask your questions can have a powerful bearing on the results of your negotiation so, and as they say, 'Think before you speak.'

1. Leigh Thompson, 'The Heart and Mind of the Negotiator-2nd Edition', Prentice Hall Business Publishing, (2001).
2. J. Lewicki, A. Litterer, W. Minton, M. Saunders, 'Negotiation', 2nd Edition, Irwin, (1994).
3. Harvard Business Essentials 'Negotiation' Harvard Business School Press, (2003).

## Negotiation Styles

### Understanding the Five Negotiation Styles

People often ask "which is the best **negotiation style**?" As with much management theory there is no single 'best' or 'right' approach. All five profiles of dealing with conflict are useful in different situations. Although we're capable of using all five, most of us tend to have one or two preferred negotiation conflict styles that we use unconsciously in most conflict situations. Why? Either because our preferred styles have worked for us in the past, or because of our temperament (nature) or because of our upbringing (nurture).

So if you're involved in business negotiations, which negotiation styles are likely to reward you with the biggest profit prizes? This question will be answered later in this article. First let's visit each of these important conflict profile styles.

### Compete (I win - You lose)

Competitive style negotiators pursue their own needs - yes, even when this means others suffer. They usually don't want to cause others to suffer and lose, they are just so narrowly focused on their shorter term gains that they plunder obliviously through negotiations like a pirate. They often use whatever power and tactics they can muster, including their personality, position, economic threats, brand strength or size or market share. At its extreme negotiators call their behaviour aggressive or psychotic.

### When to use?

When you need to act or get results quickly. Competition is critical when you are certain that something is not negotiable and immediate compliance is required.

Competition can be an effective defense or counter balance to use against negotiators with a competitive conflict profile. We would recommend that you use a blended approach though, as both negotiation parties locking horns in a competitive battle can result in a spiraling deadlock.

When you're buying or selling something as a once off (e.g. selling your own home or car to a stranger), then your negotiation will likely be more competitive than say if you were selling to a close friend or family member, or if you were in a business to business negotiation.

If you're buying or selling a commodity product or service, and you have strong competition - look out, as you best get used to competing.

### What's the Danger?

The difficulty with people who are high compete (which a large percentage of buyers are) is that competitive styles overuse competition. This means that the other party knows exactly what behaviour to expect and can prepare more easily. In a power imbalance negotiation, high compete behaviour is very likely to lead to deadlock - which will get you nowhere. They may also be more interested in "winning" rather than reaching an agreement. If you're recruiting a negotiator, a very low compete profile score would be something to be careful of. Some negotiators combine high compete with high avoid. These negotiators will compete first, and if they don't claim an easy scalp, they walk away from the negotiation table.

Unchecked competition can leave business relationships in burning tatters. Those with accommodating profile styles tend to lose the most against competitive styles. So if a relationship is important to you, and if your market reputation is important, then be careful to curb your competition. When we feel victimized, we often plot our revenge. This often results in businesses living up to the letter, but not the spirit of a contract - claiming value wherever possible, and adding zero value.

### Self Defense

The most important thing to remember is: Don't Cave In! Some people say that they make concessions in the face of a competitive negotiator demanding a concession - in order to create goodwill. Don't listen to these self deluders, they're bleeding profits. Appeasing competitive negotiators doesn't create goodwill - it just creates requests for more concessions. What's more, a competitive style negotiator will see you as weak, and come back for more. Restate your position firmly using strong language (not 'we'd like' or 'want', but rather: 'we require' or 'need') and never reward bullies.

### Accommodate (I Lose - You Win)

The opposite of competing. For accommodating style negotiators, the relationship is everything. Accommodating profiles think that the route to winning people over is to give them what they want. They don't just give products and services, they are generous with information too. Accommodators are usually very well liked by their colleagues and opposite party negotiators

### When to use?

When you or your company are at fault, repairing the relationship is critical, and if you have nothing else that would benefit the other side. i.e. an olive branch or gift to rebuild bridges.

If you are in a very weak position then sometimes your best option is to give in gracefully. Think about it: if they can crush you, and they know it, what is likely to be the outcome if you resist? Yes, bring your own bandages. It may be worth (humbly) reminding them that you will both stand to lose if they put you out of business, and ask if they really want to push you out of that market. If you both intend to work together in the longer term, then refocus the negotiations on the longer term, thereby reminding the other side that their taking advantage of you now may hurt them in the future.

### What's the Danger?

It is almost always a bad idea to accommodate when negotiating against high compete styles. With high compete negotiators your generosity will be seen as a sign of weakness to be taken advantage of.

Giving away value early in the negotiation can leave you with a poor hand to play in the rest of the negotiation. With very little to offer, and relying upon the other side's generosity, you're gambling.

Giving away value too easily too early can signal to your negotiation counterpart that you've very deep pockets, and your gift is just a taster of bigger and better gifts to come. To some negotiators, an accommodating style appears to promote harmonious relationships. What these accommodating profiles miss is the myriad of other options that create strong enduring relationships. Giving away the farm usually just creates one happy negotiator, and that's not you.

**Warning:** The faulty thinking that puts accommodates into negotiation damage control is thinking that because the goal is unimportant to you, it must have little value to the other side. Remember to do your homework and by asking the value of your concession to the other party before making your concession.

### Self Defense

When someone is offering you a gift at the negotiation table, do you humbly accept their generosity? Be careful, as theirs may be a proverbial 'Greek Gift' - i.e. they may be luring you into reciprocation, obliging you to give back something of greater value in return. So keep in mind the value of the item being given - the relative value to both sides. Make sure you don't give back something of disproportionately higher value in return.

You also need to be careful that they are not an incompetent negotiator, making big concessions that jeopardizes the viability of their business, or agreeing a deal that their managers will later veto. If they go bust because they are giving away too much, you could both end up losing.

### Avoid (I Lose - You Lose)

This is most often referred to as "passive aggressive". People who habitually use this style really dislike conflict. Rather than talk directly with you about the issue, avoid styles may instead try to take revenge without you knowing about it. The avoid style can be a typical reaction to high compete negotiators. Sellers will frequently call less often on high compete buyers (i.e. Avoiding Competitive buyers) - and may choose to invest marketing money and share their best ideas and prize promotions with non-avoid profiles.

### When to use?

When the value of investing time to resolve the conflict outweighs the benefit; or if the issue under negotiation is trivial (trivial to both parties).

Sometimes there is just not enough at stake to risk a difficult conflict situation. If there is a lot of emotion in a negotiation, it's pointless pushing through and hammering it out. Better to allow people to calm down first, let the testosterone hormone leave everyone's system first so that reason and rationality can reappear. At that point an avoid style is likely the most pragmatic alternative - suggest a timeout of 15-20 minutes.

What to do when you're dragged into a negotiation unprepared? Under these circumstances, avoidance is probably the most sensible strategy. Either avoid the meeting, or avoid discussing the issues upon which you need to prepare.

### What's the Danger?

Whoever has the greater urgency will usually end up with the short end of the avoidance stick. Stalling is a common sales tactic, when sales / the vendor knows that procurement needs their product or service yesterday.

Conversely a buyer may hold out until the last day of the a quarter or month, knowing that the sales person needs to meet his or her target. So be careful about what information you reveal about the urgency of your need.

When communication channels are cut off, you leave the other side to fill in the blanks. They may believe you need more time, or may think that you're no longer interested in a business relationship with them, resulting in their approaching your competition, or contemplating downsizing. Mutual resentment is likely to build up - leading to frosty impersonal relationships. Paradoxically, avoid profile negotiators are frequently seeking to avoid conflict - and their avoid style instead lands them in more conflict. When differences are eventually aired, emotions and negotiation positions are often more difficult and fixed than they need be.

### Self Defense

Set clear expectations of timing early on in your negotiations. Best to be detailed in defining milestones with dates attached to each.

If the other party is applying an avoid style, consider escalating the issue on one or both sides. Understand their decision making process and levels of responsibility. Having these insights can assist you in

invalidating their reasons for avoiding, and will make your sharp questions more difficult to side-step. Escalation options will also be clearer to you.

If you have a good enough relationship, then agree a process on resolving differences. As John F. Kennedy was quoted as having said: "The time to repair the roof is when the sun is shining."

### Compromise (I Lose / Win Some - You Lose / Win Some)

Compromising is the style that most people think of as negotiation, but in reality compromising is usually just haggling. Compromising often involves splitting the difference, usually resulting in an end position of about half way between both party's opening positions. In the absence of a good rationale or properly exchanged concessions, half way between the two positions seems "fair". What compromising ignores however, is that the people that take the most extreme positions tend to get more of what is on offer.

### When to use?

When you are pushed for time and you are dealing with someone who you trust. They also need to be clear that it would not be in their best interest for them to "win" a cheap victory. Both parties win and lose - but make sure you win the right things and lose the right things. Meeting half way reduces strain on the relationship, but usually leaves precious gold on the table (and with the central banking cartel's gold suppression scheme losing its grip right now, every ounce of gold counts). When you have nothing left to offer, and this is the only way to seal the deal. i.e. a lousy situation.

### What's the Danger?

When you use compromising as an excuse for not preparing properly. Without quality negotiation training, most negotiators wing it, and end up compromising. If the outcome of the negotiation is critical, then you should not compromise on things that you absolutely must have. One of the problems with compromising is: if you make concessions within your position with no strong rationale, the other party may assume that you are going to continue to make more concessions, and appeal to you using weak rationale.

Whichever negotiator starts with the more ambitious opening position wins the compromise. So calculate early on who stands to gain if it comes down to compromises.

If you get known for being a compromise styled negotiator, look out! Your trading partners will wise up to your negotiation style and they will start to make more and more extreme opening positions. Bigger opening positions result in greater chances of deadlocks. Compromises cheat both sides out of innovative solutions. Learn from collaborative styles by making it safe to explore options together. Invite the other side to join you in 'what if' frames to explore possibilities, without the danger of being tied to your idea.

### Self Defense

Only retreat within your position when you have a solid rationale for doing so, and when you're being rewarded in another way. i.e. make a reasoned exchange. Trade across goals and interest. All too often negotiators try resolve 1 single goal at time, before moving on to the next tabled agenda item. Stay with the problem or opportunity for longer. Don't give in so easily to the temptation of splitting differences until you've explored other alternatives. If the other side starts with an extreme opening position, be sure to quickly bring them back to reality, or counter balance with your own extreme position. Caution: extreme positions can lead to drawn out dog fights that result in more deadlocks.

### Collaborate (I Win - You Win)

Most people confuse "Win/Win" or the collaboration style with the compromising style. This is most definitely not the case. "Win/Win" is about making sure both parties have their needs met, and as much mutual value as can be created is created. "Win/Win" negotiators usually evolve through the other profiles, they grow into a collaborative negotiation style. This means collaborative profile negotiators can more easily revert to one or two of the other styles when pushed or when the situation calls for it. Collaborative profile negotiators are adamant that their needs must be met - and they acknowledge that the other party has needs that must be met too.

Tragically, too many account managers are overly accommodating and compromising. Resulting in competitive style buyers claiming more than their fair share. When these same competitive style buyers come up against skilled collaborative style negotiators, the competitive styles blunt coercion methods don't get rewarded with concessions. Too many buyers are stretched and under tremendous time pressure, so temptation to compromise rather than invest time in collaborating wins out.

Often referred to as 'expanding the pie', collaborative negotiators are willing to invest more time and energy in

finding innovative solutions, feeling secure in the fact that there will be more value to share out later on.

### When to use?

Under most circumstances collaboration is the primary style you should use for most goals in business to business negotiations.

As mentioned briefly in the Compete section: if a relationship is important to you, and if your market reputation is important, if the other side needs to perform and not just exchange a standard product for cash, high risk (e.g. new market or new product or both), if there is a large amount of money at stake, then you are best advised to think about all the ways in which you can build a more trusting collaborative working relationship.

If you need to understand the feelings and deeper interests or motivations of all negotiators, then collaboration is your best path.

### What's the Danger?

Be careful not to collaborate with competitive style negotiators - unless they agree to and live up to your agreed (written or unwritten) rules of collaboration. Die hard competitive negotiators can be treated in transactional trading manner - e.g. "I'll only give you this if you give me that".

When we share information we need to make sure that we share information at the same level of detail. Too much and we could be exploited - too little and the other side can lock up like a clam.

Collaboration requires more time and needs to be at the right level. So if you're a vendor and your buyer doesn't have the authority or knowledge or won't invest the time, save your effort. Best to talk with them about your style of negotiation or build a relationship at another level of their organization. Same advice goes for buyers in reverse.

### Self Defense

So when might you need to defend yourself against a Collaborative negotiator? If you have decided that it's not in your interest to use a collaborative style with a negotiator, then decide on your alternative style and flesh out what behaviour translates into. So a commodity supplier who suffers a great deal of competition in their market place will try to get their foot in your door. A wise procurement manager will be careful to not investing too much time, or give any time - unless there is value. Your time is short, so be careful who you collaborate with.

### Remember

Before you negotiate, stop and ask yourself:

- What is my preferred style of negotiation? Once you know your style, you've taken the first step to gaining flexibility in your negotiations. There is much you can do as a member of a negotiation team, if you know your fellow team members' profiles.
- Which of these 5 styles best describes your business client or vendor negotiation relationship? You may find it useful to allocate a percentage score to each style, and then ask yourself whether you're happy with the current styles balance. If not happy, then make a plan to migrate to your preferred styles.

Don't blindly apply 1 negotiation style to your negotiation. Work through your list of goals in your concession strategy, and decide which issues are best to: collaborate, compete, compromise, avoid, accommodate.

Finally - there's very seldom an escape from having to use a competitive style. At some point, you're going to need to do some claiming or sharing out the value you've created. So think carefully about which point in the negotiation you need to switch to competing. So if the other side compete too early, be prepared to pause the negotiation and have words ready to revert to another style.

### What Every Negotiator Must Know Before they Negotiate

Learn the strengths, alternatives and options that are available to every negotiator before they make an agreement.

'Ignorance is Bliss' and 'Look before you leap' are old proverbs that occasionally haunt all too many of us. We side step some of our more irksome problems, hoping that if we ignore them long enough they will simply go away. Either that, or else we tackle our daily problems without giving any thought about planning our approach and plunge right into them to get them out of the way. Quite often, the problems that we either ignored or blindly leapt into see us land in a muddled mess. Afterwards, we tend to end up salving our wounded egos when things didn't turn quite how we expected them to instead. In our post game analysis, we find ourselves woefully shaking our heads and trying to figure out what went wrong.

### Introduction

Beginning a negotiation in a state of sublime ignorance or leaping into a negotiation without preparation, we often find ourselves blindly attempting to circumnavigate and struggle our way through our meetings. If a professional league coach were to attempt to tackle their opponents without getting some key intelligence about the strengths and weaknesses of the opposing team, they would soon run into profound difficulties while trying to catch up and make adjustments during the course of what would sure to be a very trying match. Likewise, this hapless coach would add to their difficulties by failing to fully appreciate the strengths and weaknesses of their own key players. It's too late to learn as you go along because that ship has already sailed. The pre-game process for a negotiation is no less different.

### Four Steps to Eliminate Ignorance and Leaping Blind into a Negotiation

We need to access the strengths and weaknesses of our side before a negotiation. It is equally vital to do the same for our counterparts in the negotiation process. So, to help us prepare in advance, here are 4 preliminary steps we need to take before we tackle a negotiation.

#### 1. Know the consequences:

We should never automatically assume that a negotiation is going to result into a successful agreement. Always ask yourself, 'Okay! If all else fails, what other choices or options do I have?' This means that it is most desirable to have some options or alternatives to turn to when the talks collapse. To use the popular parlance of negotiation, this means we need to know our BATNA which is the acronym for Best Alternative to a Negotiated Agreement, a term popularized by Roger Fisher and William Ury in their best selling novel titled, 'Getting to Yes - Negotiating Agreement Without Giving In'.

Our BATNA is critical to know because it provides us with a boundary line. It is a warning bell to advise us when it's time to walk away from what otherwise might be a counter productive agreement which is more detrimental than beneficial. It establishes a more specific rather than a general demarcation point for our reservation price. Any agreement made below or above this point, depending on whether we are the ones making or considering an offer, would not be a beneficial agreement. So, at this point, we must have our best available alternative to turn to instead. This an essential phase of our pre-planning process.

## 2. What's the other team going to do?

Another equally vital portion of the preparation equation is to determine and try and figure out our opposite number's BATNA. We must remember that they too are considering their viable alternatives and options, and this allows them to determine a cut off point where they will walk away from the table.

No, it's not as if we are reading their minds although it might seem like it on occasion. If we can reasonably establish what our counterpart might be considering by putting ourselves in their shoes from their business perspective, we might be able to more accurately or roughly ascertain a potential zone of agreement which is mutually compatible to both parties.

## 3. What are the real issues on the table?

Fisher and Ury have said that when we sit down to negotiate, each side will be presenting their bargaining and negotiating positions. It's like a number of different styles of poker games where several cards are visible to all the players sitting at the green felt table in a smoky back room, but some of the cards are dealt face down. The cards we see are the positions that both sides reveal, while the cards we don't see might be the real cards that motivate our betting. Those cards which we don't see are similar to the real interests or driving motivations behind the positions we use at the bargaining table. This is the information that each side really wants to obtain.

We might want to increase our sales by making a strategic alliance with another company. However, our real interest might be to increase our productivity because in fact our sales are down and our bottom line is starting to get that nasty tinge of red that scares the heck out of our bean counters. Our real interest then, is to secure our professional and financial security.

## 4. Understand the priorities

Knowing our own interests and figuring out their real interests is not enough. We can't just make up a simple list and figure that's all we have to do. We need to prioritize and rank this list according to importance. By understanding our own priorities and our counterpart's priorities we can more effectively consider our concessions in terms of their strengths relative to each side. The idea is to give up on less important concessions which may have value to them, while getting the other side to give us concessions which are more important to us.

It's all part of the dance. The idea is to make sure you're not trying to Tango while they're trying to do the Foxtrot

as you're obviously going to end up tripping over each other's feet. It can be like watching a teenager dance with a grandparent to a techno beat at a wedding. As you go back and forth, you begin to get some clarity on the real issues and after awhile, and providing you're both on the same page, you can get some synchronization and realize there is a basis to help each other achieve our mutual goals and business objectives. Here is where we can both make a compatible deal through mutual problem solving.

## Summary

Don't leap into a negotiation if you are ignorant about what you need to know about your own needs and alternatives, and similarly, don't neglect to put yourself in the other side's shoes either. Good planning and preparation are essential to successful negotiations. So, play it smart or else you might find yourself completely out of the game.

1. Roger Fisher and William Ury, Bruce Patton, 'Getting to Yes-2nd Edition', Penguin Books, (1991).
2. Harvard Business Essentials 'Negotiation' Harvard Business School Press, (2003).

## Identifying the Right Counterpart

Talking to the right person is one of the key factors for ensuring the success of any negotiation. If the opposite number is highly resistant to humanitarian values, has little implementation power and does not get along with you on a personal level, negotiations are unlikely to produce useful results.

Before starting any negotiation, skilled negotiators always assess which person in a particular conflict will be their most appropriate counterpart – the person most likely to deliver what they want.

Often, humanitarians do not get to negotiate directly with top-level counterparts – the ultimate decision-makers in a government or armed group. Instead, they have to reach them by negotiating with others. And even then, humanitarians normally do not enjoy the luxury of choosing their opposite numbers in a negotiation. This means that, in most cases, the person in front of you is not your definitive negotiation partner but your intermediary. You will usually need to convince the ultimate decisionmakers *through*, or sometimes *despite*, your negotiating counterpart. But in all situations, it is crucial to understand how, and if, the person in front of you can help you to achieve your objectives by looking at the following factors.

### Who is the Right Counterpart?

#### Receptiveness to Humanitarian Values

Ideally, it is best to negotiate with people whose interests are compatible with your own, so that a mutually satisfactory agreement is more likely. Assess how receptive your counterparts are to humanitarian values by performing research and by taking the time to get to know them (also

#### Implementation Power

Implementation power is a primary determinant for the success of any negotiation. No matter how sympathetic he/she is, if your counterpart lacks the power, authority and capacity to garner institutional support for your agreement, the agreement will be void in practice or will constantly have to be re-negotiated. Safe passage at checkpoints is a notorious case in point. Often, you may agree with a high-level authority on free passage for humanitarian vehicles. But at certain checkpoints, guards who oppose the humanitarian presence and the higher authority that had given you permission to pass may block your trucks.

A quick way of assessing the implementation power of your counterpart is to gauge his or her power in four key areas.

Power to do something – the actual capacity to implement what has been agreed. For instance, being able to grant access to an IDP population or to provide a fleet of trucks.

- Power over other people – the authority to give instructions. For example, the seniority to command people within and outside of his or her immediate geographical sector or ministry.
- Power through other people – being able to profit from a dense network of friends and colleagues in government who greatly admire, listen to and cooperate with him/her. For instance, someone who may not hold a senior position but has significant moral authority across a wide constituency.
- Power from a very specific source – being able to make or shape decisions due to holding a powerful position in the national hierarchy or a unique advisory post. This might be someone with little influence over constituencies or little official authority who enjoys exceptional access to power through being a guru or confidant or spouse of a leader.

But, remember, power changes. Changes to the political situation or local command structures may suddenly increase or decrease the implementation power of your counterpart. As a humanitarian with experience in South Asia put it:

*“You need to position yourself widely because you never know who will be in power in a month from now.”*

It is important always to maintain as broad and diverse a range of counterparts or potential counterparts as possible.

#### Personal Rapport

The way you relate to, or click with, your counterpart on a personal level is obviously important. Negotiations are likely to yield better results if you both get on well. It is thus crucial always to introduce yourself, so that your counterpart can get a sense of who you are. For example, say who you work for, how long you have been in the country, whether you are married and have children. This can be done briefly and concisely. It is not necessary to expect your counterpart to do the same. In fact, it may be a sign of increasing trust, if he/she starts sharing information about him or herself at a later date.

The following three factors are likely to shape relations between humanitarians and their counterparts.

- Culture There is, of course, no general rule as to what impact elements like nationality, religion, group identity, gender and age will have on your negotiation many humanitarians report them as being highly significant depending on a given context. It is essential to judge which social and cultural factors have positive or negative ramifications in your own setting.

An aid worker reflecting on experiences in South-West Asia pointed out the advantages and disadvantages that gender can have during negotiations:

*“Being a woman can be a factor that both facilitates and blocks a negotiation. In certain countries where men are highly sensitive to female charms, there may be a greater readiness to listen to a woman than a man. With a man, you tend to arrive at difficult moments in the discussion sooner. With a woman negotiator, there will be more distance and an issue can be discussed in a more roundabout but no less effective way.”*

Personal conflict styles Negotiation theorists distinguish between four attitudes, or styles, with which individuals approach conflict: avoiding; attacking; yielding; and collaborating.

These styles are often part of our basic character or the product of our education. Be aware which of these come most naturally to you and gauge how this fits with the

attitude of your opposite number. Although we instinctively adopt a style we can be trained to adopt all four.

- Personality types Psychologists employ numerous distinctions when it comes to personality types, but the one feature that is likely to influence a negotiation most is the extent to which the other party is predictable. It will be much easier to negotiate with someone whose next move can be anticipated than with a highly manipulative or unpredictable character.
- Understanding certain characteristics of a counterpart's personality helps in anticipating what they will do next.

In a country in Southeast Europe, weapons were found in the assistance packages that a humanitarian organisation delivered to affected civilians in an area occupied by rebels. The government ordered the organisation to leave the country. The organization decided to send one of its national employees to the government to negotiate a continued presence. According to this employee, the members of the government perceived him as much more trust-worthy than his international colleagues. They repeatedly asked him to confirm that he was a patriot and that his allegiance had not been bought by international humanitarian organisations. Having convinced them of his loyalty and given other reasons for the presence of the weapons, the government eventually agreed that the organisation could stay.

#### Example 2

During the civil war in the same country, members of an armed group continuously asked to negotiate with international staff only. They were afraid that national employees would be too partial or have divided loyalties.

#### Example 3

A national employee in Southeast Europe described high staff turnover as the real factor accounting for the difference in the quality of negotiating relationships that national and international staff are able to develop with counterparts.

*"The international will leave the country and may never see these counterparts again, but we will remain here and must therefore pay much more attention to the relationships we establish."*

#### Example 4

When negotiating humanitarian assistance with a certain military commander, an international humanitarian worker in Eastern Congo always used to take a young female member of the national team with her. This young woman was able to appeal to, and convince, the commander in an emotional way, while also knowing how to keep the distance that this kind of highly personalised approach required. In contrast, when discussing sexual violence against women with the same commander, the negotiator always took a 'very macho' national male staff member with her who could speak 'man-to-man' with the commander.

#### Example 5

*"I once went with another female colleague to negotiate with a general who welcomed us with the words: 'Well, this is excellent, two lovely ladies. I have finished my working day and now we will be able to move on to more pleasant matters.' So, the negotiation got off to a very bad start. During the discussions it was almost impossible for us to be taken seriously. The general also had a series of gadgets on his desks including small toy soldiers that, if wound up, started walking while shooting with machine guns. His great delight during the 45 minutes of our negotiation was to turn the key of these little soldiers and make them advance towards us with their machine guns pointed while he burst out laughing. He gave us no chance of entering into a serious discussion. Had we been men, the discussions would have taken a very different turn."*

*(Aid worker sharing an experience in Central America)*

There are two types of counterparts who may not be very helpful.

#### Powerless Counterparts

Humanitarians can find themselves negotiating with someone who is relatively powerless, and admits it, or with someone who pretends to have power but does not. In such situations, a well-intentioned counterpart may point you towards somebody else, someone further up the hierarchy, or in a different department. By contrast, a pretender may be too afraid of losing face and thus continue to string you along. If this is the case, look for ways to go around them. Knock on additional doors and diversify your contacts until you identify people who have real power. But be careful not to offend a first contact. He or she may become more powerful one day or could spoil your wider efforts now.

### Phoney Counterparts

Sometimes, particularly resistant authorities will deliberately set you up with phoney counterparts – negotiators who are told to take your time and energy but are instructed to stall you with charm, evasion or obstinacy. If you have the feeling that you are running up against a brick wall in this way, try to find a way around it, diplomatically or forcefully. But take the hostility and obstruction seriously. Use your wider network to uncover the precise origin of, and the motive for, such obstruction, so as to understand it and to address it appropriately.

### How to Identify the Right Counterpart

Whether you are able to choose a counterpart or have them forced on you, it is essential to know as much about them as possible. This involves important research to identify and understand your opposite number (the person with whom you will negotiate) and their relationship with your ultimate counterpart (the person you most need to influence). All of this will help you to appreciate the kind of person you are dealing with and the extent of their power.

### Gather Information

Find out as much as possible about your negotiating counterparts as well as about the group of individuals that surrounds them. They will probably be doing the same with respect to you. The following sources and contacts should prove useful.

- Books, newspapers and the Internet.
- Experts like academics, journalists and diplomats.
- Colleagues who have negotiated with your counterpart before.
- Employees of other humanitarian organisations who have had contact with your counterpart.
- Any possible contact you can make who knows the person or is aware of their reputation – such as people in the street, taxi drivers, hotel owners, waiting staff or people under the person's command.

### Analyse Your Information

- Ask yourself the following questions about each of your counterparts.
- What role do they play in the overall conflict?
- What relationships do they have with other key individuals and groupings?
- What is their conflict style? Are they antagonistic, or do they collaborate?

- What is the hierarchy (official and unofficial) among the various people with whom you are dealing? Who influences whom?
- What kind of attitude do they have towards humanitarian values/ international law/your institution/you as a person/the specific subject matter you want to discuss with them?
- At which level are they placed? How much and what kind of responsibility do they have? Is the substance you are discussing with them part of their mandate?
- Do their employees hold them in high esteem? Are their orders taken seriously? Are they feared?

### Map Your Findings

Putting together a stakeholder map is a good way of helping you to establish who you should approach. Such a map helps you to understand which of your possible counterparts has the most interest in your negotiation objectives and the most power to help you realise them. The diagram below shows an example of a generic stakeholder map.

### Pre-negotiations

It is rare that negotiators will go straight into direct talks. Instead, they are likely to have one or more preliminary meetings. These pre-negotiation discussions allow negotiators to get to know their counterparts and to find out whether they are as receptive and have as much implementation power as your research suggests.

### Common Problems When Identifying Counterparts

- Changing counterparts dramatic or subtle changes in the conflict may suddenly transform the receptiveness, availability, implementation power and even personal attributes of your counterparts. In an extreme case, your most powerful counterpart may, overnight, become an insignificant actor. From one day to another, you may be faced with a whole new team of potential counterparts. This will require renewed research and counterpart identification.
- Knowledge and time constraints International employees will have limited time to unearth information on counterparts and to learn how to move within the dense web of actors in a given country. They will have to depend even more, therefore, on the information that national colleagues and other contacts can provide.

### What if your Counterpart is not Accessible?

You may find yourself in a situation where the most powerful potential counterpart is not possible to reach in person. Most often this will be because the individual does not want to see you, does not trust you or is simply too senior.

### Negotiating Through a Third Party

When access to your counterpart is denied, it is important not to spoil your chances of making direct contact with him/her by pestering him/her inappropriately. The best way to convince a counterpart of your good faith, honesty, trustworthiness and significance is to have someone who can testify on your behalf.

According to a Wolof proverb from Senegal, **‘the soap cannot wash itself’**. Just as the soap needs an external element against which to be rubbed, you need a third person that can highlight your qualities and underline your credibility. As an intermediary, this person will facilitate indirect discussions and mollify possible differences between you and your counterpart.

### How to Choose an Intermediary?

Stakeholder mapping should reveal a series of key people who are close to your counterpart. If not, it may be useful to think about recruiting more informal friends or common acquaintances as middlemen.

Whoever you select, it is vital that their identity or capacity does not damage the image of independence and impartiality that you are trying to project. It is often because such people are difficult to find that humanitarians cannot outsource negotiations. The person must be able to put the needs of victims first. National employees in your organization may sometimes be well placed to do this, but be careful not to expose them and their families to new dangers in the process. As a general rule, it is recommended that you choose an intermediary who is viewed in a friendly, not hostile, light by your counterpart.

### Checklist for Identifying Counterparts

- Have you gathered together, analysed and mapped enough information to identify several appropriate negotiation partners?
- Have you tested your counterpart’s receptivity to humanitarian values, his/her implementation power and the personal rapport that you can expect to develop with him/her during pre-negotiation talks?
- Have you considered using an intermediary to approach your counterpart?

### Checklist for Measuring Compatibility

- Can you identify your counterparts’ positions and bottom lines?
- Have you performed analysed their interests in-depth?
- Do you have a sense of how compatible your interests are and hence what the chances are to reach a principled agreement?
- Are you sure that your counterpart has a clear idea about your negotiation objectives, especially your interests? Is there anything you can do to communicate them more clearly?
- Are you aware of any historical, cultural or personal factors that may lead your counterpart to perceive you in way that is different from how you would like to be viewed?



### ASSESSING YOUR LEVERAGE

After setting objectives, identifying the right counterparts, analysing their interests and exploring levels of compatibility and overlap, the final step is to assess the leverage that you will have in the negotiation. Leverage is the power you have to influence the other party. The higher your leverage, the more likely you are to reach an agreement that is in your favour. The analytical phase enables you to get a sense of the levers at your disposal and the risks and opportunities associated with each.

Humanitarians can rely on several types of leverage. The first and most obvious type is incentives and threats.

#### Incentives and Threats

Humanitarian action is typically characterised as having five main modes: persuasion; denunciation; substitution; support; and mobilisation. Beneath each lies a specific source of power that humanitarians can utilize either as an incentive or a threat in order to increase their influence when negotiating for respect of international law. For example, humanitarians may be able to offer their counterparts possibilities to better support the people they are responsible for or they may threaten to heighten diplomatic pressure.

Which mechanism is employed depends to some degree on the organization that the humanitarian represents. A UN agency, for instance, may, in some instances, be reluctant to use the media for the purpose of public denunciation, but it may well have a significant network of state allies and a fair amount of humanitarian expertise that strengthen its leverage.

By contrast, Human Rights Watch will have significant media power but few material goods to help counterparts assist members of the affected population. During the analytical phase, you should spend time on, and give careful thought to, each incentive and threat available to you and understand which will appeal most to your counterparts. One caveat about threats: experienced negotiators and negotiation theorists generally do not encourage their use because of the high risk that they may prove counterproductive and increase levels of antagonism. Instead they recommend that you rely on incentives.

Below we discuss the different incentives and threats available to humanitarians and examine some of the disadvantages.

#### Quiet Advocacy (Persuasion)

Humanitarian law, human rights law and refugee law legitimise humanitarian action. In cases where counterparts fail to fulfil the obligations set out in these standards, humanitarians can try to persuade them to take action of their own free will to end the violations. Recognition by counterparts of international legal standards and their willingness to adhere to them can constitute a 'powerful humanitarian lever'. Counterparts may take their international legal commitments seriously, either because they are impelled by the formal recognition that this may afford them within the international community, or because they feel are concerned about the prospect of international isolation or condemnation and, in applicable cases, even criminal prosecution. Many humanitarians, however, feel that international legal authority is not a very effective source of power, especially in difficult negotiations, when counterparts lack political will or are reluctant to acknowledge international standards.

#### Loud Advocacy (Denunciation)

A more effective lever is usually use of the media, particularly public and official reporting of violations. Denunciation and targeted long-term advocacy campaigns may often put counterparts under pressure with respect to maintaining their international image and avoiding action being taken against them by states and multilateral bodies. But the application of media pressure can easily backfire and thus has to be handled very delicately in humanitarian negotiation situations. Often media representatives have their own idea of what they want to report and thus convey a message that is different from the one you wanted to communicate. This can cause irrevocable damage to a humanitarian negotiation; once a wrong message has been publicised, it is almost impossible to take it back.

#### Material Assistance (Substitute)

The aid items that humanitarians distribute can often serve as a key asset in the negotiations. Counterparts may often be interested in material assistance because it can help them secure popular support; civilians are interested in it because it can save their lives. Using aid items as a lever in a negotiation, though, can pose some ethical problems. Especially in day-to-day frontline negotiations, it can prove fatal to negotiate your way by distributing sacks of flowers just for the sake of getting a commitment. You will soon tarnish your reputation and, even more gravely, you will put the reputation of other humanitarian agencies on the line.

### Professional Expertise (Support)

Aid agencies provide specific professional services based on their technical, agricultural or medical expertise. The availability of these services and the possibility of working with humanitarians in a strategic partnership can often encourage counterparts to cooperate with humanitarians and to agree to some of their objectives.

### Allies (Mobilisation)

Many humanitarians say that rallying allies around their cause has often proved a very useful way of influencing their counterparts. Allies can be other states, multilateral bodies, such as regional organisations or the UN, international bodies, NGOs, important public figures, the media or any other group that has some bearing on counterparts' decisions. Allies can speak in favour of humanitarians and convince counterparts to accept their demands and proposals. Allies can also implement threats. For example, humanitarians may appeal to governments to introduce sanctions against counterparts or to isolate them diplomatically.

There are two main risks associated with employing allies. First, the neutrality and independence of humanitarians can be called into question if they work too closely with non-humanitarian bodies. Even if it is only by chance that powerful regional or international actors have adopted the same position as a humanitarian organisation, the latter is likely to be suspected of having collaborated covertly with them. In more extreme cases, humanitarians may run the risk of being co-opted by their ally, either consciously or unconsciously. All of this could severely damage the reputation of their organisation and of all other humanitarian actors and will provide counterparts with a good excuse not to work with humanitarians. It is important, therefore, always to keep the political agenda and interests of your ally in mind.

The second danger manifests itself when allies put too much pressure on your counterparts. This may evoke strong counter-reactions that make further negotiation impossible. A humanitarian worker with experience in Southeast Europe told us, for example, that, at some point, his counterparts felt bullied and put against a wall by the diplomatic allies of humanitarians and refused to enter into any further talks. Working with allies thus requires careful thought and preparation.

Humanitarians often search for allies in order to be able to influence counterparts:

*“We try to involve a maximum number of organisations which we know are active in the area and interested in the problem. We then also look for allies within the community with which we would like to work – this might be the prefecture or the police commissioner. We are always looking for allies.”*

*(Humanitarian talking about his experience in West Africa)*

### Threat of Withdrawal

If negotiations are very difficult, humanitarians may threaten to terminate certain programmes or to withdraw from the country altogether in an effort to get their counterparts to agree to their demands. To be credible, though, humanitarians must execute their threats, a move that may leave the affected population without assistance. This is why many humanitarians recommend never issuing such threats without having given careful thought to the consequences, and being willing to accept them. An aid worker with experience in South Asia told us, for example:

*“I would never threaten to withdraw. Because once you leave, how are you going to come back? In most cases, you need to come back in order to satisfy humanitarian needs, but if you say you are going to leave, you put the advantage in their hands.”*

As with all other form of coercion, threats of withdrawal are likely to backfire and escalate the situation, rather than help you to meet your objective.

In many humanitarian situations, the incentives and threats listed above will only yield limited results. Often, humanitarians feel that they are not in a position to propose incentives or to issue threats. Their counterparts control the territory that and the people who humanitarians would like to assist or protect and hence they can deny access. Also, counterparts may frequently show a willingness to use force against humanitarians, making the latter feel extremely vulnerable and powerless. Finally, counterparts may often simply not be attracted by humanitarian incentives or put off by humanitarian threats.

Given the limits of humanitarian power, it is even more important to consider alternative sources of leverage, such as fallbacks, credibility and a good sense of timing. Although these are less specific to humanitarian environments, one should not underestimate the impact that they can have on interlocutors.

### Fallbacks

If they are good, fallbacks will enable you to keep your footing during the push and shove of negotiations. Thinking about the fallbacks available to both parties is one of the most effective ways of increasing your leverage. Fallbacks determine what you are going to do if you fail to reach an agreement or if the other side asks you for concessions that you are not willing to make. For example, you have been trying to persuade the Minister of Defence for several months to allow your organisation to deliver food to a group of rebels assembled in a demobilisation camp, but the Minister insists that the troops have to remain in isolation as long as demobilization is ongoing. However, you know that the Minister of the Interior and a significant number of parliamentarians support your request and are willing to back you. These people are your fallback in case the Minister of Defence does not change his or her position.

How do fallbacks provide leverage? Knowing what you are going to do if no agreement is reached gives greater confidence. You are likely to present your position with more conviction and composure. More important, the other party may realise that you are not afraid to suspend talks and pursue your interests without it, which, in certain situations where interdependence is high, will put it under pressure to reach an agreement. It is important, therefore, to spend time developing fallbacks.

Leverage can also be gained by knowing the fallbacks of the other party. If it has weak fallbacks, it will not want to break off the negotiations and may even be more willing to make concessions. But if it has a very attractive fallback, you will need to convince it that its fallback is not as attractive as it thinks. Where you both have attractive fallbacks it may not be worth negotiating. As a humanitarian, though, you may often find it difficult to develop viable fallbacks.

There are dangers associated with fallbacks. If they depend on others – supportive governments or allies within the authority concerned – fallbacks always run the risk of widening the conflict and the negotiations drawing in more actors. Sometimes conflicts need to be widened to be resolved. At other times, widening a conflict can necessitate changing its terms. What was central to your negotiation may suddenly become peripheral in a conflict between your fallback group and that of your counterpart. You may move from being an active protagonist to being the grass between two fighting elephants. Once again, good judgement is required.

### Credibility and Consistency

Many negotiators agree that one of the best ways to win people over is to act consistently, so that they can always trust that you will do what you say. Consistency bestows significant credibility and means that people tend to deal with you. Credibility as a negotiator emerges from consistency in three key respects.

- Ensuring that counterparts understand what your organization can do and what your limits are. Do not raise expectations that you cannot live up to.
- Keeping your word. People want to be able to rely on you, so keep your promises. Do not make promises that you cannot keep and do not make threats if you are not willing to implement them.
- Being careful with bluffs. You only need to be found to be bluffing once and your entire credibility is lost. Bluffing may be most effective in one-off negotiations with a person whom you know you will never see again, but it is not advisable in long-term negotiating relationships.

*Humanitarians often point out the importance of setting realistic expectations: “Humanitarians should never promise anything, especially not potential positive effects that they cannot control, because in political environments nothing is certain. They should never generate illusions.”*

*(Aid worker reflecting on experiences in South Asia)*

And counterparts appreciate consistent behaviour:

*“We have very good memories of the negotiations with one staff member of a humanitarian organisation. He was a man of his word and we knew that if he said something, he would do it.”*

*(Civil servant in Southeast Europe)*

### Negotiating by Example to Gain Credibility

Sometimes the best way to argue your case is by doing yourself what you are asking others to do. At a terrible moment in an African famine, tens of thousands of refugees experienced a misguided food aid distribution of imported yellow maize when they had been used to eating white maize since childhood. They had only heard of yellow maize in the context of something used as cattle fodder in Europe and did not imagine that humans could also eat it. From the start of the distribution the refugees became frightened and angry and refused to accept it. Understandably, perhaps, they had

doubts similar to those a French person might have if asked to eat pig food. Aid workers tried to calm the situation by saying that: “The colour difference isn’t serious, the maize is the same.” But reasoned argument did not help. Aid workers only managed to restore people’s confidence by eating the maize themselves in front of a row of trusted representatives of the refugee community.

### Timing

Timing has a crucial impact on every negotiation and often influences leverage.

### Time Pressure

Humanitarians will often be negotiating under significant time pressure on behalf of people caught in extreme circumstances. They have to initiate operations as swiftly as possible to save lives. At such moments, their counterparts may often try to force them to make concessions that, usually, they would not make. It will often be easier for humanitarians to influence the negotiation process if they do not feel under pressure to have to commit to something. When assessing their leverage, negotiators try to gauge whether they still have a lot of time to reach an agreement (high leverage) or whether they are under pressure to conclude an agreement as quickly as possibly (low leverage).

### Frequency of Contact

Leverage will also depend on how often you can meet with the other party. Whether there is more or less leverage in a one off encounter than in a long-term negotiation process is not always clear. On the one hand, you could enjoy more leverage when you know that you will never see your counterpart again. You may be able to make threats and put pressure on him/her that you would not have dared to if the long-term relationship between you was important. On the other hand, you could have more leverage during prolonged and repeated negotiations, since you can assume that your counterpart has a sustained interest in negotiating with you. This may be because his/her fallbacks are weak or because the trust he/she has in you is very strong – both indicate that your leverage is high. Either way, the analytical phase helps you to think through and assess how much leverage you possess to influence your counterparts.

### Ripe Moments

If the timing of a negotiation is not right, you will have limited leverage. More than most, humanitarians may often be forced to negotiate when the moment is not ripe. But it is a hard call as to whether to wait for a better moment when faced with the immediate prospect of a starving population. The competitive nature of the humanitarian environment – with other agencies on your heels – can also pressurise staff into starting negotiations too quickly or too early.

In conflict and negotiation theory, ripe moments arise when both parties have an incentive to negotiate because they have reached a mutually hurting stalemate or are presented with mutually enticing opportunities.<sup>7</sup> In other words, they have nothing to lose or everything to gain from negotiating a deal. For instance, there may be a change in the local government and the new chief of the district is eager to attract popular support and thus is willing to engage with you. At the same time, you have just arrived in the country and are keen to start operations. The trick during the analytical phase is to recognise these moments that provide you with maximum leverage and to exploit them.

### Checklist for Assessing Leverage

Identify the sources of humanitarian power that are likely to provide you with leverage over your counterpart and think carefully about the risks and opportunities that each presents with respect to the success of your negotiation.

- Develop good fallbacks and discuss them with your colleagues.
- Understand what makes you credible in the eyes of your counterpart.
- Try to get a sense of how well you can control time within the negotiation.



# Dealing with Corruption

More than a year after the 2004 tsunami, which left an estimated 500,000 people homeless in the Indonesian province of Aceh, many thousands of families were still living huddled in tents. Instead of settling into sturdy new homes, they were victims of the corruption which devastated the housing programmes of aid agencies such as Save the Children US. Given the large amounts of money and materials involved, the construction sector is especially prone to corruption – from substandard materials and workmanship, the use of incorrect measures or the theft of materials, to kickbacks for contracts and bribery or bias in land allocation. Like many agencies, Save the Children had little experience in the sector and appointed corrupt contractors who erected flimsy housing, leaving it with hundreds of homes to rebuild. “The contractors were supposed to sink foundations up to 60cm,” reported the Aceh Anti-Corruption Movement in 2005, “but they’d just propped wooden stilts on stones and dug no foundations at all. The timber was substandard and already warping.

”When routine M&E revealed the shabby work, Save the Children immediately suspended construction while it investigated, issuing media statements acknowledging problems and promising to rectify them. The agency met with local communities and authorities, dismissed contractors and called in experts, establishing a multi-faceted team including experienced construction managers, architects and engineers. They worked closely with procurement staff, oversaw design development and programme monitoring, and verified on-site activities. The episode also led Save the Children to strengthen anti-corruption measures beyond its Aceh construction programme. It devised a specific global construction policy, and its Indonesia office established its own ombudsman committee to receive and investigate corruption allegations of any type (with a confidential whistle-blower mechanism to protect informants), and hand down sanctions, such as termination of employment and police referral. Senior staff (including the country representative and head of internal audit) gave the committee clout. By December 2007, 44 cases had been investigated, 39 of which prompted either termination or prosecution. The committee’s role includes building staff capacity to prevent and detect corruption. Key to its success is the fact that both HQ and field staff know how the ombudsman system works and welcome its existence.

([www.transparencyinternational.com](http://www.transparencyinternational.com) The global coalition against corruption Preventing Corruption in Humanitarian Operations Section II Program Support functions)

## What is corruption and why does it matter?

People's understanding of corruption varies enormously, both within and across cultures. Many people have a narrow definition, confined to fraud and embezzlement. What is considered corrupt in some cultures (nepotism, for instance) may be perfectly acceptable in others.

Transparency International's definition of corruption is: 'the abuse of entrusted power for private gain'.

This includes financial corruption such as fraud, bribery, extortion and kickbacks – but it also encompasses non-financial forms of corruption, such as the manipulation or diversion of humanitarian assistance to benefit non-target groups; the allocation of relief resources in exchange for sexual favours; preferential treatment in assistance or hiring processes for family members or friends (nepotism and cronyism); and the coercion and intimidation of staff or beneficiaries to turn a blind eye to or participate in corruption. By 'private', we mean in contrast to the concept of the public good. Private gain refers not just to individuals but to families and communities; ethnic, regional or religious groupings; political parties and organisations; corporations and professional or social associations; and warlords and militias. 'Gain' is not always financial: the abuse of power may be aimed at enhancing personal or organisational reputation or for social and political purposes – which means it's essential to recognize the many actors wielding different types of power within humanitarian crises.

The worst impact of corruption is the diversion of life-saving resources from the most vulnerable people, caught up in natural disasters and civil conflicts. That this occurs is hardly surprising: relief is delivered in challenging environments. The injection of large amounts of resources into poor economies, where institutions may have been damaged or destroyed, can exaggerate power imbalances and increase opportunities for corruption. The immense organizational challenges in suddenly expanding the scope and scale of programme delivery are often accompanied by pressure to deliver aid rapidly. And many countries in which humanitarian emergencies occur suffer high levels of perceived corruption prior to an emergency and may present risks of aid being diverted by powerful groups and embedded corrupt networks. Corruption also damages staff morale and an agency's reputation. In short, it undermines the humanitarian mission that is the *raison d'être* of emergency relief operations.

## Key recommendations

- Discussion of corruption needs to be brought into the open, with a clear emphasis that addressing it is not the same as condoning it or implying an agency's particular vulnerability to it. Rather, open discussion is the best way to establish robust prevention policies.

It is important to understand that perceptions of what constitutes corruption vary within and across cultures, and are often limited to financial mismanagement and fraud. 'Nonfinancial corruption' such as nepotism/cronyism, sexual exploitation and the diversion of aid resources to non-target groups are less often understood as corrupt practices, and in some cultures may not be considered corrupt at all. Clear definitions of what constitutes corrupt behavior are an important part of preventing it.

- Integrating analysis of corruption risks and the political environment into emergency preparedness is vital to anticipating and preventing corruption.
- Addressing corruption risks should form an integral part of quality assurance, accountability and good management strategies, and not be a marginal issue handled separately. It should be built into inductions and training for all staff.
- The separation of duties (especially in finance teams) and decision-making by committee (or at least by more than one person) in matters such as recruitment and selecting partners and suppliers, are essential for preventing individual corrupt behavior.
- On-site monitoring deters and detects corruption, but is often starved of human or financial resources.
- Greater transparency in the information made available to local governments, recipient communities and civil society organisations is important for effective monitoring and genuine accountability.
- Recent initiatives to increase accountability to aid recipients (downward accountability) can empower beneficiaries to report corruption, but local power structures and cultural inhibitions may hamper this. Be sure to provide confidential and culturally appropriate complaint handling systems, including whistle-blowing policies, so staff and beneficiaries can report corruption freely.
- Many humanitarian agencies are aware of the risks of corruption and have developed policies and practices to prevent it. The humanitarian community should share information on these practices systematically and address this problem jointly.

### Corruption and humanitarian operation dilemmas

- There is no magic formula for eliminating corruption: our field research revealed several dilemmas and tradeoffs that it's important to be aware of when formulating anti-corruption policies. For most of these dilemmas, there is no definitive answer: what is essential is finding the right balance for each particular context.
- Reputational risk vs. open discussion. Some humanitarian organisations are reluctant to discuss corruption openly for fear of damage to their organisational reputation and fundraising ability, particularly among the general public. They think (mistakenly) that 'zero tolerance' of corruption must mean 'zero discussion' of it. Similarly, corruption is often not transparently reported owing to fear of donor sanctions. Yet acknowledging publicly the corruption risks often inevitable in the challenging environments of humanitarian operations does not mean condoning corruption. Instead it lays the basis for proactive strategies to prevent it. A transparent, proactive approach to reporting and discussing corruption leads to more robust anti-corruption strategies, which strengthen organisational credibility, preempt media scandals and reassure individual and institutional donors.
- Too many vs. too few controls. Too many or too rigid controls can either paralyze the system, or cause staff to ignore the controls altogether. But too few or too weak controls open the door for corruption. The right balance will vary according to the strength of the organisations involved and the capacity of implementing staff.
- Urgency vs. prudence. It is often argued that the need to move quickly to save lives precludes a robust or systematic approach to preventing corruption – especially in the very initial phase of a disaster response or in poor security contexts. Certain simplified and more rapid procedures are indeed appropriate in such situations – but only temporarily. During recovery and rehabilitation phases or in a post-conflict situation, it's essential to set up proper systems, staffing and controls, even if that takes a little extra time.
- Pressure to spend vs. getting things right. In a high-profile emergency, there can be pressure from donors and the media to be seen to be responding rapidly. However, a high financial 'burn rate' can lead to weak systems and poor oversight, creating opportunities for corruption. To prevent this, it's worth developing a strong 'surge capacity' as part of emergency preparedness, so that experienced senior staff (particularly in finance, procurement and human resources) are there to set up systems and procedures that curb corruption right at the beginning of a response.
- Local empowerment vs. standardised procedures and controls. Humanitarian responses should always support efforts by affected communities to recover from emergencies, rather than treat them as passive victims who must be assisted. Local empowerment (including of recipient communities) and partnerships are appropriate medium-term strategies, but without an in-depth understanding of local power structures and influence groups, the empowerment of local elites could distort equitable aid provision and lead to corruption. And while adapting programmes to local circumstances is useful, agencies also need to maintain some uniform policies and procedures that conform to international standards and allow comparable reporting across operations.
- Inclusion vs. exclusion targeting errors. When aid resources are limited (almost always the case), humanitarian agencies have to strike a balance between the inclusion of non target groups as a result of corrupt manipulation of targeting criteria and registration, and the exclusion of groups that should have been targeted. Definitions of who should qualify for assistance may vary between agencies and affected communities. It's important to communicate clearly to communities that the inclusion of non-targeted groups generally results in the exclusion of beneficiaries most in need, so that affected communities can be vigilant against corrupt inclusion errors. It is also important to understand that affected communities may redistribute relief items according to their own perceptions of vulnerability and fairness.
- Transparency vs. staff and aid recipient security. While maximum transparency by humanitarian agencies is to be encouraged, the highly volatile environments in which aid is often delivered means it's important to recognize that public information about the value of programme resources and their transport may sometimes jeopardise staff and beneficiary security, particularly in conflict contexts. In such cases, security takes priority.
- Information-sharing vs. legal and liability issues. Inter-agency coordination and joint responses can help mitigate both internal and external corruption. However, such coordination requires information sharing, for example, regarding staff terminated for corruption or corrupt suppliers. Labor and liability laws in emergency-affected countries may prevent agencies from sharing this information officially; managers may need to use more informal communication channels.

Despite the need to negotiate these dilemmas and trade-offs, addressing corruption is an essential element in improving the quality, accountability and effectiveness of humanitarian responses. It's only when the humanitarian community takes ownership of the fight against corruption that risks will be reduced and the full amounts of aid will reach people caught up in humanitarian emergencies. The handbook is designed to be a living document, regularly improved and updated, so we welcome feedback on the effectiveness of its recommendations and suggestions for additional or updated measures and policies that can help tackle corruption.

## Role against corruption

Corruption risks vary with context, particularly the local institutional, political and socioeconomic situation in which an emergency takes place. Risk analysis enables you to judge the likelihood that your emergency response will be exposed to corruption, and what type of corruption that might be, so you can put preventative mechanisms in place in advance of a crisis. Risk depends on the type and phase of emergency, how well established your programme is and the amount of resources assigned for distribution and administration. By systematically collecting and analyzing information about the nature, likelihood and impact on your programme of potential corruption, you can map risks on a matrix and see clearly where the greatest threats lie. You can then set organisational policies and design your programme accordingly. Risk-mapping also helps agencies to monitor the success of anti-corruption measures.

### Implementation Measures

- Make risk analysis an integral part of programme planning. Provide regular updates and involve local partners. Ensure staff have clear understanding of corruption risks across programme support and programme departments. Give staff generic understanding of how to handle corruption, and identify a manager as the 'owner' of each risk, responsible for coordinating the response to it.
- Analyze the external environment for corruption risks. As well as your own processes, it's important to analyze the wider environment for corruption risks. Addressing corruption risks requires an understanding of the local political economy and the power structures that control access to resources or beneficiaries ('gatekeepers'). Be aware when planning your emergency response of factors beyond your control but which influence the likelihood of corruption affecting your programme. This gives you a context-specific risk analysis.

- Review risk management measures periodically examine key developments and new risks, and regularly review existing risk management strategies during programme implementation. Do they minimize the likelihood of risk occurring and reduce its impact if it does? Modify risk management measures as necessary. Share your risk analyses and strategies with other agencies.

## RISK ANALYSIS

### You'll need

- An internal function to develop and coordinate overall risk management policies, and to manage and communicate risk-related information.
- A staff network for exchanging knowledge about risks and risk reduction, and for gathering and updating relevant information.
- Interagency forums for sharing risk analyses and risk reduction strategies.

### Challenges

Different risk levels at different stages of a programme. For example, monitoring and evaluation can be an opportunity to cover up corruption, and closing a programme can be seen as the chance to 'get something extra'.

## Management Leadership

### Role against corruption

Senior management and leaders at all levels of an organisation are powerfully placed to create an environment of 'zero-tolerance' towards corruption. They define how corruption is seen within an organisation's culture: as a challenge to be addressed and overcome with pride, or as a problem that remains hidden and unacknowledged. Leaders' words, policies and actions can break the implicit taboo about discussing corruption, behind which it can thrive, and give incentives that build the necessary trust for staff to report it. Leadership also determines whether staff feel equipped to identify corruption and empowered to do anything about it. A strong internal and external focus on corruption can establish an organisation's reputation as truly accountable.

### You'll need

- A full policy rollout in the field, with appropriate training programmes and materials: this is essential. Monitor and evaluate the effectiveness of these rollouts.
- A conscious ongoing strategy for mainstreaming corruption, including positive staff incentives.
- To give leaders the right tools for fighting corruption: presentations, staff information packs, training courses.

### Challenges

Corruption prevention giving way to operational urgency in a crisis; proactive leadership must keep corruption a live issue in staff minds.

## Supply of sub-standard goods or services

### Corruption Risks

- Standardise key goods and services by sector Coordinate with other agencies to reduce the number of purchasing processes. Use existing purchasing manuals or channels (e.g. the United Nations Children's Fund, UNICEF) and purchase according to industry-wide standards, such as Sphere. Work on joint procurement through the UN sectoral cluster system or through inter-agency coordination at the country level, including pre-supply contracts for frequently needed goods and services, as part of emergency preparedness.
- Consider implementing a cash transfer or voucher system Paying cash or providing vouchers for relief goods or services directly to beneficiaries transfers quality control to them, which can reduce the opportunity for corruption.

### You'll need

- To commit resources to implementing standards within your own agency and to coordinating with other agencies to apply common standards across sectors.

### Challenges

Poor definition of technical specifications, which makes monitoring and evaluation of quality standards difficult.

## Gifts in Kind

### A. Corruption Risks

- Gifts and hospitality may be offered by interested parties in the hope of influencing decisions, or be solicited by staff in return for favourable decisions.

Yet many societies traditionally use gifts as symbols of solidarity and respect, and refusing such gifts can seem rude. Genuine and corrupt gift-giving can be distinguished by analyzing intent.

If it's to distort normal decision making, so the giver gains special advantage, this constitutes corruption, but reasonable gifts and entertainment offered openly to promote good relations or mark significant occasions are not corruption.

Explicit policies on what type and size of gift can be accepted signal clearly to staff how to behave if they're offered gifts or hospitality of any sort, and in what circumstances it would be improper to accept them.

### B. Implementation measures

- Have an unambiguous policy towards gifts and hospitality Make sure all staff and partners know under what conditions receiving gifts and hospitality is unacceptable, and why. Cover the receipt of gifts in your anti-corruption strategy and code of conduct. Procurement staff should never accept gifts of any kind, under and circumstances, from suppliers. Gifts of cash or cash equivalents (i.e. gift cards) should never be permitted.

- Reinforce your policies with specific guidelines for behavior

Don't leave room for the misinterpretation of guidelines. Be specific: gifts above a certain threshold (suitable in the local context, e.g. more than US\$ 25) should be returned to the giver with a letter explaining that staff aren't allowed to accept high-value gifts (which usually mean that the giver expects some benefit in return, possibly at a later date). All lower-value gifts, however small, should be recorded in a central procurement registry, then either distributed among staff (e.g. via lottery or auction), kept for office use or donated to charity.

- Be clear that hospitality counts as a gift

Ensure staff know that the policy applies equally to intangible 'gifts'. Invitations to lunches or dinners can be accepted if made transparently with good intent and they're in the agency's interest. Extravagant meals and social invitations should be declined, and all accepted invitations should be declared to your gifts registry.

- Require that potential suppliers make a commitment to integrity

Make it obligatory for all suppliers bidding in a procurement process to sign an ethics

statement committing them to behave with integrity and not offer, promise or give anything of real value to staff in order to influence them. Impose sanctions such as debarment on companies who break the agreement.

- Use only specially trained staff for procurement

Ensure all staff know and understand your policy on gifts, but in particular train procurement staff in dealing with supplier attempts to win their favor. Ensure rapid deployment or 'surge capacity' staff are trained in the basics of good procurement practice, so they can carry out procurements at the earliest stages of an emergency, if needed. Keep signed procurement staff declarations of conflicts of interest regularly updated.

#### A. Role against corruption

The demand for speed in the earliest stages of response to a rapid onset emergency justifies the temporary relaxation of some procedures and regulations in setting up a programme. However, it doesn't justify total abandonment of all procedures. Certain regulations remain essential if a programme is to be efficient and resistant to corruption.

Clear, pre-established procedures for rapid response, robustly designed to be corruption-resistant, provide vital programme protection from the very onset of an emergency and are an essential part of emergency preparedness.

If all staff are well-drilled, these procedures will help your organisation achieve the optimum balance between the need for speed and the obligation for accountability and transparency during the initial rush to mobilize. Well-designed emergency procedures aren't an extra layer of process that will hinder a timely response: on the contrary, they'll help you maintain control and effectiveness even when moving at high speed.

#### Challenges

- Slack record-keeping or corner-cutting that bends emergency procedures.
- Pressure from agency management

## Government Preventing Corruption in Humanitarian Operations

### A. Role against corruption

- Governments of emergency-affected countries have a strong role to play in coordinating international and national responses to emergencies, as well as in helping create neutral space for the delivery of humanitarian aid and setting an example of zero-tolerance for corruption. They must never impede the flow of relief aid through bureaucratic ploys or use of their security forces, or create or manipulate humanitarian crises to enrich themselves and advance their own interests. Agencies should engage governments as much as possible in the fight against corruption, and be clear they won't tolerate government manipulation of humanitarian relief.

### B. Implementation measures

- Support the government's aid coordination role
- It is the national government's responsibility to coordinate the work of international and national humanitarian agencies. This should help to increase transparency and the effectiveness of resource tracking systems, as well as reduce the risk of double project funding. Inform and update the government humanitarian coordination agency regularly on your programmes and partners.
- Liaise with other agencies to work with host governments
- Coordinate with fellow agencies to develop a common dialogue with the host government on dealing with corruption. Find and work with officials willing to champion anti-corruption reforms within the government.
- Promote two-way transparency in government-agency relations. Promote open dialogue and debate over the best way of implementing emergency relief and avoiding corruption in a particular context. Commit to high standards of behavior and zero tolerance of corruption, and invite the host government to do the same.
- Choose carefully who to deal with

Agencies may have to choose who to recognize as a legitimate authority, locally or nationally, e.g. militia leaders, self-declared governors, clan elders or clerics. Deal with contested political landscapes using open, consistent principles. Ensure you never undermine or reinforce the standing of different political factions. Explore the potential of working with and supporting government anti-corruption institutions, to involve them in monitoring humanitarian aid.

## TRANSPARENCY AND ACCOUNTABILITY

### You'll need

- To ensure scrupulous neutrality in conflict situations. If a government (or opposition militia) thinks agencies aren't neutral, agency personnel will become targets and the ability to deliver relief will be undermined.
- To manage your government relations according to your contextual risk analysis: in any situation, who really has the power to help you deliver effective assistance?

### Challenges

- A highly corrupt host-country government (this should be bypassed).
- Countering the perception that you're undermining governmental authority when you work directly with local NGOs.
- Governments with variable levels of capacity and political will to control the territory they claim to govern.
- Governments providing one-sided, little or no information.

## Payment for access to aid resources or beneficiaries

### A. Corruption risks

Corrupt government officials or local militia may block the flow of aid by demanding bribes or kickbacks from agency staff in return for access to the people who need assistance in an emergency, or to the aid resources the agency needs (e.g. goods in a customs warehouse). Payment may be demanded at a strategic level (for access to a whole area or for international staff visas to enter the country), an operational level (somewhere along the supply chain, e.g. customs clearance), or on the front line of aid delivery (at a roadblock outside a camp).

### B. Watch out for

- Ad hoc changes in laws and your operating environment
- Requests to staff for one-on-one meetings by officials
- Unjustified refusals to grant visas
- Repeated delays in customs clearances

- Unforeseen delays in the transport and delivery of goods
- Road blocks, official or unofficial, controlling access to sites or beneficiaries

### C. Prevention measures

- Train staff in how to deal with extortion and intimidation  
Through security officers on the ground, pre-analyze the situation to identify likely corruption risks. Develop staff negotiating skills so they can talk their way around attempted corruption: train staff to define clearly and prioritize their objectives in a given situation, and to articulate your agency's position (what you want), bottom line (the most or least you're willing to accept) and interests (why you take that position).

- Identify the right counterpart

Always try to negotiate with a counterpart (the official or person most likely to deliver what you want). Gauge your counterpart's position, bottom line and interests for compatibility with your own, and assess the power you have to influence them. Give effective, robust arguments that are objective (e.g. based on international norms, aid recipient needs and your agency's expertise) and subjective (related to your counterpart's interests, needs and beliefs). Try to bond via personal common ground, but appeal to someone's superiors if payment is insisted on.

- Identify a capable team for formal negotiations

Try never to negotiate alone: you can be exploited and vulnerable to physical threats; the other party can lie about what was said. Choose team members with diverse skills, knowledge and personalities (where possible, of the same authority, expertise and cultural background as your opposition). Consider using a 'shadow' who never takes part in negotiations, but just observes, to advise your team objectively.

- Manage cultural differences

Be aware of differences in concepts such as hierarchy, gender roles, individualism, time, respect for rules and modes of bargaining. Use common sense regarding how much to adapt to a country's prevailing cultural norms. Don't talk too much: listen actively, be seen to concentrate on what's being said, make notes, ask questions.

- Pre-agree customs and visa procedures

Pre-plan arrangements as part of emergency preparedness to prevent opportunistic demands for bribes. Have all customs and visa paperwork ready or pre-lodged.

Pre-negotiate minimal or no cargo inspection, clearance outside official working hours or designated locations, and the waiving of duty and transit procedures. (If possible, obtain registration as a duty-free entity.) Liaise with other agencies in negotiations for waivers, fast-tracking and pre-arrival clearance. Seek the implementation of any existing regional agreements or sectoral concessions.

- Report blockages transparently Report to donors and government authorities any efforts by officials or private groups (e.g. militias) to block or delay humanitarian operations. Coordinate with other agencies facing these problems and develop joint responses.

#### **You'll need**

- To think in advance about how you'll deal with aggressive tactics, such as 'take it or leave it'.
- To report and carefully document these problems and decisions made. Challenges
- Compromises that involve second-best solutions or concessions.

## **Diversion of Aid**

### **A. Corruption risks**

The diversion of aid goods during transport may be pre-planned or spontaneous. It may come from a corrupt driver or transporter, possibly in collusion with a member of staff. They may claim that they had to pay a proportion of supplies as a bribe (payment for access), that goods were stolen or that they were damaged and had to be abandoned, when in fact the goods were diverted by the driver for sale. Corrupt local officials or soldiers may divert goods at roadblocks through extortion and intimidation, or transport may be raided by armed militias or rebels.

### **B. Watch out for**

- An unusual number of reports of irreparably damaged supplies
- Packages that appear to have been tampered with
- Missing or incomplete shipping documents, or those with manual corrections
- Deliveries that take unusually long to arrive

- Higher than normal mileage on delivery trucks
- Relief goods on sale at local stores or markets in large quantities

### **C. Prevention measures**

- Use reliable transporters and agree security measures Build security measures into transporters' contracts. Ensure vehicles are in optimum mechanical condition; that they travel only during daylight hours and are never loaded beyond capacity. Goods should be kept from view, covered or ideally with a sealed cargo door, which must be opened only by the load recipient. Agree security measures with the driver, especially if vehicles must remain loaded while parked overnight. Only display your agency name or logo if you're sure they won't attract unwanted attention.
- Pre-plan your route carefully. Choose the safest route, even if it's not the fastest, and inform everyone responsible for a shipment, from point of origin to destination. Identify key services and potentially insecure segments. Any deviation must be communicated immediately to the nearest base. Be clear who is responsible for a shipment at each stage. Coordinate transport routing with local authorities and other agencies, and ensure that vehicles travel in convoy for long journeys or through insecure terrain (liaise with other organisations if necessary), and that they have effective communications facilities.
- Document the entire supply chain. Have record-keeping staff at all points along the supply chain, with a coordinator to oversee the entire process and resolve issues. Keep agency and beneficiary community managers informed in writing about the state of the supply chain at various stages: supplies on hand; additional supplies needed, ordered, in transit and delivered. Use official consecutively numbered forms, and include copies for everyone responsible for the shipment. Recipients must verify goods immediately and notify the sender: both count and weigh all or a comprehensive random sample of packages, check their condition and cross-check with shipping documents. Document and investigate any discrepancies. Specialized items should be checked by technical personnel.

### Extortion, Intimidation and coercion of staff

#### A. Corruption risks

Humanitarian action necessitates bringing large amounts of resources into resource-poor environments – inevitably attracting attention; often creating an impression of boundless availability; and sometimes igniting the desire to extract goods or money. Without adequate protection mechanisms, staff may be exposed to physical threat or psychological coercion to pay for access to relief goods or beneficiaries, hand over goods or money or to participate in corrupt activities. These risks are particularly acute in conflict situations. A programme without adequate security measures is a soft target for corrupt actors ready to use extortion or to intimidate staff.

#### B. Watch out for

- Unusual signs of staff stress
- Odd explanations for unforeseen payments made in the field
- Aggressive or threatening behaviour by local leaders, militia, politicians or the military

#### C. Prevention measures

- Have a clear policy on how to respond to threats
- Assess corruption risks and related security threats as part of emergency preparedness, to help you design the best response possible in a particular security context. Listen to local staff and people to ascertain the nature and timing of potential threats. Make the observation of security rules mandatory and ensure personal behaviour doesn't increase risk, e.g. careless talk about assets. Clarify that staff should not put their own safety or that of beneficiaries at risk.
- Train and thoroughly brief all staff on security. Fully train all staff in general security principles (e.g. travel protocols), incorporating potential corruption risks; give detailed briefings on country and local circumstances; and include security in job-specific training (e.g. defensive driving techniques). Train staff in negotiating skills. Ensure equitable access to security training for all staff: don't assume that local knowledge and acceptance make national staff less vulnerable than international staff.

- Clarify that corruption will hurt beneficiaries. There is often a perception that relief resources come from rich foreigners and thus are 'fair game'. Staff should explain to the extorters that the funds or goods don't really belong to the agency, but to the emergency-affected people, and that diverting them will increase the suffering of their own communities.
- Report incidents of intimidation transparently. Oblige staff to report and document all field security incidents so you can collect and analyze data. If payment of bribes is unavoidable due to physical threats to staff or beneficiaries, report this transparently. Ensure that those who report coercion will be taken seriously and adequately protected, in the same way as whistle-blowers. Share learning across your organisation and with other organisations.
- Cooperate with other agencies on security matters. Create inter-agency security forums at field level, so you can share security tools and methods; identify threats, patterns and trends; share experience of commercial security providers; agree on joint policies and engage collectively with local authorities to increase security.

#### You'll need

- A thorough knowledge of the local context.
- To discuss this issue openly with all staff, your donors and implementing partners.
- The clear segregation of duties, to protect staff (so no one employee can facilitate a corrupt act alone).

#### Challenges

- Staff reluctance to report all security incidents for fear of further threats, HQ interference in the programme or career damage if an incident is seen as an individual's fault.

### Behaviour conducive to corruption

#### A. Corruption risks

Wasteful, careless or provocative behaviour by agency staff, especially expatriates can create an enabling environment for the corrupt abuse of aid resources by local authorities, beneficiaries or local agency staff. Power imbalances mean local people can perceive agency resources as belonging to rich outsiders, rather than to the affected community and therefore requiring careful stewarding.

If they see international agencies paying inflated prices for accommodation, vehicles, goods and staff, local people may consider agencies wasteful and conclude it's legitimate to exploit them. (They may even consider profligacy as a form of corruption, especially if effective assistance is not being delivered). Staff lifestyles and private behaviour may be inappropriate in terms of local culture and customs. While not necessarily constituting corruption, such behaviour can alienate local people, creating an enabling environment for corruption by causing them to see an agency and its resources as legitimate targets for exploitation and abuse.

#### **B. Watch out for**

- Reports of local people speaking with contempt about international aid agencies, their staff or resources
- Local media reports about the waste, profligacy or ineffectiveness of international aid agencies
- Reports of inappropriate private behaviour of agency staff, especially expatriates or managers

#### **C. Prevention measures**

- Monitor and evaluate aid recipient opinions of your agency Use formal and informal channels to keep in touch with beneficiaries' opinions of international aid agencies in general, and yours in particular. Encourage staff to talk informally with beneficiaries while working with them on programme design and implementation, and carry out periodic surveys of their perceptions of agency effectiveness as part of M&E. Respond proactively to build strong community relations.
- Encourage beneficiaries to feel ownership of aid resources Empower local communities to take greater control of and responsibility for humanitarian aid resources. Include beneficiaries in decision-making on targeting, allocation and distribution, and make them responsible for monitoring the equitable use of aid. Be clear that violations of trust and failure to full fill his responsibility will be sanctioned and may even lead to the withdrawal of assistance. Brief communities on reporting inappropriate staff behaviour.
- Brief staff thoroughly on local customs, morals and values. Carry out a thorough contextual analysis as part of emergency preparedness. Before an emergency posting, train all staff (especially expatriate) in local culture, customs and appropriate behaviour. Relate this to your agency's values and code of conduct. emphasise that all behaviour, whether professional or personal, affects

the agency's image and effectiveness. Encourage staff to show empathy and be sensitive both to local values and universal human feelings. Staff should avoid arrogant or disrespectful behaviour, flaunting personal resources, violating local customs, excessive drinking, or sexual relations with

- Provide staff with guidance on ethical behaviour and stress-management support support staff through an ethics office or designated person to advise them confidentially on ethical matters regarding colleagues' or their own behaviour, and on handling pressures for corruption from outside the agency.
- Be open with staff about benefits for international vs. local employees Explain clearly to all staff the benefits for international vs. local staff, and why they are set this way, so international benefits don't seem like unfair perks. Have clear policies and limits on benefits, and harmonise local and international staff benefits as far as possible, to reduce the temptation for unethical behaviour.

#### **You'll need**

- Negotiating the fine line between necessary expenditure, waste and corruption (perceptions of which often vary between agencies and local communities).
- Extreme stress impairing staff judgment about their own behavior; expatriate staff may behave quite differently from the way they would at home.

## **Issues in Cash based programming**

#### **A. Corruption risks**

Programmes that have cash-for-work components or that use cash transfers to beneficiaries may need to keep a substantial amount of cash on hand. Large amounts of readily available cash may generate strong temptation to corruption. Cash may easily be stolen or embezzled by staff, who may falsify or fail to keep records in order to cover their tracks, or may be bribed or coerced into informing thieves about cash availability.

#### **B. Prevention measures**

Outline specific procedures for cash-only operations. Have clear written guidelines for working in a cash environment, and ensure all staff are familiar with them. Make careful security provisions to protect cash and financial records. Ensure a daily cash ledger is kept; strict procedures for the transport and custody of cash

are observed, and all transactions documented. Always separate your accounting and cash-custodian functions, however small your team.

- Instigate strict cash controls
- Enforce strict cash receipts procedures
- Insist supporting documents are always kept and filed

### A. Corruption risks

The need to obtain permits, licences and access to public services such as electricity, water supply or telephone lines provides opportunity for officials to seek or respond to bribes, especially if the process is slow. Officials may demand a bribe to speed things up or to overlook real or concocted infringements of rules. Agencies may inadvertently (or deliberately) ‘outsource’ the problem by using local intermediaries who bribe on their behalf (“facilitation payments”).

### B. Watch out for

- Deliberate delays by officials in processing permits, licences or service requests
- Officials inventing extra rules, procedures or fees that are not in the published regulations
- Extraordinary difficulty in accessing public services such as electricity, etc.
- Fees that are higher than expected for public services
- Substantial payments to agents or other local intermediaries
- Agents claiming personal relations with high-level officials; who are recommended by officials you’re negotiating with; who appear just as you encounter problems; or who want payment in cash via third parties

### C. Prevention measures

- Pre-arrange paperwork with authorities As part of emergency preparedness, familiarise yourself with all procedures and regulations for accessing public services, so applications are lodged correctly and bribes can’t be extracted in return for ‘overlooking’ a mistake. Have all paperwork ready or pre-lodged with relevant authorities.

- Train staff to deal with demands for bribes Train staff in how to handle specific situations through cultural awareness and negotiating skills, e.g. play for time; treat officials with politeness and respect, even if they’re apparently breaking rules; show patient determination; ask to see a senior official. Back this with a clear anti-corruption policy and a code of conduct (useful weapons for staff when asked for payment). Publicise your policies: if your organisation is known for its strong stand against corruption, it’s easier for staff to resist demands and you’re less likely to be asked in the first place.
- Have a clear policy on the role of agents and on facilitation payments. Make any third parties (e.g. local agents) sign a contract agreeing to abide by your code of conduct and declare any conflicts of interest. Ensure they won’t bribe on your behalf. Use a strict selection process and clearly record your decision making. Review the justification for all payments made to agents or other third parties.
- Unite with other agencies against corrupt facilitation payments. Coordinate with other agencies to issue a joint anti-corruption declaration, and hold joint staff training in how to act when faced with corrupt demands for payment.

### You'll need

- To avoid meeting officials alone. It's harder to seek bribes with witnesses.
- Procedures for recording transparently all payments to officials.
- To document all discussions and contract negotiations (different teams or people sometimes carry forward negotiations).
- To be aware of corruption risks in your operating environment.

### Challenges

- Dealing with unavoidable payments (e.g. if staff face danger from intimidation or coercion). Ensure staff know that their safety and that of beneficiaries comes first, but that they must report payments of such bribes.



# Crowds, Mobs and Safety

The following short reading is from an internet advice site for crowd safety in large public events such as concerts, and football matches. It provides some thoughtful insight into crowd safety for these as well as other crowd situations you might encounter.

The original document is “Crowd Safety Tips for Concert Go- ers @ [www.loslobos.org/safety.asp](http://www.loslobos.org/safety.asp)  
Published by the UNHCR ESS & ecentre, 2004



## Crowd Safety Tips

The following tips will help you avoid crowd-panic situations, and help you survive should you find yourself in one.

- 1) When entering a venue, check the emergency exits and share and confirm the locations and status with your companions. As you position yourself in the venue, make a note of the nearest exit, preferably a secondary exit -- NOT the main entry/exit.
- 2) If you have trouble locating emergency exits, ask someone working the venue where they are. If you find one that is blocked or chained shut, notify venue security immediately. Don't make a scene, be polite and helpful. If the venue refuses to un-block an emergency exit, consider using a cell phone to notify police or fire authorities, or leave the venue.
- 3) Have a point-of-contact plan with your companions. Decide where (outside & inside) you will meet and account for each other, should you get separated in a crisis.
- 4) Control your intoxication level. Have fun, but do not become incapacitated.
- 5) Be aware of the atmosphere. Panic situations can often be anticipated, giving you the advantage in executing your exit plan. Mere seconds can make all the difference.
- 6) Should you find yourself swept up in a panicked crowd remember that seconds may make the difference:
  - a) Abandon personal belongings. DO NOT STOP or backtrack for your purse, beer, or so-called valuables.
  - b) Use non-verbal communication when the noise level is too loud for shouting. Grab a companion's hand or shoulder to stay together.
  - b) Move away from the direction of the main crowd pressure. If possible, move sideways to the crowd movement and find a wall. Stay against the wall and try to remain standing until the main crush subsides, or until you have a clear path to a secondary exit.
  - d) Try to move toward any exit other than the main or most obvious exit. Remember your survey of exits.
- e) When you reach a clear secondary exit, you may want to prop the exit open. If you feel safe, remain at the secondary exit and try to attract the attention of patrons still in the venue and direct them to the secondary exit.
- f) If you fall and cannot get up, you may want to cover your head with your arms and curl up.
- g) In fire and/or heavy smoke situations, stay low and even crawl if necessary. The air will be less smokey near the floor.
7. After exiting a panic situation, revert to your point-of-contact plan (item 3) and account for your friends. If you cannot locate them, try to alert someone, preferably an emergency professional such as a fireman, paramedic, or police officer. Often venue security are off-duty professionals rely on them and their training to help you find your friends.



# Approaching & Dealing with Checkpoints

This short text is taken from the OFDA/InterAction PVO Security Task Force training materials on Vehicles and Travel. This piece was written by Jan Davis, RedR drawing on documentation produced by CARE, Save the Children, Harlan Hale, and Steve Penny



## Checkpoints

It is important to distinguish between the different types of check-points. In normal circumstances check-points are designed to observe and control vehicle circulation; examine the road worthiness of vehicles; ensure compliance with driver and vehicle documentation, and to check for stolen cars, unauthorized drivers and transport of contraband. In insecure areas legitimate check-points also serve to identify vehicle occupants and the reason for transiting the area. They are also to check for the transport of guns, explosives, or combatants.

Personnel at authorized check-points, therefore, have a job to do, it may not be that pleasant (especially in extreme weather conditions) and the check-point personnel may feel more at risk than yourself. If you are co-operative, patient and polite, all your papers are correct and you have a legitimate job to do then it is in the interests of all concerned to speed you on your way as swiftly as possible.

However, in many countries personnel on authorized check-points can be underpaid (or not paid at all), frustrated, scared and they do not see why you should proceed without question or without some compensation to them. In this situation it is important to remain in the right and to stress the legitimacy of your position.

Another category of potentially more hazardous check-point is the impromptu barrier erected by unauthorized or irregular forces for a variety of possible purposes: defining the limits of a territory, extortion, robbery, car-jacking, assault, kidnapping and/or execution/assassination.

It is therefore, important to recognize the difference between a legal, sanctioned check-point designed to protect the public safety and a check-point erected for the personal benefit and gain of the check-point personnel.

It is potentially dangerous to lay down strict guidelines on behaviour at different types of check point since this will vary from country to country. For example, it may be customary to keep the engine running in one location but it may give the wrong signal in another situation. Therefore, on arrival in a new situation find out where the check-points are located and ask about the accepted form of behaviour.

Be aware that check-points can vary from an official red and white custom made barrier to a piece of string or stones across a track. Therefore, before travelling find out how to recognize the usual forms of local check-point.

Notwithstanding what has been said above, the accompanying box suggests possible conduct at a check-point but this should always be checked against recommended local practice.

## Suggested check-point behaviour

Important note: even though you may have experience from elsewhere, always check local guidelines on check-point behaviour before embarking on a journey for the first time in a new location. You may establish a procedure to radio your position to your agency base on approaching each check-point.

- During the approach quickly appraise the situation and decide on a response.
- If something looks suspicious then keep your distance, hold back and covertly report by radio.
- Agree before reaching the check-point who in the vehicle is going to speak and what you are going to say. Ensure everyone has the same story as unintentional conflicting remarks can create suspicion.
- Take off sunglasses before stopping. Turn off radio/tape. At night, turn off headlights well before check point and turn on an interior light.
- Slow down. You may not need to stop unless asked to do so. NGO vehicles may be automatically waved through.
- Keep a reasonable distance between vehicles. If there is an incident then a vehicle behind can report problems and hopefully evade danger.
- Be sure you understand the signals given by check-point personnel (e.g. are they waving me on or into the side of the road?). Stop if unsure.
- Be friendly, co-operative and alert.
- Have all your documents in order – passport/identity card, vehicle papers, driving license, permit to travel, cargo manifest.
- Show identification if requested, but try not to hand it over.
- Keep your hands visible at all times. Do not make any sudden movements that could be misinterpreted. Explain what you are going to do first (e.g. “I have to get my papers from the glove compartment”).
- Never willingly surrender your advantage. Unless otherwise indicated:
- Keep your doors locked.

- Stay in your vehicle unless strongly requested to get out and then try to remain close to the vehicle.
- Only switch off the engine if requested or it is the norm to do so.
- Open windows just enough to talk through and pass documents.
- Avoid bribes, 'a dash', at all costs.
- Find out what the local 'customs' are prior to getting into a compromising situation.
- Even if you don't smoke, carry cigarettes and matches, or pens as small acceptable 'gifts' when asked "have you got something for me?"
- If at all possible, refuse lifts to armed or uniformed personnel.
- Do not carry contraband: drugs, banned alcohol, undeclared currency, pornography, restricted items. If vehicle and/or baggage is searched, observe closely to prevent unauthorized removal and/or planting of any items.
- Protest strongly, but calmly and politely, at the removal/confiscation of any items from the vehicle or occupants—but do not resist if the guard is persistent, violent or armed.
- Avoid looking back after passing through a check-point as this can create suspicion if witnessed. Drive away at a normal speed.
- When out of view of the check-point and if it is agreed procedure then report clearance of the check-point by radio.

Avoid transiting check-points in the late afternoon in tense conflict situations. In many countries soldiers at check-points may alleviate tension, or boredom, by drinking or taking drugs. In the late afternoon they may be intoxicated and prone to over-react to otherwise normal behaviour, or they may openly threaten and extort.

Many check-points are legitimate and they can be used to your advantage. Non-threatening check-point personnel can be a good source of information concerning the road conditions, recent incidents and possible risks ahead. They can help to update your broad picture of the security situation.

Soldiers may be assigned to a check-point over a period of time. It is an opportunity to establish a rapport which can be beneficial in a number of ways. Obtaining helpful information on the security situation is one potential benefit. Another is if the general situation does take a turn for the worse then soldiers who have got to know you, even in a small way, may be more understanding of what you are trying to do and more likely to be helpful, or even protective. It is potentially dangerous, however, if you become accustomed to being waved through a check-point without stopping and without checking with the personnel. One day the check-point personnel will change and you will have to go through the routine of re-introducing yourself and explaining what you are doing. It will not be the first time an aid vehicle will have been fired upon simply because you have become complacent and fail to stop on the day the personnel change!.



# Convoy Driving

## Usage of vehicles on mission

Depending on the mission circumstances, AusMAT teams may be transported by local mass transport e.g. bus or minibus, or in smaller vehicles with local drivers, or by driving themselves. Before departure, vehicles should be checked for road worthiness, fuel and water levels, and adequate tyres and tyre pressure. If using the vehicle for the first time, engine bays should be inspected, as well as the under carriage for damage, road worthiness and in high risk areas, contraband or explosive devices.



If moving as a convoy, specific planning is required before departure as outlined below.

### Convoy Driving Tips

1. Before departing hold a drivers meeting and give each driver a printout of the route and a trip plan.
2. Review any key road rules applicable to country of mission. Determine 'Actions On' procedures and ensure all drivers are aware of signals and manoeuvres required in the event of an incident occurring.
3. "Actions On" procedures that should be discussed include;
  - Accident (with and without casualties, local and team) or Mechanical breakdown with repair possible/impossible
  - Separation of convoy in traffic
  - Becoming lost
  - Road blocks and checkpoints
  - If high risk of "Contact" e.g. coming under attack etc specific plans need to be discussed
4. Assign someone with a radio to be the sweeper, often the deputy team leader. (The sweeper is the last car that lets the group leader (often first car) know when everyone has made a light or a turn onto a new road.) Determine a radio frequency to set the portable or fixed radios to. Assign call signs to each vehicle.
5. Drive with lights on. Set odometers to zero. Do a radio check before moving off.
6. Generally speaking only eight or ten cars can make it through a traffic light before it changes. If your convoy is larger than ten, it is best to break it down into separate convoys with a different leader and sweeper. Separate the convoys by approximately five to ten minutes so as to avoid confusion on the radios. You may wish to use different channel frequencies.
7. Signal all turns early and relentlessly.
8. Favour the slow lane when on 4-lane highway.
9. Allow suitable clear distance between you and the car in front of you. This will prove its value as judgments are made whether to stop or proceed through the several stoplights on the route. Always try to keep the car in front of you in sight. Generally keep close in built up areas and traffic, and allow more distance as road speeds increase.
10. Watch the car behind you. If he slows down, you slow down. As the leader sees the car behind him slowing down, it is his cue to slow down also.
11. All members within a team should remain alert for signs of hazards, and maintain "overlapping arcs of vision" allowing each occupant to have a specific quadrant to specifically monitor, giving full 360 degree coverage amongst the team.
12. If a non-convoy driver needs or wants to cut in, let him! There will be plenty of time to regroup on stretches of four lane road or at rest stops.
13. If the convoy gets separated, the group leader will proceed until he can find a safe place to pull over and let the rest of the convoy catch up. If your section of the convoy gets separated, do not dangerously speed to catch up.
14. If the leader or any other driver or assistant sees an imminent stop ahead, simply say "braking" or "stopping" by radio to let everyone know. This can assist drivers behind and improve overall reaction time.
15. Use your best judgment when approaching a long green or yellow traffic signal. Don't be concerned about delaying those behind you by conservatively judging the light. Judge it as you would if you were travelling independently of a group.
16. When the leader sees oncoming traffic on a narrow road it's good practice to alert everyone in the group by radio to warn against passing.
17. Passing: if you need to pass a slow car or cars, it should be done "one car at a time". In other words, don't all move out at the same time and pass at once. Pass as an individual, not as a group.
18. If the group leader misses a turn, do not "knee jerk". Announce the error on the radio and proceed cautiously to a place where the convoy can safely turn around.

## Suggested Checklist For Vehicle Convoys.

This list is for Convoys traveling for longer than one day.

**ALWAYS PLAN FOR THE UNEXPECTED. DELAYS CAN LAST A LOT LONGER THAN YOU ANTICIPATE.**

- 1/ PERSONAL DOCUMENTS.
- 2/ VEHICLE DOCUMENTS AND MAPS.
- 3/ COMMUNICATION ITEMS, HANDSETS, SPARE BATTERIES, SPARE HF /VHF ANTENNAE.
- 4/ COMPLETE TOOL KIT. 2 SPARE TYRES. SPARE INNER TUBES. FANBELT ENGINE OIL. FUEL AND OIL FILTERS. SHOVEL AND MACHETE.
- 5/ FIRST AID KIT.
- 6/ MATTRESS IN PLASTIC SHEETING.
- 7/ SPARE FUEL IN JERRYCANS.
- 8/ DRINKING WATER IN JERRYCANS.
- 9/ CATERING EQUIPMENT AND SMALL GAS STOVE.
- 10/ RUBBISH BAGS. PLASTIC BOWLS.POT SCRUBBERS.
- 11/ SOLAR LAMPS. TORCH AND SPARE BATTERIES. MATCHES.
- 12/ INSECT REPELLANT. MOSQUITO COILS. MOSQUITO NET.
- 13/ TOILET PAPER.

### Parking and securing vehicles

Vehicles should always be parked ready for immediate departure with a clear exit route and no possibility of being “boxed in”. Team members should be clear who has the keys, and how to contact the person if required. The vehicle should be left as secure as possible, with no visible valuables of any kind on display. Secure parking, particularly over-night should be actively sought.

**Trip Plan**

Source		Information	Comments on reliability
Purpose of trip			
Authorisation Granted			
Format for Movement			
	Vehicles		
	Drivers		
	Seating Plan		
	Roles/Responsibilities		
Route Out			
	Primary		
	Secondary		
Route Back	Primary		
	Secondary		
	Safe Houses /Emergency RV's		
	Vulnerable points		
Communications Plan			
Equipment List			
Vehicle Requests / Maintenance			
Emergency Actions	Road Traffic Accident		
	Others		

## Daily vehicle check assessment

Candidate's name: \_\_\_\_\_ Date: \_\_\_\_\_

	Item	Check	Review	Pass
1	Fuel	Fuel tank full or sufficient for the planned journey. Jerry cans for fuel if necessary. Fuel sedimentor and filter clear. No discernible fuel leaks.		
2	Engine oil	Oil level at, or just below, fill level with vehicle on level ground		
3	Other fluids	Cool coolant between minimum and maximum marks in the expansion tank. Screen washer fluid topped up.		
4	Battery	Battery connections and holding bracket(s) are good		
5	Lights	All lights and indicators function, including interior light		
6	Wheels & Tyres	Wheel nuts. Tyre tread depth, tyre damage, especially sidewalls, uneven wear. Spare tyre(s).		
7	Horn	Does the horn work?		
8	Tools and equipment	Jack, wheel spanner, first aid kit, seat belts, small tool kit, essential spares (e.g. fan belt)		
9	Brakes	Hydraulic brake oil; Brakes work		
10	Doors, windows & mirrors	Doors can be locked. Windows are clean and can be opened and closed. Wipers work.		
11	Vehicle documents	Required vehicle documents are in the vehicle or with the driver		
12	Start engine	Oil pressure and battery charging lights come on when ignition switch turned on but go off when engine running		

Assessor's name and status: \_\_\_\_\_

Organization: \_\_\_\_\_

# The Humanitarian Security Environment Today



## Security of What?

Affects Personnel, Information, Property all need to be protected

## Risk

- All activities carry some form of risk. Risk management is how we deal with that risk
- Risk can be described in various ways. These include :
- Risk = Threat or Hazard x Vulnerability
- Risk = Probability x likely Impact (seriousness)
- Vulnerability may depend upon race, nationality, age, sex, ethnic group, language, religion, etc.
- It is fairly easy to define individual threats or hazards these may be a mixture of natural (hazards) or man- made security (threats)

## How will you find out about threats and hazards?

- Speak to people.
- Read the local and international press.
- Discuss the situation with colleagues.
- Look and really listen to what people on the street are saying.
- Analyse not only past and present threats but also be proactive in planning ahead - look for threats that may arise due to political events, holidays, etc.

## Security threats tend to come from 5 main sources:

- Military & terrorist activities
- Politically motivated actions
- Criminal action
- Action by disaffected population
- Action by disaffected staff

You can use the Risk Matrix to look at each threat or hazard and discuss with colleagues the aspects of risk associated with each threat or hazard you list.

RISK MATRIX

SEVERITY OF THE THREAT

VERY HIGH

HIGH

MEDIUM

LOW

VERY LOW


VERY LOW

LOW

MEDIUM

HIGH

VERY HIGH

PROBABILITY OF EVENT HAPPENING

UNHCR ESS & eCentre 34 29 August 3 September, 2004  
Pranburi, Thailand

## Using the Risk Matrix

This lets us record both the degree of probability and likelihood of impact, for a more rational understanding of overall risk

You will need to plot various threats/hazards on this matrix in order to discuss and understand the relative risk of various events that may occur. This tool and its use as an exercise are subjective, so it is best done by groups in order to get group consensus if possible

## Severity Of The Event

After plotting several threats on the matrix, try to determine a line or threshold of acceptable risk (again this will be a very subjective line!)

Note that after plotting the threats, you can now rank risks (from highest risk downwards). Remember that this will vary greatly between agencies.

The goal of risk management is to push each threat down towards the left-hand corner of the matrix. You should actively look for ways and strategies to accomplish this remembering that there may be other factors ready to push threats up towards top right hand corner

Regular revisiting this matrix and updating will help show you trends in the overall security environment, as well as help you evaluate if you are really reducing your risk in any significant ways.

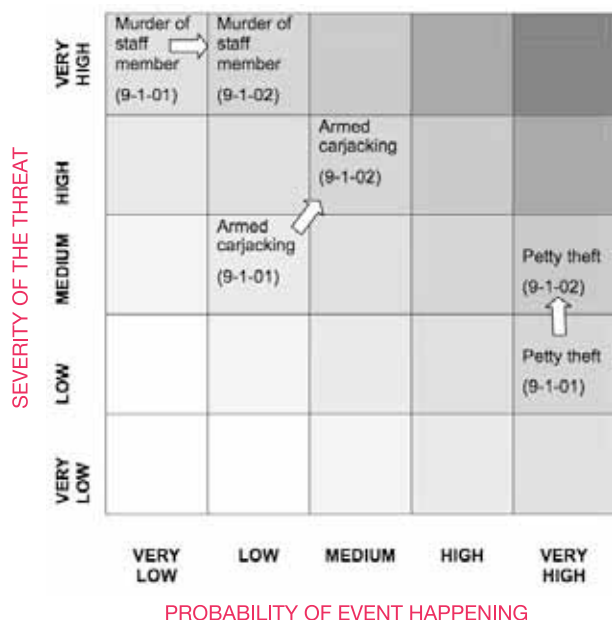
## Risk Management

A Risk Management Approach includes the following elements:

- Identifies each Risks
- Assess Risks – Each risk can be tackled in one of three ways:
- Risk Prevention Risk Reduction Risk Acceptance and Preparedness
- Action - Monitor performance/change

## To do in Field

- Meet with staff and do Risk Assessment (plot out threats on Risk Matrix)
- Prioritise Risks
- Look at ways of preventing / minimising / accepting and preparing for) main risks



## Sample Risk Matrix Recorded Over Time

Note: The reason for re-examining the risk matrix at regular intervals is to establish trends. Are things getting safer or more dangerous? Do these changes require changes to the overall security planning and safety measures? Who decides?

# Team Management



# Deployed AusMAT Team Medical Welfare



## Introduction

AusMAT Team Leaders along with EMA and AusAID will have responsibility for deployed Australian team medical care. This will cover both preventative measures to maintain health in country (in conjunction with environmental health staff), and in preparation for and management of any illness or injuries suffered by team members. The following is not an exhaustive summary, but highlights some of the issues and solutions available. Specific risk assessment and standard operating procedures will be in place during your deployment, and you should be familiar with them. Policies and procedures under development by the departments of the federal government will continue to refine issues raised in this text. Recommendations and comment made are in generality, and should be discussed and questioned openly before your deployment, in the interests of taking ownership of your own welfare and safety.

## Pre-departure

AusMAT teams will be comprehensively vaccinated prior to deployment. Seroconversion time for all vaccines is well known and available in the vaccine product literature. This ranges from days or weeks (e.g. typhoid, 2 weeks) to months (e.g. Hepatitis B, 6 months or more). This means vaccinations or boosters just prior to departure are ineffective. AusMAT team members should have some form of fitness and medical assessment during their induction into AusMAT. Medical checks may be repeated just prior to departure, particularly for austere deployments with difficult extrication routes. AusMAT members who keep themselves healthy and fit can expect to perform better on deployment and deal with heat acclimatisation and other challenges faster. (see heat acclimatisation chapter).

## Prophylaxis

Malaria prophylaxis remains the most likely form of prophylaxis used on deployment (see section on travel and malaria). This will be according to best CDC advice on efficacy and resistance level for area of deployment. Several options may be available to those who have reactions to specific drugs (e.g. doxycycline). Members should remember to ask about receiving tablets several days prior to deployment if feasible, to begin prophylaxis, and to either have enough tablets for your entire expected deployment or a clear plan to receive more medications while deployed (least preferred option). Access to post exposure prophylaxis should be considered by teams including HIV, TB, Hep. B, tetanus, rabies and snake bite anti-venom.

## Environmental health

Environmental health practitioners can be vital members of the Australian mission. Their skills and value becomes clear on reading the environmental health chapter of this text. Personal responsibility is carried by each team member in ensuring they keep themselves healthy and comply and assist the environmental health team in maintaining a safe and healthy camp. Some key risk areas to consider include heat illness, gastroenteritis (either from patients, or through poor camp hygiene), vector and rodent/animal control (e.g. malaria, dengue, rabies etc). Preventive measures will aim to make treatment of staff a rarity.

This includes thrice daily weight measurement in severe heat climates and access to emergency cooling baths if required.



Makeshift emergency cooling bath, NTPFRS Tactical response group.

### Personal medical equipment

Personal supply of simple analgesics, anti-nausea medications if required, oral rehydration salt (ORS), anti-diarrhoeal agents if appropriate etc may be provided in your packs, but if not, should be considered as part of your own personal equipment. You may also consider a small supply of your own intravenous needle, line, swabs etc in case of personal injury. This also may be supplied as standard by your AusMAT team. Candidates are responsible for supplying their own personal medications, enough for the duration mission and possible delays.

### Australian responder illness and injury

Medical illness amongst staff needs timely and appropriate care. Mission specifics and time from activation to response will vary, but planning to allow treatment of minor to major illness and injury in any responding member will be of high priority to the team leadership and Australian agencies. Specific packs designed for team health ranging from minor complaints to full resuscitation capacity may be available. Staff skill and access is unlikely to be problematic, but ready supply of Australian standard care for life threatening illness, during a mission tasked as general practice or basic humanitarian aid, needs careful planning.

General practice type consultations need discussion in a confidential manner, by appropriately skilled staff. This “sitting” type consultation area can expect to handle basic complaints of ENT, gastrointestinal upset, rashes etc, all of which may be common on mission. A small screened area to allow appropriate examination needs to be available. Psychosocial complaints need to be remembered as a real risk to deployed members, and be considered during consultation. Lack of privacy during discussions will mean these issues are unlikely to be volunteered, reinforcing the need for such an area. Deployed team members may occasionally require overnight stays in a ward bed. Ideally this should be a specific staff area, and will require appropriate equipment, medications and staff for appropriate observation and an on-call roster or alert system.

Major resuscitation (illness or injury) needs to be planned for. Options may include but not limited to; purposely set up resuscitation bay for staff use, use of bays within response medical facility as required, or plans for early evac after “pre-hospital” aid has been rendered, when working in the field.

### Evacuation

Evacuation of the sick or injured need careful consideration prior to deployment, and will depend on accessibility and standards of local health care, distances and transport options available. Evacuations may be urgent or non-urgent, but will almost always require a second (or more) team member to accompany and assist.

### Return from deployment

On return from deployment, AusMAT members will generally be offered some form of medical screening. Issues to consider include continuation of malaria prophylaxis for the required duration on return (e.g. 2 weeks for doxycycline), worming tablets on departure from scene, and post return checks for infectious disease like TB etc as appropriate, and dependant on exposure risk. Immediate formal psychological debriefing has been shown poorly effective in preventing post traumatic stress disorder, and in some cases harmful in a Cochrane review. (Rose S, Bisson J, Churchill R, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews 2002, Issue 2. Art. No.: CD000560. DOI:10.1002/14651858.CD000560.)

Specific procedures will be in place to offer support to those who require it, and various measures to ensure a review at an appropriate time (usually 3 months) will be offered. Some agencies will require this to be conducted prior to any further deployments.

If you feel unwell on return from deployment, particularly if you have fever or night sweats etc. ensure you present to your GP or health centre and state you are a “returned traveler”. Tropical and infectious disease needs to be specifically excluded as a cause of your illness.

# Managing Stress

This brief guide has been prepared in consultation with Response Psychological Services and various UN texts that provide information for International Volunteers on general mental health and psychological considerations of living and working overseas.



## Coping with stress

### Introduction

There is insufficient awareness of the impact on alertness, performance and judgement and the resulting negative implications in terms of operational mistakes and harmful effects on the health of staff exposed to stressful situations. Police, fire-fighters and emergency medical personnel all experience strong emotional reactions to the emergency and disaster situations which they are required to manage. For that reason, it is now standard operating procedure in many countries for these individuals to be provided with appropriate training to enable them to carry out their functions without adverse effect.

Staff working in a disaster zone are often exposed to the same types of traumatic situations. It is therefore essential that all personnel serving in the field be fully briefed regarding all aspects of stress and stress management.

### Definition of terms

- Stress: Any demand or change that the human system (mind, body, spirit) is required to meet or respond to.
- Distress: Any stress that occurs too often (frequency), lasts too long (duration) and is too severe (intensity).
- Critical incident: An event outside the range of normal human experience which is distressing to almost everyone. Such events are usually sudden and life-threatening, and often involve physical or emotional loss.
- Cumulative stress: Stress which builds up over time. Some issues may be large and of long duration, while others may be small or just part of the problems of everyday life.
- Defusing: A process which allows those individuals involved in a critical incident to describe what happened and to talk about their reactions directly after the event - defusing is usually carried out by one's peers who have been trained in this area.
- Debriefing: A process designed to lessen the impact of a critical incident. It is a structured intervention by specially trained personnel. It occurs in an organized group meeting and is designed to allow and encourage those involved in a critical incident to discuss their thoughts and reactions in a safe, non-threatening environment. Ideally, it takes place 48 to 72 hours after the critical incident.

## Understanding Mental Health

Mental health is a parallel to physical health. It comprises all the aspects that make up the psychological life of the individual including thought, perception, emotion and behaviour. Although current research indicates that mental ill health and disorder will affect 1 in 5 Australians during their lifetime, such experiences are often transient and effective treatment options are available for most mental health issues. We are all prone to experience difficulties in life, and our ability to confront and overcome these issues is a primary consideration in determining our mental health.

Generally speaking, a mentally-healthy individual is someone who:

- Confronts life's problems
- Identifies solutions
- Overcomes obstacles
- Engages in rewarding behaviours
- Takes positive control
- Functions effectively vocationally and socially
- Is 'their own' person

### Indicators of Mental Health

The external signs of mental health issues are wide and varied. Recognising these signs can be an important first step in providing support to others.

Some examples include:

- Poor work performance
- Behavioural problems
- Social withdrawal
- Mood swings
- Low frustration tolerance
- Increased anger and/or aggression
- Substance abuse
- Suicidal ideation &/or self-harm
- Financial problems

### Maintaining Good Mental Health

There are many ways through which we can improve and maintain our own mental health. Central to this is a readiness to recognise, confront and identify solutions to our own problems. Some considerations in maintaining mental health include:

- Be proactive in maintaining self-esteem:
- Be honest with yourself
- Be willing to improve
- Do your best
- Set your own goals
- Take care of your mind and body
- Exercise regularly
- Eat the right foods
- Get enough rest
- Plan social and personal activities
- Limit or control stressful influences

*Maintaining a personal routine that includes some form of regular social interaction and suitable physical exercise is a simple but powerful way of maintaining mental balance.*

Physical health will help maintain life. Mental health will improve overall quality of life. Maintaining your own mental health should be a constant consideration and ensuring that others are supported in managing theirs should be also. Stress can be defined as:

*‘The physiological and psychological reaction that occurs when we perceive an imbalance between the level of demand placed upon us and our capability to meet that demand’*

Response Psychological Services Pty Ltd. 2009.



## What is stress?

Stress can be defined as any change or demand that the human system (mind, body and spirit) is required to meet or to respond to. There are normal stressors such as those consistent with life: breathing, blood circulation, walking, eating, talking and playing. These functions are common to everyone and are part of everyday life. Without these stressors and other physical demands on the human system, you would not continue to live.

The more you know and understand about stress, the better prepared you will be to manage and control its effects. Stress becomes a problem when it occurs too often (frequency), lasts too long (duration), and is too severe (intensity). In these circumstances, distress occurs. It is extremely important to note that what may be distressful for one person may not necessarily be distressful for someone else. Your perception of the event, the degree of threat you feel and the amount of control you have over the circumstances most often determine the degree of distress you will experience.

Some factors which influence your perception and your control of distress are who you are and what your past experiences have been. Your education, your skills, your philosophical approach to life, your age, your sex, your level of physical fitness and your personal esteem are all factors which can influence the degree to which you will be affected by a given distressful event or a series of events.

Given the frequency, intensity and duration of a situation, anyone can become a victim of stress. In 1936 Dr. Hans Selye made an important discovery - when threatened, the body always reacts with the same general adaptive mechanism. He defined this concept as follows:

### The alarm phase

In order to understand the effects of both useful and harmful stress, it is necessary to understand the mechanisms of a basic life-protecting reaction. In the presence of a threatening or dangerous situation, the person reacts with the “fight or flight” response. This is a reaction which causes our adrenaline to increase and prepares us to run or to fight. If we respond in a physical manner, such as by running, fighting or even with verbal aggression, much of the stress-produced fear, anger or hostility can be greatly reduced or dissipated altogether. The “fight or flight” response is a primitive physical protective reaction. In today’s society, it may not be appropriate to respond to some threats in a physical manner.

### The adaptation phase

When a stressor continues without being resolved, the intensity of the alarm stimulus is often lessened but not lost, and the person enters what Seyle calls the Adaptation Phase. In this phase, vital biochemical, physiological, psychological and spiritual resources are spent to sustain the person against the original distressors. However, adaptation or adjustment to the situation is not a solution.

### The exhaustion phase

After an undetermined period of time, which varies from person to person, as a consequence of long-term distressors or daily cumulative stress, an individual may begin to exhibit signs of breaking down. This may be manifested in the form of physical, mental or behavioural syndromes which are symptoms of long-term, unresolved distress. Some common symptoms are:

#### Physical

- Fatigue, Back pain, Headache, Ulcer, Cumulative stress management

#### Psychological

- Memory loss, Poor concentration, Decrease in esteem, Depression

#### Behavioural

- Verbal outburst, Increased smoking, Increased alcohol use, Eating disorders

What can be done about stress? Most people suffer from cumulative stress which results from a build-up of stress over time. Some issues may be large and of long duration. Others may be small stressors of everyday life. Cumulative stress must be recognized before it leads to burn-out. Some of the small daily frustrations which can lead to cumulative stress are, inter alia:

Housing (lack of privacy or comfort, noise, shortage of water, cold heat); Travel (risks, threats, roadblocks); Food (shortages, lack of variety); Immobility or lack of activity; and

### What should you do?

Cumulative stress first leads to unproductive hyperactivity, then to physical and emotional exhaustion and finally to burn-out. You must be self-disciplined and know your limits. Accept the fact that you cannot take care of others without also taking care of yourself, and be aware that everyone is primarily responsible for his/her own stress. Understand that stress is inherent to duty in the field.

### Stress & Stress Management

#### Coping with stress

Every person needs to take steps to control stress in their life. A simple combination of time management, communicating feelings, proactive control and relaxation is an effective approach:

- Organise your time
- Talk with others
- Limit stressful situations
- Learn relaxation techniques
- Try new approaches

#### *‘The mind is ever ingenious in making its own distress’*

Oliver Goldsmith, 1728-1774, Anglo-Irish Author, Poet, Playwright

Because we often carry our stress for some time and have difficulty overcoming it alone, talking with others and using professional counselling can be invaluable in finding permanent solutions.

Stress affects all of us throughout our lives although its impact can be effectively managed.

#### Stress Symptoms

The symptoms of stress are exhibited in physical, mental, emotional and behavioral ways:

Physical	Mental	Emotional	Behavioural
Tension Fatigue Sleep Disturbances Indigestion Nausea Diarrhea Dizziness Breathing problems Excessive sweating Sexual difficulties	Concentration Memory Judgment Decision Making Self confidence Self Esteem Cynical thoughts Negativity	Fear Hyper-alertness Irritability Intolerance Mood swings Anger Depression Anxiety	Interpersonal Social withdrawal Risk taking Expression Over-reactions

## Dealing with Separation

During your assignment you will inevitably miss home, friends, family and normal routines. A major trap to avoid while In-country is failing to establish networks, routines and communication with home.

*‘People are lonely because they build walls instead of bridges’*

Joseph Fort Newton

When arriving in-Country, some important considerations include:

- Identify people you can trust and feel comfortable around
- Establish networks in-country and make the most of early opportunities for social engagement
- Think about your personal routine – what you do at home and what you do when on assignment?
- What are your methods of communicating with home and others In-country? – make a routine of contacting others and ask friends and family to correspond with you
- Think about Skype, video, digital diaries, digital photo servers and of course, letters!
- Prepare two diaries or calendars before departure logging shared goals and events with your partner, family or friends
- Talk about conflict resolution and managing arguments before they happen
- Consider how you are managing stress and dealing with issues on your assignment
- How are you maintaining your diet and personal health?
- You should arrive with an intention to quickly develop a schedule that allows you to socialise, stay healthy, keep occupied and have fun.
- Coping with personal issues should be a key consideration and you should make every effort to seek professional help if problems affect you during your assignment.

Importantly, don't forget to:

- Think about your objectives and keep them in mind throughout your assignment
- Have fun and enjoy the time while you are In-Country
- Seek professional help if you experience difficulty

## Adjustment & Cultural Impact

Everyone who arrives in a foreign culture is affected in some way by their experience.

Culture shock was first defined in the 1960's by Dr. Kalervo Oberg, an anthropologist who stated that culture shock is initiated by “the anxiety that results from losing familiar signs and symbols of social intercourse”.

Dr. Oberg went on to define six aspects of cultural shock:

1. Strain due to the effort required to make necessary psychological adaptations.
2. A sense of loss and feelings of deprivation regarding friends, family, status, career and possessions.
3. Being rejected by and/or rejecting members of the new culture.
4. Confusion in role, role expectation, values, feelings and self-identity.
5. Surprise, anxiety and even disgust and indignation after becoming aware of cultural differences.
6. Feelings of impotence due to not being able to cope with a new environment.

From this definition of cultural shock, Oberg developed a six-month model, which is still in use today. Basically, the model defines one's behaviour in terms of activities, attitudes, emotions and physical responses associated with each month of a six-month time frame, although the cycle or parts of it can be repeated at any time with a variety of reactions and time periods.

This six-month model considers the process of culture shock and adjustment as follows:

**Pre-Departure** Excitement and apprehension predominate outlook. Preparing for the departure with packing, farewells, administration are main focus.

**First Month** Excitement of travel and novelty of food, culture and environment. Need to learn basic of local language becomes a focus. Integration and activities with peers and establishment of routine is critical.

**Second Month** Some differences experienced as being unpleasant. Inconveniences of accommodation, language barriers, lack of familiarity more noticeable. Stressors may increase likelihood of colds, flu, sickness and weight changes.

**Third Month** Often signals the lowest point in the adjustment period. Language skills and personal productivity may stagnate. Family, friends and routines back home are missed greatly. Fatigue, boredom, rejection of environmental stressors and physical impact are common.

**Fourth- Fifth Month** Often marked by a returned enthusiasm for friends, locals and situational routines. Improved openness to novelties and integration socially and culturally. Emotions, confidence and physical health often improve and stabilize.

**Sixth Month** Establishes normality of lifestyle, positive routines and social integration. Stressors are accepted or dealt with effectively, and you feel comfortable in your environment.

Although everyone does not follow this cycle, an overwhelming majority does.

*Often for Volunteers the same process applies over a shorter timeframe with most individuals having adjusted positively by the third month of being in country.*

The advantages of being aware of this cycle are that you will be easier on yourself, your friends and family members, when you or they are experiencing a new period, because of the change in culture. You can also be a great help in explaining things to others who may not understand what they are experiencing. It is important to remember that certain aspects of culture shock can be triggered at any time, and are not necessarily limited to the initial six-month period following relocation.

Some considerations to minimise the negative impact of this include:

- Taking the time to research the history, politics, culture, language and behavioural norms of your destination
  - Expressing respect by observing cultural expectations
  - Maintaining your own culture without offending others
- Key traits that support individual resilience and coping in a foreign culture include:
- Good physical and mental health
  - Ability to confront issues/courage
  - Adaptability and perseverance
  - Resourcefulness
  - Sociability and networking
  - Independence
  - Broad mindedness, acceptance
  - Integrity

- Willingness to compromise
- A love of travel
- A sense of humor
- An adaptable palate

A desire to live life to its fullest

Culture shock can affect anyone and it is important to remain aware of the resources available to you if you are threatened or finding it difficult to cope.

Seek counselling support if you are unable to overcome the early impact of culture shock and adjustment.

## Living with Others

Living with others can often form one of the greatest challenges when on assignment. Domestic arrangements should be supportive and conducive to mental health, not distracting and negative. To avoid this, every effort should be made to prepare and develop yourself individually to accept and maintain a comfortable living situation.

*'If you live in the river you should make friends with the crocodile'*

*Indian proverb*

Some basic considerations for living with others are:

- Being prepared to accept other's views and ways of doing things
- Being willing to express your own preference and try not to allow your own comforts to be eroded
- Remaining proactive in identifying and effectively resolving differences and problems
- Although you might be coping well with your own assignment, you also have a critical role to play in supporting other ambassadors:
- Accept stress responses in others
- Be available and approachable
- Listen
- Be careful with advice and do not judge
- Know your limits
- Be sensitive to changes in people

## Conflict Management

Overseas assignments involve numerous forms of communication. An ability to resolve differences effectively can prove critical to a successful assignment in terms of living and working with others.

Essentially, conflict involves:

- Two or more interdependent people
- Perceived differences in goals, values, beliefs, needs, desires or ideas
- A barrier to interpersonal cohesion

There are typically four distinct types or stages of conflict:

### Latent Conflict

- No outward signs
- Preconditions for conflict exist
- Goal differences

### Perceived Conflict

- Negative perceptions begin to develop

### Felt Conflict

- Attempts to resolve
- Manifest Conflict
- Active engagement

### Resolving Conflict

Regardless of the nature of the conflict itself, effective resolution requires 5 phases:

- Phase 1: Identify issues
- Phase 2: Define issues
- Phase 3: Generate solutions
- Phase 4: Select solution(s) and implement
- Phase 5: Evaluate

### Effective conflict management incorporates:

- Sound communication skills
- Listening
- Reflecting
- Speaking with a purpose
- Managing emotions
- Employing suitable styles
- Engaging in a phased process for outcomes

## Communication Skills

### Three common problems in communication are:

- Parties may not be talking to each other
- Other party may not be hearing you
- Misunderstandings

### Overcoming communication problems:

- Listen actively and acknowledge what is said and heard (reflection)
- Speak to be understood
- Speak about how you see the situation, not how they should, could or would see it
- Speak for a purpose and a solution

### Take steps to manage the emotional content of your communication:

- Seek release but ensure closure
- Seek assistance if your emotions are a barrier to effective Communication
- Focus on the issue at hand, not how it makes you feel
- Assume positive responsibility

### Make an effort to manage emotions in others by:

- Listening
- Communicating respect
- Avoiding retaliation
- Stating your own feelings and objectives



### Critical Incident

Unfortunately, accidents and traumatic events are bound to happen when travelling or at home.

**Traumatic events are defined as:**

*“an event or series of events outside the range of usual human experience”*

Such events include:

- serious threat to life
- threat to the life of someone close to you
- suicide
- destruction of living quarters or community
- seeing another person killed or injured
- any incident which would cause considerable stress to most people

All individuals will experience some degree of reaction to such events.

Such reactions may differ from person to person and professional assistance is available. Psychological attention provides a professionally supported approach to working through the impact of a traumatic event:

Response Psychological Services Pty Ltd. 2009.

*Critical incident stress is a normal reaction to an abnormal situation. Reactions may be physical, cognitive or emotional. Reactions may also develop over time. The table below outlines normal immediate and delayed reactions to a critical incident:*

Immediate reactions	Emotional	Cognitive
Physical Nausea Muscle tremors Sweating Dizziness Chills Rapid heart rate Hyperventilation High blood pressure	Anxiety Anger Fear Irritability Guilt Grief Hopelessness	Confusion Inability to decide Impaired thinking Memory loss.

The severity of an individual's reactions to a critical incident depends on several factors:

Physical	Resentment	Flashbacks
Emotional	Poor concentration	Nightmares
Cognitive	Substance abuse	Numbness
Fatigue	Alienation	Restlessness
Feeling abandoned	Memory problems	Depression
Decreased attention span	Sleep difficulties	
Startle response	Withdrawal	

Research and experience provide a variety of techniques to assist you both during and after the event.

During the critical incident:

- Recognize the signs of critical incident stress,
- Maintain a positive attitude;
- Try to control breathing - slow and regular;
- Focus on immediate task;

After a critical incident:

- Stay in contact with others by talking;
- Care for yourself - food, water, clothing, rest; and If prolonged exposure, take breaks and rotate tasks
- Talk about the event, what you saw, heard, smelled, did
- Talk about your reactions, particularly how you felt;
- Practice stress management techniques, such as:
- Deep-breathing exercises;
- Progressive relaxation;
- Meditation;
- Physical activity;
- Music, reading;
- Humour, to facilitate acceptance of reactions
- Participate in critical incident stress defusing as soon as possible after the event and later in critical incident stress debriefing. Critical incident stress defusing

Critical incident stress defusing occurs in a group meeting of those involved, directly after the event. The purpose of critical incident stress defusing is to allow those involved to describe what happened and to talk about their reactions, as well as to provide information about normal stress reaction, support services and details of the follow-up critical incident stress debriefing.

### Critical incident stress debriefing

Debriefing is a military term for a report which a subordinate submits on his mission and the conclusions drawn by his supervisor. By extension, it is used in psychology to describe the detailed account which is given on return from a mission, concerning the facts and emotions experienced in the field and the thought to which they give rise. Critical incident stress debriefing (CISD) is a process designed to lessen the impact of a critical incident. It is not designed to provide counselling, but rather to provide a safe opportunity to deal with immediate reactions to a stressful, traumatic situation. It includes:

- a) A structured intervention by specially trained members of a critical incident stress team; and
- b) An organized group meeting which allows and encourages those involved in a critical incident to openly discuss their thoughts and reactions in a safe, non-threatening environment 48 to 72 hours after the critical incident.

For most people, most symptoms will diminish both in intensity and in frequency within a few days or weeks. The process will be greatly assisted by a formal debriefing and by discussing concerns with trusted family members and friends.

### Post-traumatic stress disorder

*If the symptoms last more than a month, they may lead to post-traumatic stress disorder (PTSD). This is a more serious condition, a complication of psychological stress which could be compared to a wound that will not heal naturally. To be diagnosed, the following factors must be present:*

#### Trauma

A persistent tendency to relive the trauma in the form of memories, nightmares, flashbacks or intense emotional reactions to any event reminiscent of the trauma

A tendency to avoid any thought, emotion or activity which reminds one of the traumatic event

A marked hyperactivity, accompanied by an exaggerated startle reaction, a quick temper and sleep disorders, particularly upon falling asleep; and

A persistence of these symptoms for at least a month. Diagnosis and treatment of PTSD must be carried out by a specialist.

### Suggestions for family and friends

Anyone who has undergone a traumatic experience will be changed by what he/she has experienced. In the aftermath of this incident, the various emotions which the individual experiences are perfectly normal. It is the experience/event which is abnormal. The emotional reaction to this experience should be considered as a psychological wound. As with all wounds, you can best help the individual by:

- Listening carefully. A person who has overcome a traumatic experience must learn to talk about the event and the emotions he/she felt at the time with those closest to him/her;
- Spending time with the affected person-;
- Offering your assistance and listening ear;
- Reassuring them that they are safe and normal-; Helping them with routine tasks like cleaning, cooking, caring for the family; Allowing them some private time;
- Not taking their anger or other feelings personally;
- Telling them you are sorry such an event has occurred, and you want to understand and assist them, and
- Calling for help or support as soon as you feel you need it.

### Suggestions for family and friends

Anyone who has undergone a traumatic experience will be changed by what he/she has experienced. In the aftermath of this incident, the various emotions which the individual experiences are perfectly normal. It is the experience/event which is abnormal. The emotional reaction to this experience should be considered as a psychological wound. As with all wounds, you can best help the individual by:

- Listening carefully. A person who has overcome a traumatic experience must learn to talk about the event and the emotions he/she felt at the time with those closest to him/her;
- Spending time with the affected person-;
- Offering your assistance and listening ear;
- Reassuring them that they are safe and normal-; Helping them with routine tasks like cleaning, cooking, caring for the family; Allowing them some private time;
- Not taking their anger or other feelings personally;
- Telling them you are sorry such an event has occurred, and you want to understand and assist them, and
- Calling for help or support as soon as you feel you need it.



# Returning Home

Just as it is sometimes difficult adjusting to another culture, people often experience problems returning home to their own culture and society. A moderate balance of integration with the host culture and retaining your own cultural beliefs is an important determining factor in your ability to transition between places.

Although it is important to do some of what Romans do when in Rome, it is critical to your own mental health that you can become less Roman when returning home. Only a small part of your host country will fit in your luggage!

Think about how you will prepare yourself for homecoming during your assignment. This includes the process of farewelling others you may have become close with and reorganising your routines and personal management.



### Homecoming

The homecoming phase of the deployment cycle presents a range of challenges to most deployees. Although typically excited to be back, the deployee will often experience a range of thoughts and emotions through the readjustment process including:

- Lack of engagement as the tempo of deployment contrasts with domestic and work routines
- Reverse culture shock and readjustment stress as new routines are established
- Possible jealousy expressed by workmates, family or friends depending on their view of the deployment
- Readjustment to possible changes in home routines as tasks and chores may have been reassigned during absence
- Family members may have developed capabilities and confidence in handling tasks that were formerly the responsibility of the deployee
- Lack of stimulation at home and work
- Difficulties reconnecting emotionally with loved ones, especially young children
- Attitudes may have changed toward materialism and resource usage/wastage
- Life priorities may change
- Adjusting to dietary and sleeping differences
- Survivor guilt may be an issue for some

Considerations for returning home include:

- Accepting changes in self and others
- Committing adequate time to family, friends and loved ones
- Talking with others about your deployment and their experiences during your absence
- Staying connected with other deployees or peers with similar experience
- Seeking occupation and engagement through work or other routines such as personal, social or sporting outlets
- Exercising regularly and maintaining a balanced diet
- Avoiding excessive use of alcohol

Following these considerations will significantly improve the readjustment process. Most deployees will readjust with the first 2-3 weeks of returning home while some may take up to 3 months before feeling fully at home. Key determinants of this include re-establishment of routines and vocational or other engagement.

Professional debriefing and counselling is a useful resource to draw on if the readjustment process is proving difficult at any time, especially if the deployee is not feeling at home after 2-3 months. Returned deployees should seek professional assistance immediately on return if they have been exposed to traumatic events during their deployment.

The Emotional Stages of homecoming include:

- Re-establishing relationships
- Adjusting to changes
- Getting back on track

### Support Options Available

Confidential counselling is available to all Volunteers via telephone, email, skype and in person pre-departure and on return.

Counselling provides a professional, objective and confidential forum to discuss issues and identify effective solutions. 24-hour telephone counselling is available for all personal issues that might impact on you during your assignment.

Support options include:

- Psychologist
- Social Worker

Counsellors should have extensive experience in:

- Overseas and remote deployments
- Cross-cultural issues
- Clinical counselling
- Trauma debriefing

### When to seek counselling

Counselling should be accessed at any time you are experiencing significant difficulties dealing with issues during your assignment.

Specific examples include:

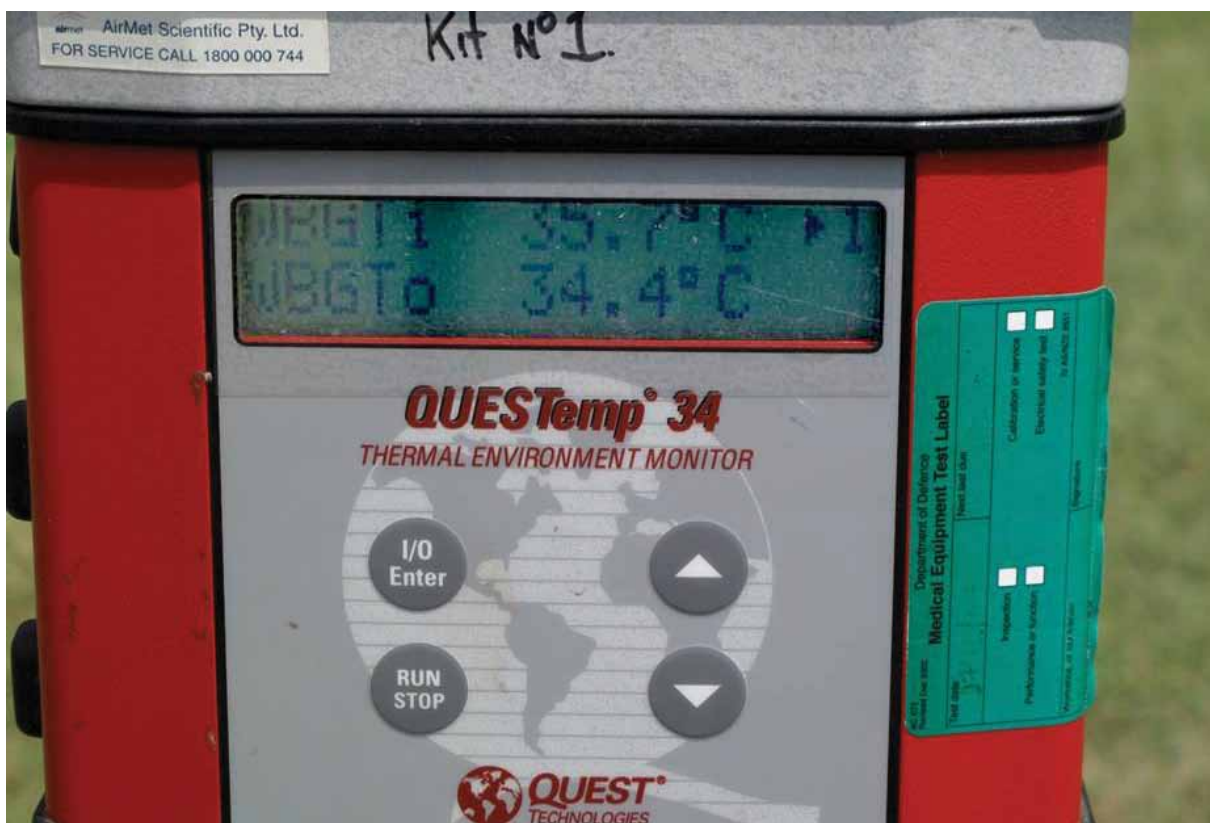
- Difficulty coping
- Stress
- Depression
- Frustration
- Adjustment difficulties
- Interpersonal problems
- Problems at home
- Critical Incidents
- Any personal issue

All access to counselling to AusMAT team members remains confidential and your initial session can be organised either by direct referral or via your in-country management.

Response Psychological Services Pty Ltd. 2009.

# Fitness and heat

Deployment requires adjustment to local customs and conditions, including the local environment. Northern Australia and South East Asia are considered tropical regions where high ambient temperatures are common and may be accompanied by seasonal elevation of environmental moisture. AusMAT deployments to tropical regions will be influenced by the hot and possibly humid conditions, as responding in the heat places the additional impost of body heat storage on AusMAT members. Physical fitness and heat acclimatisation are the 2 key strategies to maximise tolerance in hot and humid conditions. The following recommendations are based upon the literature and practical experiences while working with athletes and emergency responders based in Darwin, NT over the past 10 years.



### Physical Fitness

AusMAT members possessing physical fitness through chronic endurance training will adapt rapidly to new climates, exhibiting greater tolerance than untrained counterparts. Adaptations to chronic exercise mimic those of heat acclimatisation, therefore those AusMAT members possessing physical fitness have achieved partial heat acclimatisation. A minimum 12 weeks of physical training incorporating at least 3 sessions per week is recommended prior to the commencement of any heat acclimatisation program. In this regard, AusMAT members should maintain a level of fitness year round.

There are many options to achieve the suggested minimum of 3 sessions each week. To assist AusMAT members, a point based system is recommended to quantify training and compare to the suggested standard of 120 points per session. Points are calculated by multiplying the duration of the session (in minutes) by the intensity or rate of perceived exertion of the session from Table x. For example, a 45 minute session that was rated as hard (equivalent to 5) would be calculated as follows  $45 \times 5 = 225$  points.

The points system can be utilised for all activities whether they are self paced or not. So aerobics sessions conducted at a fitness centre can be calculated by this method, it's simply a matter of rating the session. Examples of sessions that achieve the minimum 120 points are:

- 60 minutes of walking (2/fairly light) = 120 points
- 45 minute aerobics class (4/somewhat hard) = 180 points
- 50 minute 'bootcamp' session (5/very hard) = 250 points
- 40 minute social basketball league game (3/moderate) = 120 points
- 30 minutes of rowing machine intervals including rest periods (5/hard) = 150 points

Individual pacing will determine the rating of each session so these examples are just that, suggestions to get you started.

Table x. Rate of perceived exertion scale

Rating	Descriptor
0	Nothing at all
0.5	Very, very light
1	Very light
2	Fairly light
3	Moderate
4	Somewhat hard
5	Hard
6	
7	Very Hard
8	
9	
10	Very, very hard (Maximal)

### Heat Acclimatisation

Heat acclimatisation can be defined as the adaptation to sustained thermal stress in the natural environment. While acute heat storage causes immediate changes in cutaneous blood flow and sweating, repeated bouts of thermal stress lead to physiological and perceptual adaptation thereby improving tolerance of hot and humid conditions.

Adaptations improve heat loss via both dry and evaporative heat exchange through adaptations that take ~14 days to confer (Table 1.). Such adaptations are best stimulated by physical activity as opposed to passive acclimatisation. Simply being in a hot climate will not confer heat acclimatisation; body heat storage is the stimulus.

The purpose of each session is to elevate and maintain core temperature beyond 38.5°C throughout the session. Given the lack of valid core temperature data during training, thermal sensation ought to be relied upon to determine pacing, with an overall perception of very warm to hot considered appropriate during the sessions. A concomitant high sweat volume should also be experienced.

Table 1. Adaptations Observed during Heat Acclimatisation

Week 1	Week 2
Expansion of plasma volume	Decreased resting core temperature
Increased cutaneous blood flow	Decreased exercise core temperature
Decreased heart rate	Increased sweat secretion
Decreased perception of effort	

## Factors Influencing Heat Acclimatisation Status

**Obesity.** In addition to poor fitness levels, obesity is a factor associated with a prolonged periods to develop heat acclimatisation. Obesity is also a predisposing factor for illness when exercising in the heat, as heat storage is augmented by the insulative properties of adipose and its high specific heat content. Consideration of these factors are necessary to ensure appropriate activity is undertaken in the heat.

**Age and Gender.** Heat acclimatisation appears to be equally as effective for individuals irrespective of age or gender when matched for physical/anthropometric variables (Avellini et al., 1980).

**Seasonal Influence.** It's intuitive to expect that daily activity during the summer months would assist the achievement of heat acclimatisation. Behaviours such as avoiding the hottest part of the day and the use of air conditioning limit physiological strain and the associated stimulus of adaptation. Unless specific sessions that induce substantial heat storage are undertaken by AusMAT members during the summer months, minimal benefit is anticipated.

**Summary.** AusMAT members that undertake chronic endurance training will be partially heat acclimatised year round, an advantageous physiological state for deployment to tropical regions. Conversely, low fitness levels and/or obesity extend the period of acclimatisation, classifying these AusMAT members in a less ready physiological state for deployment. Age and gender pose no barrier to development of heat acclimatisation and the summer months cannot be relied upon to confer heat acclimatisation without undertaking specific sessions.

## How to Become Heat Acclimatised

The Acclimatisation Table details a 14 day program to achieve heat acclimatised status. AusMAT members with high levels of physical fitness will achieve heat acclimatisation in less than 14 days. These recommendations are suitable for individuals with minimal to moderate training history. The objective of each session is to elevate and maintain core temperature beyond 38.5°C. Given the lack of valid core temperature data during training, thermal sensation ought to be relied upon to determine pacing, with an overall perception of very warm to hot considered appropriate during the sessions. A concomitant high sweat volume should also be experienced.

The sessions should commence prior to deployment where possible. If residing in a cool climate, utilise additional layers of clothing to promote heat storage and train in the warmest part of the day. Tropical regions provide the optimal environment for heat acclimatisation.

Particular attention should be given to heat storage during the initial 4 sessions, as heat related illnesses are most likely to present early in the program. Despite the low point scores required during these sessions, a harsh climate and lack of heat acclimatisation can result in high core temperatures. AusMAT members should train with a partner and/or close to assistance during these sessions. A day without training should round out the initial week, allowing recovery for the higher volume sessions of the second week. The required point scores progress such that sessions of 300 points should be achieved in the later stages of acclimatisation.

**Acclimatisation Table Heat Acclimatisation Program for AusMAT Members with Minimal Training Experience**

Days	Point Score	Descriptor
1 – 2	80 – 120	Train with a partner and/or at a venue where assistance is within a manageable distance.  Example sessions include 40 minutes of brisk walking (3/moderate); 60 minutes of easy walking (2/fairly light).
3 – 4	120 – 200	e.g. 60 minutes of brisk walking (3/moderate); or 40 minutes of tempo cycling (4/somewhat hard).
5 – 6	200 – 250	e.g. 70 minutes of brisk walking (3/moderate); or 50 minutes of tempo cycling (4/somewhat hard).
7		Recovery. Following 6 days of training, allow a complete day without training to assist you to adapt and complete the remaining 6 sessions.
8 – 10	250 – 300	e.g. 85 minutes of brisk walking (3/moderate).
10 – 14	300 +	e.g. 100 minutes of brisk walking (3/moderate).

### General Advice for avoidance of heat illness

Simple measures that may be used by the AusMAT team leadership to monitor your risk of heat illness and your hydration include thrice daily weight measurements, to monitor development of chronic dehydration, and self measurement of heart rate and “heat perception scores”. Simple personal measures to aid adaption and tolerance to the acclimatisation phase include careful weight maintenance through hydration, consumption of increased levels of salt added to food, while drinking copiously at mealtime (to compensate initially high salt concentration in sweat), and ensuring adequate rest in cool environments when available.

### Acclimatisation to cold conditions

There is less scope for adaption to cold than hot conditions, placing a greater emphasis on behaviour to maximise performance in cold environments. Behavioural adjustments in the cold, including wearing of additional layers of clothing, insulation of working environments from the cold climate, minimising workplace airflow and consumption of warm food and fluids improve work capability and reduce cold induced injury risks.



# Travel Tips



### Traveling Overseas

Before you go, organise a variety of ways to access your money overseas, such as credit cards, Traveler's cheques, cash, debit cards or cash cards. Australian currency and Traveler's cheques are not accepted in many countries. Consult with your bank to find out which the most appropriate currency to carry is and whether your ATM card will work overseas.

- Check the latest travel advice at [smartraveller.gov.au](http://smartraveller.gov.au) and subscribe to receive free email notifications each time the advice for your destination is updated.
- Before travelling overseas register your travel and contact details online at [smartraveller.gov.au](http://smartraveller.gov.au), or at the local Australian embassy, high commission or consulate once you arrive so we can contact you in case of an emergency.
- Obey the laws of the country you're visiting even if these appear harsh or unfair by Australian standards.
- Don't expect to be treated differently to the locals just because you're Australian. Corporal punishment, including the death penalty, is a mandatory sentence for specific offences in some countries. The death penalty has been carried out against Australians overseas.
- Make sure you have the right visas for the countries you are visiting or transiting. Remember that a visa doesn't guarantee entry.
- Find out about taking medication overseas – certain medicines aren't allowed in some countries. Medication available over-the-counter or by prescription may be illegal in some countries. Check with the embassy or consulate of your planned destination whether your medication is legal. You should also carry your medication in its original packaging and take a letter from your doctor explaining your need to take the drug.
- Make sure your passport has at least six months validity from your planned date of return to Australia.
- Make two photocopies of valuable documents such as your passport, tickets, visas, Traveler's cheques, credit card numbers, insurance policy, itinerary and phone card details.
- Keep one copy with you in a separate place to the original and leave another copy with someone at home.
- While traveling, don't carry too much cash and remember that expensive watches, jewellery, cameras and electronic items may be tempting targets for thieves.
- As a sensible precaution against luggage tampering, including theft, lock your luggage. Information on luggage safety is available from Australia's Civil Aviation Safety Authority.

Your passport is a valuable document that is attractive to criminals who may try to use your identity to commit crimes. It should always be kept in a safe place. You are required by Australian law to report a lost or stolen passport. If your passport is lost or stolen overseas, report it online or contact the nearest Australian Embassy, High Commission or Consulate as soon as possible.

#### PREPARE A WILL

AusMAT team members should establish a legal will to address what would happen to personal property, financial accounts and dependents in the event that they did not return home.

You may also want to think about a 'living will' with instructions on handling medical situations if you become physically and/or mentally incapacitated.

For more information regarding wills, please obtain independent legal advice.

#### POWER OF ATTORNEY

Depending on the length of the deployment consider giving someone you trust power of attorney to act on legal matters in your absence. This can be your spouse a relative or a trusted friend. You can specify which decisions they can and cannot make, and you can cancel it when you return.

If you make the power of attorney too restrictive, some financial institutions may not accept it. Make sure your financial institution(s) will honor your power of attorney before you leave.

A power of attorney does not give someone the right to make decisions about your lifestyle, medical treatment or welfare. Should you wish someone to make health related decisions on your behalf if you lose capacity to make your own decisions you will need to appoint an Enduring Guardian. For more information contact your local government authority.

#### Medical consultation before travel

A medical consultation should be conducted every six months for AusMAT volunteers. A pre – trip travel consultation should be arranged if time permits

The consultation will determine the need for any vaccinations and/or antimalarial medication and identify any other medical items that the responder may require. A basic medical kit will be prescribed or provided, supplemented as appropriate to meet individual needs. Dental and for women gynaecological check-ups are advisable before prolonged travel to developing countries or to remote areas. This is

particularly important for people with chronic or recurrent dental or gynaecological/obstetric problems.

### Medical kit and toilet items

Sufficient medical supplies should be carried to meet all foreseeable needs for the duration of the trip. A medical kit should be carried for all destinations where there may be significant health risks, particularly those in developing countries and/or where the local availability of specific medications is uncertain.

This kit will include basic medicines to treat common ailments, first-aid articles, and any other special medical items, such as syringes and needles, that may be needed and can in some cases be used by the individual traveller. Certain categories of prescription medicine or special medical item should be carried together with a medical attestation on headed paper, signed by a physician, certifying that the responder requires the medication or the items for medical condition. Some countries require not only a physician but also the national health administration to sign this attestation.

Toilet items should also be carried in sufficient quantity for the entire visit unless their availability at the travel destination is assured. These will include items for dental care, eye care (including contact lenses), skin care and personal hygiene.

### Contents of a basic medical kit

First-aid items:

- adhesive tape
- antiseptic wound cleanser
- bandages
- emollient eye drops
- insect repellent
- insect bite treatment
- antihistamine cream or tablets
- nasal decongestant
- oral rehydration salts
- scissors and safety pins
- simple analgesic (e.g. paracetamol – do not pack analgesic containing codeine)
- sterile dressing
- clinical thermometer
- sunscreens
- earplugs

Additional items according to destination and individual needs:

- antidiarrhoeal medication (to include an antibiotic, an antimotility drug and oral rehydration sachets with appropriate written instructions regarding their use)
- broad spectrum antibiotics (e.g. flucloxacillin, amoxicillin)
- antifungal powder
- antimalarial medication
- bed net

Health risks and precautions: general considerations

- adequate supplies of condoms and the oral contraceptive
- medication for any pre-existing medical condition
- sedatives
- sterile syringes and needles
- water disinfectant
- sunscreen
- other items to meet foreseeable needs, according to the destination and
- duration of the visit

### Medical examination after travel

AusMAT team members should be advised to have a medical examination on their return if they:

- experience illness in the weeks following their return home, particularly if fever, persistent diarrhoea, vomiting, jaundice, urinary disorders, skin disease or genital infection occurs;
- they received treatment for malaria while travelling;
- consider that they have been exposed to a serious infectious disease while travelling;
- have spent more than 3 months in a developing country.

AusMAT team members should provide medical personnel with information on recent travel, including destination, and purpose and duration of visit.

Frequent travellers should give details of all journeys that have taken place in the preceding weeks and months.

**Note.** Fever after returning from a malaria-endemic area is a medical emergency and members should seek medical attention immediately.

### LOCAL LAWS

When you are overseas, be aware that local laws and penalties, including ones that appear harsh by Australian standards, do apply to you. Learn as much as you can about the laws of the countries you will visit. If you are arrested or jailed, the Australian Government will do what it can to help you but we can't get you out of trouble or out of jail.

Information on what Australian consular officers can and cannot do to help Australians in trouble overseas is available from the Consular Services Charter.

- Penalties for drug offences in some countries, including for small amounts of 'soft drugs', may include the death penalty or lengthy imprisonment.
- Sharia (Islamic) Law is enforced in some Islamic countries.
- In most countries, taking photographs of military installations and other sites deemed to be sensitive to domestic security, such as police stations, is prohibited and may result in arrest or detention. Photographing local people, particularly women and children, is also illegal in some countries.
- In some destinations it is illegal to buy, sell or wear camouflage-style clothing.
- Severe penalties may be imposed in some countries for attempting to export antiquities or culturally significant items.
- Homosexual acts are illegal in some countries. Penalties can include the death penalty, corporal punishment and long prison sentences.
- Preaching and importing religious material is illegal in some countries.
- Some Australian criminal laws, such as those relating to money laundering, bribery of foreign public officials, terrorism and child sex tourism, apply to Australians overseas. Australians who commit these offences while overseas may be prosecuted in Australia.
- Australian authorities are committed to combating sexual exploitation of children by Australians overseas. Australians may be prosecuted at home under Australian child sex tourism laws. These laws provide severe penalties of up to 17 years imprisonment for Australians who engage in sexual activity with children under 16 while outside of Australia.

### Jet lag

Jet lag is the term used for the symptoms caused by the disruption of the body's "internal clock" and the approximate 24-hour (circadian) rhythms it controls. Disruption occurs when crossing multiple time zones, i.e. when flying east to west or west to east. Jet lag may lead to indigestion and disturbance of bowel function, general malaise, daytime

sleepiness, difficulty in sleeping at night, and reduced physical and mental performance. Its effects are often combined with tiredness caused by the journey itself. Jet lag symptoms gradually wear off as the body adapts to the new time zone. Jet lag cannot be prevented but there are ways of reducing its effects.

### General measures to reduce the effects of jet lag

- Be as well rested as possible before departure, and rest during the flight. Short naps can be helpful. Depending on the time of day you may be able to rest during the flight. Short naps (less than 20 min) can be helpful.
- Eat light meals and limit consumption of alcohol. Alcohol increases urine output, with the result that sleep may be disturbed by the need to urinate. While it can accelerate the onset of sleep, alcohol impairs the quality of sleep, making it less restful. The after-effects of excessive consumption of alcohol ("hangover") can exacerbate the effects of jet lag and travel fatigue. Alcohol consumption should not be consumed by AusMAT team members particularly in the pre-departure or during travel to a response mission. Caffeine should be limited to normal amounts and avoided within a few hours of an expected period of sleep. If coffee is drunk during the daytime, small amounts every two hours or so are preferable to a single large cup.
- At the destination, try to create the right conditions when preparing for sleep and to get as much sleep in every 24 h as normal. A minimum block of 4 h' sleep during the local night – known as "anchor sleep" – is thought to be necessary to allow the body's internal clock to adapt to the new time zone. If possible, make up the total sleep time by taking naps during the day in response to feelings of sleepiness. When taking a nap during the day, eyeshades and earplugs may help. Exercise during the day may help to promote sleep, but avoid strenuous exercise immediately before trying to sleep.
- The cycle of light and dark is one of the most important factors in setting the body's internal clock. Exposure to daylight, preferably bright sunlight, at the destination will usually help adaptation. When flying west, exposure to daylight in the evening and avoidance in the morning (e.g. by using eye shades or dark glasses) may be helpful; flying east, exposure to light in the morning and avoidance in the evening are to be recommended.
- Short-acting sleeping pills may be helpful. They should be used only in accordance with medical advice and should not normally be taken during the flight, as they may increase immobility and therefore the risk of developing DVT.

- Melatonin is available in some countries. It is normally sold as a food supplement and therefore is not subject to the same strict control as medications. The timing and effective dosage of melatonin have not been fully evaluated and its side-effects, particularly in long-term use, are unknown. Moreover, manufacturing methods are not standardized: the dose per tablet can be very variable and some harmful compounds may be present. For these reasons, melatonin cannot be recommended.
- Trying to adjust to local time for short trips of up to 2–3 days may not be the
- best coping strategy, because the body clock may not have an opportunity to synchronize to the new time zone, and re-synchronization to the home time zone may be delayed after the return flight. If in doubt, seek specialist travel medicine advice.

## Environmental health risks

AusMAT team members often experience abrupt and dramatic changes in environmental conditions, which may have detrimental effects on health and well-being. Travel may involve major changes in altitude, temperature and humidity, and exposure to microbes, animals and insects. The negative impact of sudden changes in the environment can be minimized by taking simple precautions.

### Altitude

Barometric pressure falls with increasing altitude, diminishing the partial pressure of oxygen and causing hypoxia. The partial pressure of oxygen at 2500 m, the altitude of Vail, Colorado, for example, is 26% lower than at sea level; in La Paz, Bolivia (Plurinational State of) (4000 m), it is 41% lower. This places a substantial stress on the body, which requires at least a few days to acclimatize; the extent of acclimatization may be limited by certain medical conditions, especially lung disease.

An increase in alveolar oxygen through increased ventilation is the key to acclimatization; this process starts at 1500 m. Despite successful acclimatization, aerobic exercise performance remains impaired and team members may still experience problems with sleep. High-altitude illness (HAI) results when hypoxic stress outstrips acclimatization. HAI can occur at any altitude above 2100 m but is particularly common above 2750 m. In Colorado ski resorts, incidence of HAI varies from 15% to 40%, depending on sleeping altitude. Susceptibility is primarily genetic, but fast rates of ascent and higher sleeping altitudes are important precipitating factors.

Age, sex and physical fitness have little influence.

The spectrum of HAI includes common acute mountain sickness (AMS), occasional high-altitude pulmonary oedema and, rarely, high altitude cerebral oedema. The latter two conditions, although uncommon, are potentially fatal. AMS may occur after 1–12 h at high altitude. Headache is followed by anorexia, nausea, insomnia, fatigue and lassitude. Symptoms usually resolve spontaneously in 24–48 h and are ameliorated by oxygen or analgesics and antiemetics.

Acetazolamide, 5 mg/kg per day in divided doses, is an effective chemoprophylaxis for all HAI; it is started one day before travel to altitude and continued for the first two days at altitude. Acetazolamide should not be given to individuals with allergies to sulpha drugs.

- Precautions for team members unaccustomed to high altitudes
- Avoid one-day travel to sleeping altitudes over 2750 m if possible. Break the journey for at least one night at 2000–2500 m to help prevent AMS.
- Avoid overexertion and alcohol for the first 24 h at altitude; drink extra water.
- If direct travel to sleeping altitude over 2750 m is unavoidable, consider prophylaxis with acetazolamide. Acetazolamide is also effective if started early in the course of AMS.
- AusMAT team members planning to climb or trek at high altitude will require a period of gradual acclimatization.
- AusMAT team members with pre-existing cardiovascular or pulmonary disease should seek medical advice before travelling to high altitudes.
- AusMAT team members with the following symptoms should seek medical attention when experiencing, at altitude:
  - symptoms of AMS that are severe or last longer than 2 days;
  - progressive shortness of breath with cough and fatigue;
  - ataxia or altered mental status.

### Heat and humidity

Sudden changes in temperature and humidity may have adverse effects on health. Irritation of the skin may be experienced in hot conditions (prickly heat). Fungal skin infections such as tinea pedis (athlete's foot) are often aggravated by heat and humidity.

A daily shower, wearing loose cotton clothing and applying talcum powder to sensitive skin areas help to reduce the development or spread of these infections. Exposure to hot, dry, dusty air may lead to irritation and infection of the eyes and respiratory tract. Avoid contact lenses in order to reduce the risk of eye problems.

### Ultraviolet radiation from the sun

The ultraviolet (UV) radiation from the sun includes UVA (wavelength 315–400 nm) and UVB (280–315 nm) radiation, both of which are damaging to human skin and eyes. The intensity of UV radiation is indicated by the Global Solar UV Index, which is a measure of skin-damaging radiation. The Index describes the level of solar UV radiation at the Earth's surface. The values of the Index range from zero upwards the higher the Index value, the greater the potential for damage to the skin and eyes and the less time it takes for harm to occur. Index values are grouped into exposure categories, with values greater than 10 being “extreme”.

In general, the closer to the equator the higher is the Index. UVB radiation is particularly intense in summer and in the 4-hour period around solar noon. UV radiation penetrates clear water to a depth of 1 m or more.

The adverse effects of UV radiation from the sun are the following:

- Exposure to UV radiation, particularly UVB, can produce severe debilitating sunburn particularly in light-skinned people.
- Exposure of the eyes may result in acute keratitis (“snow blindness”), and long-term damage leads to the development of cataracts.
- Exposure to sunlight may result in solar urticaria – a form of hives associated with itching and redness on areas of skin exposed to sunlight. It can occur within minutes of exposure to the sun and is usually short-lasting.
- Long-term adverse effects on the skin include:
  - the development of skin cancers (carcinomas and malignant melanoma), due mainly to UVB radiation;
  - accelerated ageing of the skin, due mainly to UVA radiation, which penetrates more deeply into the skin than UVB.
- Adverse reactions of the skin result from interaction with a wide range of medicinal drugs that may cause photosensitization and result in phototoxic or photoallergic dermatitis. A variety of different types of therapeutic drugs such as antimicrobials as well as oral contraceptives, some prophylactic antimalarial drugs may

cause adverse dermatological reactions on exposure to sunlight. Phototoxic contact reactions are caused by topical application of products, including perfumes, containing oil of bergamot or other citrus oils.

- Exposure may suppress the immune system, increasing the risk of infectious disease, and limiting the efficacy of vaccinations.

### Precautions

- Avoid exposure to the sun in the middle of the day, when the UV intensity is greatest.
- Wear clothing that covers arms and legs (covering the skin with clothing is more effective against UV than applying a sunscreen).
- Wear UV-protective sunglasses of wrap-around design plus a wide-brimmed sun hat.
- Apply a broad-spectrum sunscreen of sun protection factor (SPF) 15+ liberally on areas of the body not protected by clothing and reapply frequently.
- Take particular care to ensure that children are well protected.
- Take precautions against excessive exposure while on or in water.
- Check that medication being taken will not affect sensitivity to UV radiation.
- If adverse skin reactions have occurred previously, avoid any exposure to the sun and avoid any products that have previously caused the adverse reactions.

### Food borne and waterborne health risks

Many important infectious diseases (such as cholera, cryptosporidiosis, cyclosporiasis, giardiasis, hepatitis A and E, listeriosis, Campylobacter, Salmonella, Shigella and typhoid fever) are transmitted by contaminated food and water.

### Traveller's diarrhoea

Traveller's diarrhoea is a clinical syndrome associated with contaminated food or water that occurs during or shortly after travel. It is the most common health problem encountered by team members and, depending on length of stay, may affect up to 80% of travellers to high-risk destinations. Traveller's diarrhoea most commonly affects persons travelling from an area of more highly developed standards of hygiene and sanitation to a less developed one. Diarrhoea may be accompanied by nausea, vomiting, abdominal cramps and fever. Various bacteria, viruses and parasites are the known causes of traveller's diarrhoea, but bacteria are responsible for the majority of cases.

The safety of food, drink and drinking-water depends mainly on the standards of hygiene applied locally in their growing, preparation and handling. In countries with low standards of hygiene and sanitation and poor infrastructure for controlling the safety of food, drink and drinking-water, there is a high risk of contracting travellers' diarrhoea. To minimize any risk of contracting food borne or waterborne infections in such countries, members should take precautions with all food and drink, including that served in good-quality hotels and restaurants. Some simple measures include;

- avoiding the use of ice in drinks,
- only eating fruit that you can peel,
- selecting eateries that are busy with high turn over of fresh produce

While the risks are greater in poor countries, locations with poor hygiene may be present in any country.

### **Treatment of diarrhoea**

Most diarrhoeal episodes are self-limiting, with recovery in a few days. It is important, especially for children, to avoid becoming dehydrated. When diarrhoea starts, fluid intake should be maintained with safe liquids (e.g. bottled, boiled or otherwise disinfected water).

### **Amounts of ORS solution to drink**

Patients of 10 years or older As much as wanted, up to approximately 2lt a day.

If ORS solution is not available, a substitute containing 6 level teaspoons of sugar plus 1 level teaspoon of salt in 1 l of safe drinking-water may be used, in the same amounts as for ORS. (A level teaspoon contains a volume of 5 ml.)

Antibiotics such as fluoroquinolones (e.g. ciprofloxacin or levofloxacin) may be used as empirical therapy in most parts of the world and usually limit the duration of illness to an average of about one day. However, increasing resistance to fluoroquinolones, especially among *Campylobacter* isolates, may lower their efficacy in some parts of the world, particularly in Asia. In such cases, azithromycin may be taken as an alternative treatment.

When members need immediate control of symptoms, antidiarrhoeal drugs such as loperamide may be additionally used.

Prophylactic use of antibiotics is controversial. There is a role for their use in members with increased susceptibility to infection, e.g. people with hypochlorhydria or small intestinal pathology and individuals on critical missions. Antidiarrhoeal medicines such as loperamide are always contraindicated for prophylactic use.

Medical help should be sought if diarrhoea results in severe dehydration or has not responded to empirical therapy within 3 days and particularly when bowel movements are very frequent and watery, or when there is blood in the stools, repeated vomiting or fever.

In the event of distressing symptoms suggesting a diagnosis other than Traveller's diarrhoea, medical advice should be sought rapidly.

### **Intestinal parasites: risks for AusMAT team members**

Team members, particularly those visiting tropical and subtropical countries, may be exposed to a number of intestinal parasitic helminth (worm) infections. The risk of acquiring intestinal parasites is associated with low standards of hygiene and sanitation, which permit contamination of soil, water and foodstuffs with human or animal faeces. In general, the clinical effects are likely to become apparent some time after return from travel and the link with the travel destination may not be apparent, which in turn may delay the diagnosis or lead to misdiagnosis. The following are the main intestinal parasitic helminths to which team members may be exposed.

#### **■ Hookworms**

Human and canine hookworms, particularly *Necator* and *Ancylostoma* species, may be a risk for team members, notably in places where beaches are polluted by human or canine faeces. Humans become infected by larval forms of the parasite which penetrate the skin. *A. caninum* produces a characteristic skin lesion, cutaneous larva migrans, which is readily treated by anthelmintics such as albendazole or ivermectin.

#### **■ Tapeworms**

The tapeworm *Taenia saginata* is acquired by consumption of raw or undercooked beef from cattle that harbour the larval form of the parasite. *T. solium* is similarly acquired from raw or undercooked pork. Cattle and pigs become infected with the larval stages of tapeworm as a result of access to human faeces, from which they ingest tapeworm eggs, spread by human tapeworm carriers. Humans, who are the usual definitive host of the parasite, may also become an intermediate host by direct ingestion of *T. solium* eggs in food contaminated by human faeces; this is particularly dangerous, since the larval forms of the parasite cause cysticercosis, which may cause serious disease. The tapeworm *Echinococcus granulosus* causes cystic hydatid disease due to infection by the larval form of the parasite; the adult tapeworms infect dogs, which excrete eggs in the faeces. Human infection is acquired by ingestion of eggs following close contact with infected dogs or consumption of food or water contaminated by their faeces.



### ■ Roundworms and whipworms

The intestinal roundworm (nematode) parasites *Ascaris lumbricoides* and whipworm *Trichuris trichiura* are transmitted in soil. Soil containing the eggs of these parasites may contaminate foods such as fruit and vegetables, leading to infection if the food is consumed without thorough washing; infection may also be transmitted by the hands following handling of soil-contaminated foods, for instance in street markets, or by contaminated water.

AusMAT team members should be offered a dose of 'worming' tablets such as albendazole on departure from the region.

### Summary of practical measures for food and water hygiene and to avoid mosquito bites

- Common sense precautions for avoiding unsafe food and drink
- Avoid food that has been kept at room or ambient temperature for several
- hours, e.g. uncovered buffet food, food from street and beach vendors.
- Avoid uncooked food, apart from fruit and vegetables that can be peeled or shelled, and avoid fruits with damaged skins.
- Avoid ice unless it has been made from safe water.
- Avoid dishes containing raw or undercooked eggs.
- Avoid ice cream from unreliable sources, including street vendors.
- Avoid brushing the teeth with unsafe water.
- In countries where poisonous biotoxins may be present in fish and shellfish, obtain advice locally.
- Boil unpasteurized (raw) milk before consumption.
- Always wash your hands thoroughly with soap and water before preparing or consuming food.
- Boil drinking-water if its safety is doubtful; if boiling is not possible, a certified, well-maintained filter and/or a disinfectant agent can be used.
- Bottled or packaged cold drinks are usually safe provided that they are sealed.
- Beverages and thoroughly cooked food served at a temperature of at least 60 °C are usually safe.

### Treating water of questionable quality

- Bringing water to a visible rolling boil is the most effective way to kill disease causing pathogens.
- Chemical disinfection of clear, non-turbid water is effective for killing bacteria and viruses and some protozoa (but not, for example, *Cryptosporidium*).
- A product combining chlorine disinfection with coagulation/flocculation (i.e. chemical precipitation) will remove significant numbers of protozoa, in addition to killing bacteria and viruses.
- Turbid water should be cleared of suspended solid matter by letting it settle or filtering it before chemical disinfection is attempted.
- Portable point-of-use (POU) devices (such as ceramic, membrane and carbon block filters) remove protozoa and some bacteria. Selecting the most appropriate filter pore size is crucial; a size of 1 mm or less for the filter media pore is recommended to ensure removal of *Cryptosporidium* in clear water. Some filtering devices also employ iodine impregnated resins to increase their efficiency.
- Unless water is boiled, a combination of methods (e.g. filtration followed by chemical disinfection or boiling) is recommended, since most POU filtration devices do not remove or kill viruses. Reverse osmosis (very fine pore filtration that holds back dissolved salts in the water) and ultra filtration devices (fine pore filtration that passes dissolved salts but holds back viruses and other microbes) can theoretically remove all pathogens.
- A carbon filter can improve taste and, in the case of iodine treatment, can remove excess iodine.

### Animals and insects

Undomesticated animals tend to avoid contact with humans and most do not attack unless provoked. Some large carnivores, however, are aggressive and may attack. Animals suffering from rabies often become aggressive and may attack without provocation. Wild animals may become aggressive if there is territorial intrusion, particularly when they are protecting their young. Animal bites may cause serious injury and may also result in transmission of disease.

Rabies is the most important infectious health hazard from animal bites. In many developing countries, rabies is transmitted mainly by dogs, but many other species of mammals can be infected by the rabies virus. After any animal bite, the wound should be thoroughly cleansed with disinfectant or with soap or detergent and water, and medical or veterinary advice should be sought about the possibility of rabies in the area.

Where a significant risk of rabies exists, the patient should be treated with post-exposure rabies vaccination and immunoglobulin.

A booster dose of tetanus toxoid is also recommended following an animal bite.

Team members who may be at increased risk of exposure to rabies may be advised to have pre-exposure vaccination before departure. Pre-exposure rabies vaccination does not eliminate the need for treatment after the bite of a rabid animal, but it reduces the number of vaccine doses required in the post-exposure regimen.

### Precautions

- Avoid direct contact with domestic animals in areas where rabies occurs, and with all wild and captive animals.
- During an AusMAT mission avoid contact and do not encourage domestic animals to loiter around camp.
- Avoid behaviour that may startle, frighten or threaten an animal.
- Treat any animal bite immediately by washing with disinfectant or soap and seek medical advice.

### Snakes, scorpions and spiders

Team members travelling to tropical, subtropical and desert areas should be aware of the possible presence of venomous snakes, scorpions and spiders. Local advice should be sought about risks in the areas to be visited. Most venomous species are particularly active at night.

Venom from snake and spider bites and from scorpion stings has various effects in addition to tissue damage in the vicinity of the bite. Neurotoxins are present in the venom of both terrestrial and aquatic snakes, and also often in the venom of scorpions and spiders. Neurotoxins cause weakness and paralysis. Venom contacting the eyes causes severe damage and may result in blindness. Most snake venoms affect blood coagulation, which may result in haemorrhage and reduced blood pressure. Toxins in the hair of spiders such as tarantulas may cause intense irritation on contact with the skin.

Poisoning by a venomous snake, scorpion or spider is a medical emergency requiring immediate attention. The patient should be moved to the nearest medical facility as quickly as possible.

First-aid measures involve immobilizing the entire affected limb with splints and firm, but not tight, bandaging to limit the spread of toxin in the body and the amount of local tissue damage. However, bandaging is not recommended if local swelling and tissue damage are present in the vicinity

of the bite. Other traditional first-aid measures (incisions and suction, tourniquets and compression) are harmful and should not be used.

Antivenom if required should be administered in a medical facility and should be given only if its stated range of specificity includes the species responsible for the bite and the patient is displaying symptoms of envenomation.

### Precautions

- Obtain local advice about the possible presence of venomous snakes, scorpions and spiders in the area.
- Avoid walking barefoot or in open sandals in terrain where venomous snakes, scorpions or spiders may be present; wear boots or closed shoes and long trousers.
- Actively manage camp areas that may harbour snakes or their food source e.g. frogs.
- Avoid placing hands or feet where snakes, spiders or scorpions may be hiding.
- Be particularly careful outdoors at night.
- Examine clothing and shoes before use for hidden snakes, scorpions or spiders.
- Sleep under a mosquito net.

### Insects and other vectors of disease

Vectors play an essential role in the transmission of many infectious diseases. Many vectors are bloodsucking insects, which ingest the disease-producing micro-organism during a blood meal from an infected host (human or animal) and later inject it into a new host at the time of another blood meal. Mosquitoes are important insect vectors of disease, and some diseases are transmitted by bloodsucking flies.

In addition, ticks and certain aquatic snails are involved in the life cycle and transmission of disease. The principal vectors and the main diseases they transmit are shown in Table 3.1.

Water plays a key role in the life-cycle of most vectors. Thus, the transmission of many vector-borne diseases is seasonal as there is a relationship between rainfall and the existence of breeding sites. Temperature is also a critical factor, limiting the distribution of vectors by altitude and latitude.



Table 3.1 Principal disease vectors and the diseases they transmit\*

Vectors	Main diseases transmitted
Aquatic snails	Schistosomiasis (bilharziasis)
Blackflies	River blindness (onchocerciasis)
Flies	Plague (transmitted by fleas from rats to humans) Rickettsiosis
Mosquitoes	
Aedes	Dengue fever Rift Valley fever Yellow fever Chikungunya
Anopheles	Lymphatic filariasis Malaria
Culex	Japanese encephalitis Lymphatic filariasis West Nile fever
Sandflies	Leishmaniasis Sandfly fever (Phlebotomus fever)
Ticks	Crimson-Congo haemorrhagic fever Lyme disease Relapsing fever (borreliosis) Rickettsial diseases including spotted fevers and Q fever Tick-borne encephalitis Tularemia
Triatomine bugs	Chagas disease (American trypanosomiasis)
Tsetse flies	Sleeping sickness (African trypanosomiasis)

\* Based on extensive research, there is absolutely no evidence that HIV infection can be transmitted by insects.

Team members are usually at lower risk of exposure to vector-borne diseases in urban centres, especially if they sleep in air-conditioned rooms. They may, however, be exposed to the vectors of dengue which are frequent in urban centres in tropical countries and which bite mostly during the day. Team members to rural areas or to areas with low standards of hygiene and sanitation are usually at higher risk of exposure to disease vectors, and personal protection is therefore essential. Evening/night time activities outdoors may increase exposure to malaria vectors.

### Protection against vectors

Team members may protect themselves from mosquitoes and other vectors by the means outlined in the following paragraphs.

**Insect repellents** are substances applied to exposed skin or to clothing to prevent human/vector contact. The active ingredient in a repellent repels but does not kill insects. Choose a repellent containing DEET (N,N-diethyl-3-methylbenzamide), IR3535 (3-[N-acetyl-N-butyl]-aminopropionic acid ethyl ester) or Icaridin (1-piperidinecarboxylic acid, 2-(2-hydroxyethyl)-1-methylpropylester). Insect repellents should be applied to provide protection at times when insects are biting.

Care must be taken to avoid contact with mucous membranes. Insect repellents should not be sprayed on the

face, applied to the eyelids or lips, or applied to sensitive, sunburned or damaged skin or deep skin folds. Always wash the hands after applying the repellent.

Repeated applications may be required every 3–4 h, especially in hot and humid climates when sweating may be profuse. When the product is applied to clothes, the repellent effect lasts longer. However, label instructions should be followed to avoid damage to certain fabrics. Repellents should be used in strict accordance with the manufacturers' instructions and the dosage must not be exceeded.

**Mosquito nets** are excellent means of personal protection while sleeping. Nets can be used either with or without insecticide treatment. However, treated nets are much more effective. Pre-treated nets may be commercially available. Nets should be strong and with a mesh size no larger than 1.5 mm. The net should be tucked in under the mattress, ensuring first that it is not torn and that there are no mosquitoes inside. Nets for hammocks are available, as are nets for cots and small beds.

**Mosquito coils** are the best known example of insecticide vaporizer, usually with a synthetic pyrethroid as the active ingredient. One coil serves a normal bedroom through the night, unless the room is particularly draughty. A more sophisticated version, which requires electricity, is an insecticide mat that is placed on an electrically heated grid, causing the insecticide to vaporize. Battery-operated vaporizers are also available. Such devices can also be used during daytime if necessary.

**Aerosol sprays** intended to kill flying insects are effective for quick knockdown and killing. Indoor sleeping areas should be sprayed before bedtime. Treating a room or a tent with an insecticide spray will help to free it from insects, but the effect may be short-lived. Spraying combined with the use of a coil, a vaporizer or a mosquito net is recommended. Aerosol sprays intended for crawling insects (e.g. cockroaches and ants) should be sprayed on surfaces where these insects walk.

**Protective clothing** can help at times of the day when vectors are active. The thickness of the material is critical. Exposed skin should be treated with a repellent.

Insect repellent applied to clothing is effective for longer than it may be on the skin. Extra protection is provided by treating clothing with permethrin or etofenprox, to prevent mosquitoes from biting through clothing. In tick- and flea infested areas, feet should be protected by appropriate footwear and by tucking long trousers into the socks. Such measures are further enhanced by application of repellents to the clothing.

Team members camping in tents should use a combination of mosquito coils, repellents and screens. The mesh size of

tent screens often exceeds 1.5 mm, so that special mosquito screens have to be deployed.

Screening of windows, doors and eaves reduces exposure to flying insects. Accommodation with these features should be sought where available. Air-conditioning is a highly effective means of keeping mosquitoes and other insects out of a room as long as the room has no gaps around windows or doors.

In air-conditioned hotels, other precautions may not be necessary indoors. Avoid contact with freshwater bodies such as lakes, irrigation ditches and slow running streams in areas where schistosomiasis occurs.

### Protection against vectors

- Insect repellents (e.g. repellents containing DEET (N,N-diethyl- 3-methylbenzamide), IR3535 (3-[N-acetyl-N-butyl]-aminopropionic acid ethyl ester) or Icaridin (1-piperidinecarboxylic acid, 2-(2-hydroxyethyl)-1-methylpropylester).
- Mosquito nets.
- Mosquito coils. Aerosol sprays.
- Protective clothing.
- Screening.
- Air-conditioning.

Vaccinations provided to AusMAT team members prior to a deployment.

The table below outline the expected duration for protection once the vaccination course is complete. For some vaccines, the duration of protection is not confirmed.

Disease	Duration	Vaccine
Polio	Life	Sabin, IPV Primary Course + booster
Diphtheria, Tetanus, Pertussis	5-10 years	Tet tox/ADT/Boostrix/Adacel
Measles, Mumps, Rubella	Life	Priorix/ MMR
Chickenpox	Life	Varivax/Varilrix
Flu vaccine	1 year	Fluvax/Vaxigrip/Fluarix/Intanza
Typhoid	2-3years	Thphim vi/ Typhex
Hepatitis A	Life	Vaqa /Havrix/ Avaxim /Twinrix
Hepatitis B	Life	HBVaxII / EngerixB /Twinrix
Cholera	2 years	Dukoral oral

Japanese Encephalitis	1 year	JE-VAX
Rabies	Until bitten	Rabies (pre exposure)
Yellow Fever	10 Years	Yellow Fever
Meningococcal meningitis • pneumonia • conjunctivitis	5 years	Meningococcal Vaccine

### Exposure to blood or other body fluids

For traveller's, the need for a blood transfusion almost always arises as a result of a medical emergency involving sudden massive blood loss, such as:

- traffic accident;
- gynaecological or obstetric emergency;
- severe gastrointestinal haemorrhage;
- emergency surgery.

### Blood transfusion

The safety of blood and blood products depends on two key factors:

- A supply of safe blood and blood products through the careful selection of voluntary unpaid blood donors from low-risk populations who donate repeatedly, testing all donated blood for transfusion-transmissible infections and correct storage and transportation at all steps from collection to transfusion with an adequate quality system.
- The appropriate prescription (only when there is no other remedy), proper cross-match between the blood unit and the recipient, and safe administration of the blood or blood product at the bedside, with correct patient identification.

In many developing countries, safe blood and blood products may not be available in all health care facilities. In addition, evidence from every region of the world indicates considerable variations in patterns of clinical blood use between different hospitals, different clinical specialities and even between different clinicians within the same speciality. This suggests that blood and blood products are often transfused unnecessarily.

While blood transfusions correctly given save millions of lives every year, unsafe blood transfusions – as a result of the incompatibility of the blood, the volume transfused or the transmission of infections such as hepatitis B, hepatitis C, HIV, malaria, syphilis or Chagas disease – can lead to serious reactions in the recipient. The initial management of

major haemorrhage is the prevention of further blood loss and restoration of the blood volume as rapidly as possible in order to maintain tissue perfusion and oxygenation. This requires infusing the patient with large volumes of replacement fluids until the haemorrhage can be controlled. Some patients respond quickly and remain stable following the infusion of crystalloids or colloids and may not require blood transfusion.

In malaria-endemic areas, there is a high risk of acquiring malaria from transfusion. It may be necessary to administer the routine treatment for malaria to the transfused patient.

### Precautions

- Team members should carry a medical card or other document showing their blood group and information about any current medical problems or treatment.
- Team members should take all possible precautions to avoid involvement in traffic accidents.
- AusMAT members with chronic medical conditions such as thalassaemia or haemophilia, which necessitate regular transfusion of blood or plasma-derived products, will not generally be deployed to international missions in countries without an Australian standard blood service

### Accidental exposure to blood or other body fluids

Exposure to blood borne pathogens may occur in case of:

- contact with blood or body fluids with a non-intact skin or with mucous membranes;
- percutaneous injury with needles or sharp instruments contaminated with blood or body fluids.

### Exposure to blood or other body fluids

These exposures may occur:

- when using contaminated syringes and needles for injecting drugs;
- as a result of accidents or acts of violence, including sexual assaults;
- in case of sexual exposure if there was no condom use, or if the condom was broken;
- as occupational exposure, within and outside health care settings, to health care and other workers (such as rescuers, police officers) in the course of the work or to patients; during natural or man-made disasters.

Accidental exposure may lead to infection by blood borne pathogens, particularly hepatitis B, hepatitis C and HIV. The average risk of seroconversion after a single percutaneous

exposure to infected blood for hepatitis C is approximately 2% and for hepatitis B it is 6–60%. The average risk of seroconversion to HIV after a single percutaneous exposure to HIV-infected blood is 0.1–0.3%.

**Pre-exposure vaccination.** Hepatitis B vaccination can be given before exposure to protect AusMAT members from hepatitis B infection (Chapter 6). There are no vaccines for hepatitis C or HIV.

**Post-exposure prophylaxis (PEP).** PEP is an emergency medical response given as soon as possible to reduce the risk of transmission of blood borne pathogens after potential exposure. It is available for HIV and hepatitis B.

Accidental exposure to potentially infected blood or other body fluids is a medical emergency.

The following measures should be taken without delay:

1. Refer to a service provider and report the accident.
2. First-aid care.
3. PEP, if applicable.

First-aid care management of exposure to blood borne pathogens

### After percutaneous exposure

- Allow the wound to bleed freely.
- Do not squeeze or rub the injury site.
- Wash site immediately using soap or a mild solution that will not irritate the skin.
- If running water is not available, clean site with clean site with hand-cleaning solution or gel.
- Do not use any strong solutions, such as bleach, iodine or alcohol-based products, as these may irritate the wound and make the injury worse.
- After a splash of blood or body fluids onto unbroken skin
- Wash the area immediately with running water.
- If running water is not available, clean the area with any hand-cleaning solution.
- Do not use alcohol-based antiseptics.
- Do not rub the skin.

### After exposure of the eye

Irrigate the exposed eye immediately with water or normal saline.

Sit in a chair, tilt the head back and ask someone to gently pour water or normal saline over the eye, gently pulling the eyelids up and down to make sure the eye is cleaned thoroughly.

If wearing contact lenses, leave them in place while irrigating, as they form a barrier over the eye and will help protect it. Once the eye has been cleaned, remove the contact lenses and clean them in the normal manner. This will make them safe to wear again.

**Do not** use soap or disinfectant on the eye.

After exposure of the mouth

Spit the fluid out immediately.

Rinse the mouth thoroughly, using water or normal saline, and spit out again.

Repeat this process several times.

**Do not** use soap or disinfectant in the mouth.

In all cases, a health care worker should be contacted immediately.

Post-exposure prophylaxis (PEP)

### HIV

For HIV, PEP refers to a set of comprehensive services to prevent HIV infection in the exposed individual. These services include risk assessment and counselling, HIV testing based on informed consent and – according to the risk assessment – the exposure to blood or other body fluids provision of short-term antiretroviral (ARV) drugs, with follow-up and support. Counselling and risk assessment are critical before providing PEP for HIV. HIV testing is strongly recommended for both the exposed person and the source person (if known). Testing should never be mandatory or conditional for PEP; any case should be supported with appropriate counselling and the provision of PEP should be based on informed consent.

PEP should be started as soon as possible after the incident and ideally within less than 2 h. The decision to provide ARV drugs depends on a number of factors, including the HIV status of the exposed and source individual (if known), the nature of the body fluid involved, the severity of exposure and the period between exposure and the beginning of

treatment. PEP should not be given to people who test or are known to be HIV-positive. The recommended PEP regimen is, in most cases, a combination of two ARV drugs that should be taken continuously for 28 days. In some instances, when drug resistance may be suspected in the source person, a third drug may be added. Expert consultation is especially important when exposure to drug-resistant HIV may have occurred. More information is available at: [www.who.int/hiv/topics/prophylaxis/en/](http://www.who.int/hiv/topics/prophylaxis/en/)

If an initial HIV test has been done, subsequent tests should be repeated at 8 weeks after exposure and at 6 months if ARVs have been taken. People who test positive at any stage should be offered psychological support and appropriate treatment when needed.

Even when taking ARVs for PEP after exposure to HIV infection, the exposed individual should not have unprotected sexual intercourse or give blood until the 6-month post-exposure tests confirm that he or she is not seropositive. Women should avoid becoming pregnant during this period.

### Hepatitis B

For those who may be exposed to hepatitis B virus, infection can be prevented before exposure through vaccination and after exposure through PEP. Recommended post-exposure management algorithms for testing and administration of hepatitis B vaccine and/or hepatitis B immune globulin should be followed.

### Hepatitis C

There is no vaccine against hepatitis C virus. People exposed to hepatitis C virus may be screened for hepatitis C virus RNA at baseline, 4–6 weeks and 4–6 months after exposure.

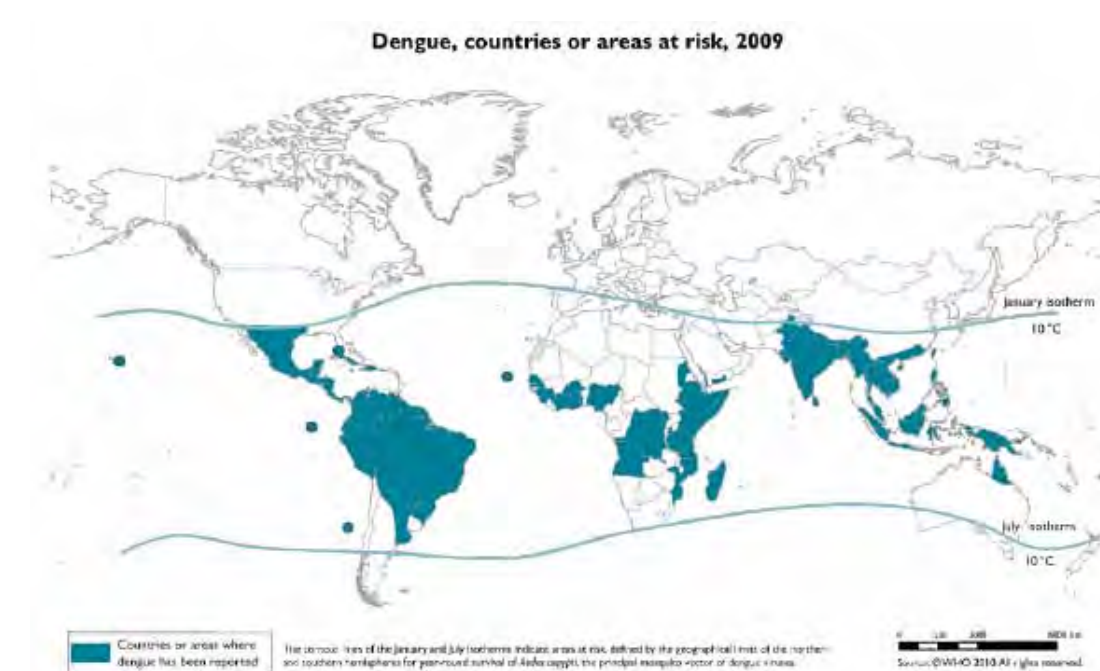
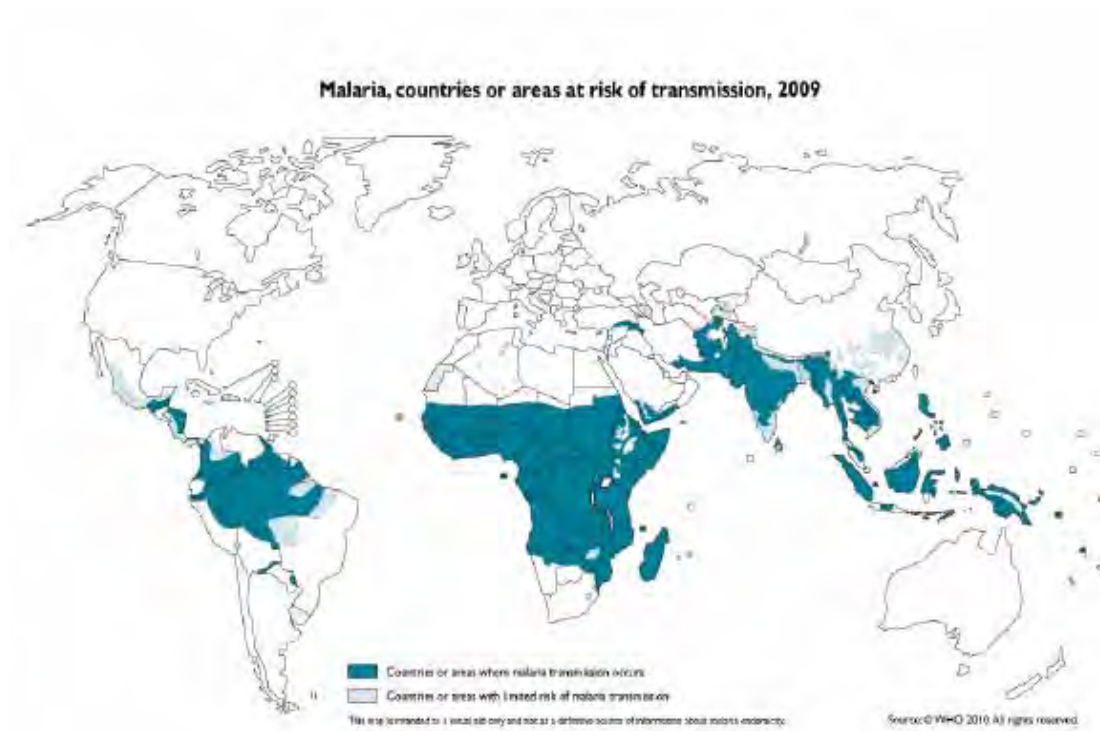
### Hepatitis E

There is no commercially available vaccine against hepatitis E virus. People exposed to hepatitis E virus may be screened for anti-HEV IgM antibodies or for Hepatitis E virus RNA.

### Further reading

Post-exposure prophylaxis for HIV: [www.who.int/hiv/topics/prophylaxis/en/](http://www.who.int/hiv/topics/prophylaxis/en/)

Updated U.S. Public Health Service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for post exposure prophylaxis. Morbidity and Mortality Weekly Report, 2001, 50(RR-11) (available at: [www.cdc.gov/mmwr/PDF/rr/rr5011.pdf](http://www.cdc.gov/mmwr/PDF/rr/rr5011.pdf))

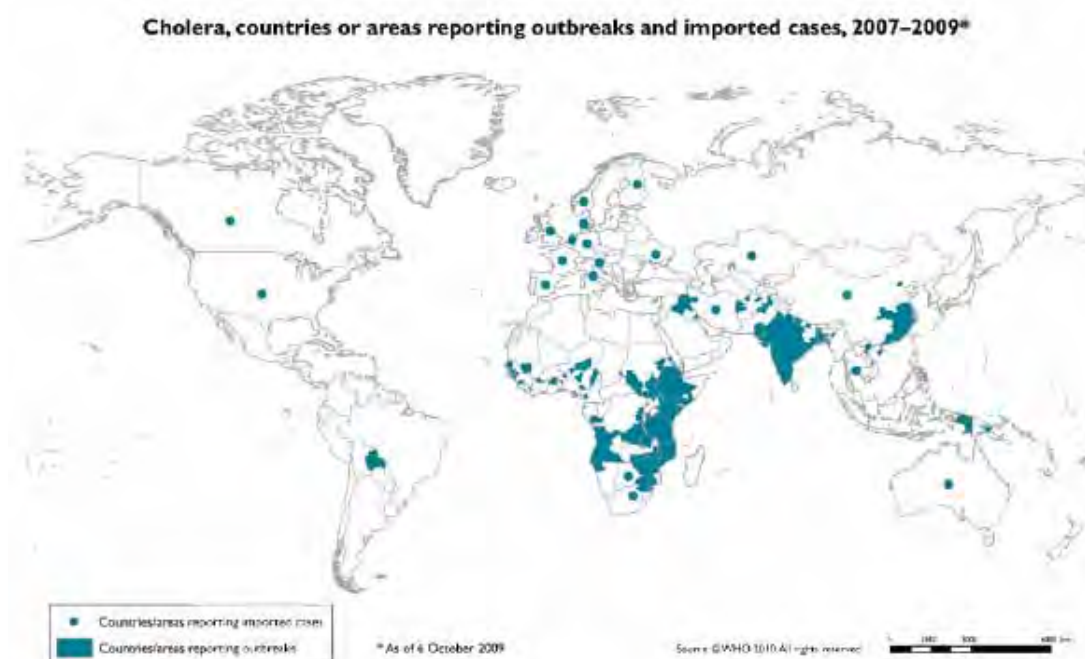


**Japanese encephalitis, countries or areas at risk, 2008**

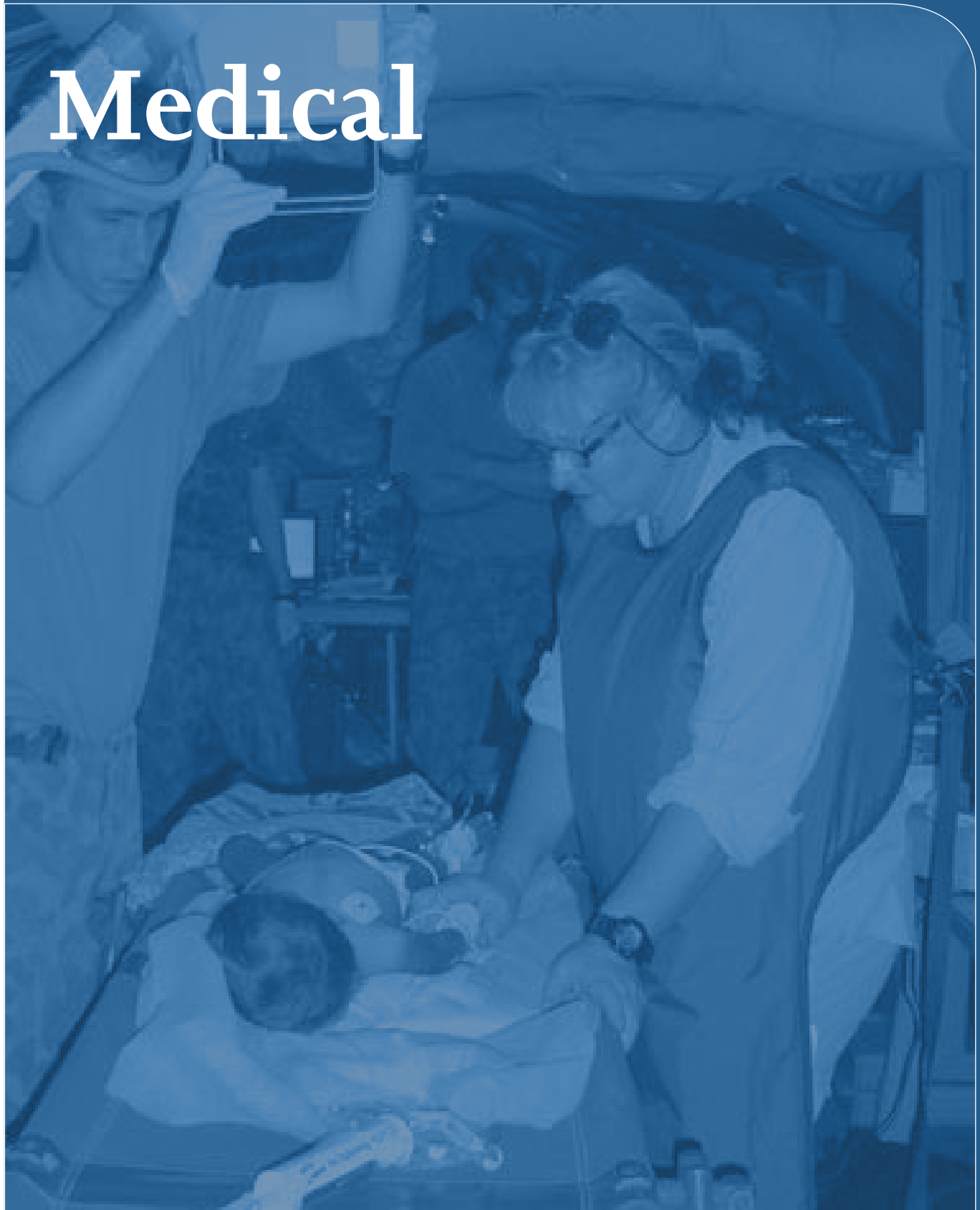


**Tuberculosis, estimated new cases, 2007**





# Medical



# Infectious Diseases



## Infectious Diseases Encountered During a Disaster Response

Timothy J. Gray MBBS, MPH&TM, BMedSci (Hons)

Caring for the health needs of a population following a disaster requires an understanding of endemic diseases in the response area. Disasters have the potential to increase the frequency of some infectious diseases. Increases may occur for many reasons, including:

- Population movement and crowding
- Disrupted sanitation and / or safe water supply
- Damaged housing and public buildings
- Overwhelmed local health infrastructure and disruption to public health programs
- Increase in vector numbers (particularly mosquitoes).
- Behaviour change eg sleeping outside

Disease outbreaks following disasters are rare occurrences. The major diseases that cause excess mortality in displaced populations are:

- **Malaria**
- **Measles**
- **Diarrheal diseases**
- **Acute respiratory tract infections (including pneumonia)**
- **Malnutrition (see Chapter 6)**

This chapter gives a brief overview of these significant infectious diseases as well as other endemic diseases that one may encounter in the tropics, with a particular focus on Southeast Asia. As outlined in the sections below, treatment options are often determined by regional susceptibility data. Discussion with local experts at the time of the disaster response is usually necessary.

## Vector borne disease

### Malaria

Malaria is a parasitic disease that is transmitted by the bite of a female *Anopheles* mosquito. After the parasite is injected with the mosquito bloodmeal it travels to the liver where it matures. A person becomes symptomatic approximately 2 weeks after the bite when the parasite escapes the liver and then enters and destroys the red blood cells. When another *Anopheles* mosquito bites a person with malaria the mosquito becomes infected and can pass it onto other individuals.

More details of this lifecycle can be seen in Figure 1

There are 5 types of malaria that infect humans with the common two being *Plasmodium falciparum* and *Plasmodium vivax*. Typically malaria produces fever, rigors (shakes), sweating, headache, vomiting and other flu-like symptoms. Malaria can kill by destruction of red blood cells, causing anaemia, or by altering the function of vital organs, including the kidneys, lungs and brain (cerebral malaria). *Falciparum* malaria is the species that most commonly causes severe disease, particularly in children and pregnant woman and when diagnosed should be treated urgently. *Vivax* malaria is able to survive in the liver in a dormant form for months or years before reproducing the disease.

Malaria can be diagnosed by using a microscope to visualise the parasite in the blood or by rapid diagnostic tests (RDTs) that detect parasite protein in a blood sample. RDTs are particularly useful in the field as they do not require a laboratory or skilled microscopists to make a diagnosis. The WHO recommends confirming the diagnosis of malaria in all patients suspected of malaria before treatment is started.

An overview of the treatment of malaria is provided in Box 1. It is important to consider other causes of the symptoms, such as bacterial infection, particularly in a person who is unwell. Specific drugs that are used to treat malaria include chloroquine for susceptible *vivax* infection and artemisinin based therapies for *falciparum* malaria. Primaquine is used to kill the dormant form of *vivax* malaria. There is an evolving problem of chloroquine resistant *vivax* malaria in Indonesia, Papua New Guinea, East Timor and Pacific Island Nations and as a result, chloroquine may not be effective against *vivax* infection in these regions. In other areas chloroquine remains the first line treatment for *vivax* malaria but clinicians should remain vigilant for treatment failures.

### Box 1 – Treatment of malaria

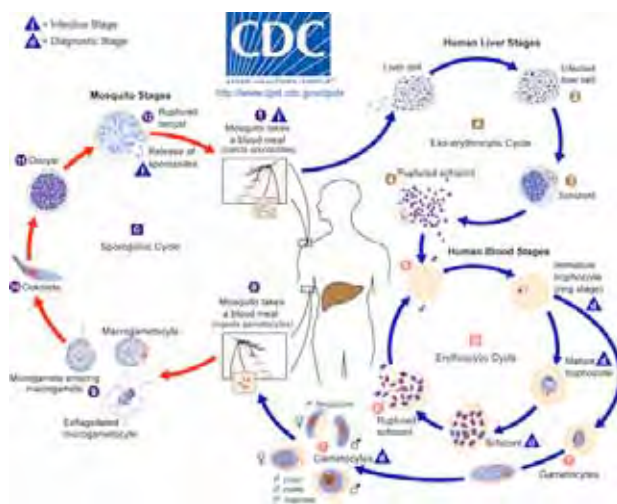
1. Lower temperature using physical cooling measures and paracetamol
2. Control nausea and vomiting early to allow specific malaria drugs to be given by mouth which is appropriate for most cases.
3. Assess and treat
  - a. Dehydration
  - b. Hypoglycaemia (low blood sugar)
  - c. Seizures
4. Treat with specific anti-malarial medications, detailed doses are outlined in the WHO Manual for the health care of children in Emergencies (see further reading)
5. Consider elimination of hibernating liver stage in *vivax* infections with primaquine.

It is not possible to prevent all malaria infections but there are multiple measures that reduce individual and population risk of malaria:

- Awareness of risk
- Prompt recognition and treatment of disease
- Reducing mosquito bites particularly between dusk and dawn when the Anopheles mosquitoes are most active
- Use of prophylactic drugs (eg doxycycline)

Comprehensive treatment guidelines for the diagnosis and management of malaria including in managing resistance, epidemics and complex emergency situations have been published by the WHO and can be found at: [www.who.int/malaria/publications/en/](http://www.who.int/malaria/publications/en/)

A discussion of the different prophylaxis options for travellers to endemic malaria areas can be found at: [www.cdc.gov/malaria/travelers/drugs.html](http://www.cdc.gov/malaria/travelers/drugs.html)



**Figure 1** Detailed life cycle of the malaria parasite from the CDC website. [www.dpd.cdc.gov/dpdx/html/malaria.htm](http://www.dpd.cdc.gov/dpdx/html/malaria.htm)  
 Abi/Ian I am a bit concerned about the 'excess detail in this diagram. Happy for you to leave it in or take it out!

### Dengue Fever

Dengue fever is an illness caused by one of four types of the dengue virus which is spread by the bite of an infected female mosquito of the Aedes family. Following infection an individual acquires long term immunity to the infecting strain, but not the other 3 types. The dengue carrying Aedes mosquitoes are 'peri-domestic', commonly breeding in small bodies of water around dwellings and rarely fly more than 200 metres from the breeding site. They preferentially feed

on humans, mostly during the day and take frequent, small bloodmeals. The bite of this black and white striped mosquito is frequently unnoticed (see figure).



Female *Aedes aegypti* mosquito feeding.  
 Image by James Gathany - License: Public Domain.

Dengue virus is found in most tropical countries, including in north-eastern Australia. Dengue infection does not always cause symptoms but when it does they arise 3 to 14 days after the initial bite. Characteristic symptoms include high fever lasting 3 to 7 days, severe frontal headache (particularly behind the eyes), muscle and joint pains. Other symptoms may include a loss of appetite, nausea, vomiting and diarrhoea, a blanching rash and minor bleeding which may occur from the nose or gums. Only a small number of infected individuals with dengue fever progress to severe disease with organ dysfunction and severe haemorrhage.

There are no specific tests available outside of high technology laboratories that reliably diagnose dengue. The rapid diagnostic tests showing the most promise for field clinics detect the presence of antibody to dengue that arises about 5 days into the illness. Routine blood tests may reveal low white blood cells, low platelets, and mild elevation in liver enzymes, but these findings may also occur in malaria or other infections.

Individuals with dengue fever should be encouraged to drink plenty of fluid and paracetamol should be given for fever and body aches. Aspirin and its related drugs should be avoided as these may make bleeding worse. People should be advised that prolonged lethargy and depression after recovery are common.

There is currently no vaccine available for dengue fever. Measures to protect individuals from infection should focus on avoiding mosquito bites and environmental measures focusing on the removal of breeding sites in and around populated areas. Further information about dengue fever can be found at: [www.cdc.gov/dengue/](http://www.cdc.gov/dengue/)

## Yellow Fever

Yellow Fever is a viral illness transmitted by the bite of an infected *Aedes aegypti* mosquito, the same species that transmits the dengue virus. The illness is only found in Central America and Africa. The illness occurs in two phases. The first phase is typically a mild illness with headache, fever, nausea and vomiting and loss of appetite. The second phase occurs in approximately 10-15% of cases and is often fatal with severe liver failure (hence the name yellow fever), and bleeding from the mouth, eyes and stomach. There is a highly effective vaccine available. Further information is available at: [www.cdc.gov/ncidod/dvbid/yellowfever/](http://www.cdc.gov/ncidod/dvbid/yellowfever/)

## Chikungunya

Chikungunya is a viral illness which causes fever, joint inflammation, muscular aches and other flu-like symptoms. A person acquires the illness 3 to 12 days after they are bitten by an infected *Aedes* mosquito, the same species that transmit the dengue virus. The illness is found in Africa and throughout Southeast Asia, including East Timor and Indonesia. Diagnosis is by antibody tests which can only be performed in high technology laboratories. There is no specific treatment for the virus. Joint pains can last for weeks to months following infection and usually respond to paracetamol and anti-inflammatory medication. The virus is not found in Australia, although the closely related Ross River Virus is endemic to Australia. There is no vaccine available for chikungunya. Further information is available at: [www.cdc.gov/ncidod/dvbid/chikungunya/](http://www.cdc.gov/ncidod/dvbid/chikungunya/)

## Japanese Encephalitis

Encephalitis is inflammation of the brain tissue usually caused by infection. Japanese Encephalitis is a virus transmitted by the bite of an infected *Culex* species of mosquito. The mosquitoes are infected with the virus when they feed on pigs which serve as the main natural amplifier of the virus. The virus is found throughout Asia and cases have been reported in the Torres Strait region of Australia. When humans are infected with the virus less than 1% develop any symptoms. When symptoms do occur they typically include fever, headache and vomiting. Young children are particularly vulnerable to progressing to severe disease with seizures, neck stiffness, drowsiness, confusion and coma in severe cases. Approximately half of the individuals who develop severe disease will have permanent disability and a quarter will die. There are no specific treatments for Japanese Encephalitis, however, there is an effective vaccine available. Further information is available at: [www.cdc.gov/ncidod/dvbid/jencephalitis/index.htm](http://www.cdc.gov/ncidod/dvbid/jencephalitis/index.htm)

## Lymphatic Filariasis

Filariasis is a parasitic disease caused by several species of filarial worms that live in the lymphatic tissues of the legs and occasionally the arms. The worms may be up to 10 cm long and release immature forms into the blood stream of infected individuals. The illness is transmitted by the bite of a mosquito that has fed on these immature forms. The illness is found throughout the tropics, including in Indonesia, East Timor, PNG and the Pacific Island Nations.

Once infected with filarial worms there are usually no symptoms for 8 to 16 months. Adult worms may live in lymph tissue for many years. The worms interfere with drainage of fluid and impair the immune function to the affected limb leading to recurrent skin infection of the limb and rarely the genitals. Cumulative damage over years can lead to chronic swelling (lymphoedema) of the limbs and in severe cases the tissues harden and thicken to cause elephantiasis.

The diagnosis can be made by identifying the immature forms of the worm in the blood, although this often requires a night time blood sample and a skilled microscopist. An ultrasound examination of the limbs can sometimes identify the movement of adult worms. The WHO is working towards elimination of lymphatic filariasis and recommends at least annual treatment of all individuals living in endemic areas with combination anti-worm treatments. Because much of the damage to the lymphatic vessels is from secondary bacterial infection of the skin it is important to treat skin infection early in these patients. Further information on the diagnosis and treatment of filariasis can be found at: [www.who.int/topics/filariasis/en/](http://www.who.int/topics/filariasis/en/)

## Airborne disease

### Tuberculosis

Tuberculosis is an infectious disease caused by the bacterium *Mycobacterium tuberculosis*. It is spread when someone with the disease in their lungs coughs, sneezes or breathes the bacteria into the air. When other people inhale the bacteria they become infected. Tuberculosis usually infects the lungs but any part of the body can be involved. Most the time when a person is exposed to tuberculosis their immune defences “wall off” the bacterium leading to a latent or inactive tuberculosis infection. One third of the world’s population have latent tuberculosis. These people are not infectious and do not suffer ill health while the bacteria remains walled off. Occasionally the inactive disease will become active leading

to symptomatic disease, sometimes occurring years after initial exposure to tuberculosis. The more common signs and symptoms of active tuberculosis are outlined in box 2. Often a person with tuberculosis will have only 1 or 2 of these findings and they may be mild for many months.

## Box 2. Signs and symptoms of active tuberculosis infection

- Persistent coughing
- Sputum production
- Coughing up blood
- Fever or night sweats
- Weight loss
- Shortness of breath
- Enlarged glands

Tests for inactive or latent tuberculosis include the Mantoux test or a specialised blood test called gamma interferon assay. To test for active disease a chest x-ray and sputum culture can be performed. The chest x-ray usually shows infection of the upper portion of the lungs (Figure 3). If a person is suspected or known to have untreated tuberculosis they should be encouraged to wear a mask while in public areas.



Figure 3. A chest x-ray of a man with tuberculosis showing infection of the right upper lung.

There is a serious growing worldwide problem of tuberculosis resistance to antibiotics. An important factor contributing to resistance is not completing the prescribed

course of treatment, which is typically 6 months or more. For this reason it would rarely be appropriate to start treatment of tuberculosis in the emergency setting, unless there were direct links to the local tuberculosis treatment programs in the area. It is important to remember that the household crowding that occurs following many disasters increases the risk of tuberculosis transmission within communities. Further information about tuberculosis can be found at: [www.who.int/topics/tuberculosis/en/](http://www.who.int/topics/tuberculosis/en/)

## Measles

Measles is one of the most infectious communicable diseases. The virus is spread by the cough and sneezes of infected persons. Measles cases in Australia are now rare but the disease continues to circulate in the developing world. In refugee populations it is one of the major causes of death and it is preventable. Measles infection commences about 7 to 10 days after exposure to the virus with fever, cough, runny nose and conjunctivitis (inflammation of the eyes). After a further 2 to 4 days a red rash starts on the head and spreads down to cover the body lasting for up to 8 days. One third of people with measles develop complications including diarrhoea, pneumonia, ear and eye infections and occasionally encephalitis (inflammation of the brain). In vulnerable populations the death rate can be as high as 30% of cases.

A person with measles is infectious from 24 hours before the onset of symptoms until 4 days after the appearance of the rash. A malnourished person may remain infectious for a longer period of time. There are no specific treatments for the illness. People with measles should have plenty of fluids and have symptoms treated as they arise. If a case of measles is suspected it is essential to urgently communicate this to the local health authorities. A highly effective measles vaccine is available. Further information about measles can be found at: [www.cdc.gov/measles/index.html](http://www.cdc.gov/measles/index.html)

## Food and Water borne diseases

### Enteric fever

The two main causes of enteric fever are typhoid fever and paratyphoid fever. The illness occurs when a person ingests food or water contaminated with a specific *Salmonella* species of bacteria from the faeces of an infected person. Typical symptoms include fever, rigors (shaking) abdominal discomfort, headache and constipation. Occasionally, particularly in children, it may present with diarrhoea. Sometimes persisting high fever alone is the only symptom. It can be hard to differentiate this illness



from malaria. Diagnosis is usually made by culturing the typhoid bacteria from the blood. Untreated, the disease may progress to rupture of the intestines and prolonged excretion of the bacteria in the faeces. There is a growing problem with antibiotic resistance when treating typhoid fever and therefore treatment choice should be guided by local experts. Drugs that may have activity against typhoid include ciprofloxacin, chloramphenicol and amoxicillin. Ciprofloxacin is considered non-active for all infections acquired in the sub-continent. There are vaccines available for typhoid fever, but they are not active against the closely related paratyphoid fever. Further information can be found at: [www.cdc.gov/nczved/divisions/dfbmd/diseases/typhoid\\_fever/](http://www.cdc.gov/nczved/divisions/dfbmd/diseases/typhoid_fever/)

### Cholera

Cholera is a bacterial infection caused by *Vibrio cholerae*. In disaster settings acute watery diarrhoea is synonymous for cholera infection. The bacteria is spread when faeces of an infected person contaminates drinking water or food. Symptoms come on 1 to 5 days after exposure to the bacteria with sudden onset severe watery diarrhoea which looks like 'ricewater' because it is flecked with mucous. Vomiting often comes on after the diarrhoea begins. Fever is uncommon in adults with the illness. Diagnosis can be made in specialised laboratories that culture the bacteria from stool samples. People with cholera die as a result of severe dehydration and therefore treatment needs to focus on rehydration (see box 3). It is important to check blood sugar levels as these can be low. In most cases oral rehydration solutions may be used. The WHO recommends zinc supplements which reduce the duration of a diarrhoea episode by 25% and are associated with a 30% reduction in stool volume. Antibiotics including doxycycline, cotrimoxazole and ciprofloxacin have also been shown to reduce duration of diarrhoea, but are not necessary in mild cases. Resistance to antibiotic is a common problem. There is a cholera vaccine available. Information regarding the management of diarrhoea including in outbreak situations is available at [www.who.int/topics/diarrhoea/en/](http://www.who.int/topics/diarrhoea/en/)

### Dysentery

Dysentery is a term used to describe diarrhoea with visible blood and mucous. Shigellosis is the major bacterial cause of bloody diarrhoea, passed on when infected faeces contaminates food or water. One to three days after exposure a person develops diarrhoea, sometimes with blood and mucous, fever, vomiting and stomach cramps. The illness typically lasts 3 to 7 days. In some the illness may only be mild but may cause high mortality in displaced populations

with poor sanitation. Infected people may excrete the bacteria for many months after symptoms resolve. Diagnosis is made by growing the bacteria from stool specimens and this requires a specialised laboratory. Assessment of dehydration and replacement of lost fluid is the most important aspect of treatment (see box 3). Antibiotics can be used to treat severe cases and where spread of the disease is likely. The use of effective antibiotic will reduce the excretion of bacteria in the faeces. Drugs that can be used include ciprofloxacin, trimethoprim-sulfamethoxazole and azithromycin. There is currently no vaccine for shigellosis. For further information see: [www.cdc.gov/nczved/divisions/dfbmd/diseases/shigellosis/](http://www.cdc.gov/nczved/divisions/dfbmd/diseases/shigellosis/)

A second major cause of dysentery is *Entamoeba histolytica* which is a protozoa species passed on through contaminated food or water. It may cause severe colitis with bloody diarrhoea which is clinically indistinguishable from shigellosis. Invasive *E. histolytica* infection may also cause liver and brain abscesses in a smaller proportion of patients. It can be diagnosed using a microscope to visualise the cysts in the stool, although other parasite cysts that do not cause disease can look similar. Treatment is with rehydration and metronidazole. For further information see: [www.cdc.gov/parasites/giardia/](http://www.cdc.gov/parasites/giardia/)

**Box 3. Treating a child with diarrhoea and dehydration Regardless of the cause of diarrhoea the most important and immediately life saving therapy is to replace the lost fluid.**

**Step 1: Assess the level of dehydration by looking for the following signs:**

- Severe dehydration (if 2 of more signs present)
  - Lethargic or unconscious
  - Sunken eyes
  - Not able to drink or drinking poorly
  - Skin pinch goes back very slowly
- Moderate dehydration (if 2 or more signs are present)
  - Restless, irritable
  - Sunken eyes
  - Drinks eagerly, thirsty
  - Skin pinch goes back slowly

### Step 2: Treat the dehydration

- Severe dehydration needs to be treated urgently with intravenous fluids or nasogastric fluid replacement.
- Moderate dehydration should be treated with oral rehydration solution and zinc. Breastfeed children should continue breastfeeding.

Detailed guidelines including preparing oral rehydration solutions, amount of fluid to prescribe in dehydration and instructions for parents can be found in the WHO Manual for the Health Care of Children in Emergencies.

- Treatment of dehydration
- Rehydration can be by mouth, by nasogastric tube or by intravenous lines.
- Need amounts per kg for children and adults.

### Worm infestation

Parasitic worms infect more than a third of the world's population with the highest rates in 6 to 15 year olds. The main worm types that infect humans are:

- Schistosomes
- Soil transmitted helminths
- tapeworms

Schistosome worms are passed on through complex lifecycles which result in infection when an immature worm burrows into human skin while submerged in fresh water. There are 5 main schistosome species which infect the wall of the gut or urinary bladder. Schistosome infection is usually asymptomatic. Sometimes early infection is identified by a characteristic rash and itch when the immature worm form burrows into the skin, or in latter infection, when recurrent bleeding into the urine or stool occurs. A person with a heavy and prolonged burden of schistosome worms is at risk of liver or kidney failure as well as high rates of bladder cancer. Schistosome infection is diagnosed by identifying the large characteristic eggs under microscopic examination of the stool or urine. It is treated with praziquantel.

The soil transmitted helminths are the most common infection worldwide and include the hookworm, roundworm and whipworm. These worm's eggs are passed in the stool and require a stage in soil to develop into infective forms. Once mature, the eggs are either ingested, or in the case of hookworm, a larval form penetrates the human skin. The adult worms live in the gut lumen. Symptoms of worm infection include diarrhoea, abdominal pain, weakness and may affect learning capability and physical growth. Hookworms may cause anaemia. The WHO strategy to reduce the morbidity in endemic areas is to treat all school

aged children and high risk adults at least once per year. Treating worm infection in children improves growth rates and is fundamental in addressing malnutrition. Effective medications include albendazole, mebendazole and levamisole.

Beef and pork tapeworms are the common tapeworm infections in humans. These infections are acquired when a person eats undercooked meat containing embryonic forms of the worm which subsequently grow (sometimes to greater than 5 meters long) and reside in the human gut. Eggs are passed into the soil with human stool and when consumed by pigs or cattle the immature forms migrate from the animal gut to their muscle. The lifecycle is completed when another person consumes this infected meat. A serious illness called cysticercosis occurs when a human acquires the infection by eating the pork tapeworm egg from contaminated food or soil rather than acquiring it from eating undercooked meat. The egg does not evolve into an adult worm but invades the gut wall and may lodge in any tissue, including the brain. Treatment of cysticercosis can be complicated by worsening symptoms, because the larval forms in the human tissue can swell when treatment is given. Drugs active against tapeworms include praziquantel and albendazole.

### Giardiasis

Giardiasis is an infection of the bowel caused by the parasite *Giardia lamblia*. A person becomes infected with giardia when they ingest food or water contaminated with faeces passed by an infected person or animal. Many people do not develop symptoms, but when they do, they arise 7 to 14 days after ingestion of the parasite. Symptoms include sudden onset of foul-smelling diarrhoea, abdominal cramps, bloating, nausea, weight loss and occasionally vomiting and fever. Untreated, the illness typically lasts 2 to 4 weeks before resolving in most cases. A small proportion of people will develop chronic giardiasis with milder symptoms that can last for many months. In young children chronic giardiasis is a significant contributor to chronic malnutrition. Diagnosis is made by identifying the characteristic parasite in stool samples using a microscope. Patients who are symptomatic with giardiasis should be treated with antibiotics with the active agents including metronidazole and tinidazole.

## Skin conditions

### Infected wounds

The skin provides an important physical defence against infection by preventing bacteria normally found on the skin and the surrounding environment from entering the deeper tissues. When a person suffers an injury to the skin bacteria and occasionally other pathogens may enter and establish infection. When a wound is infected a person experiences increased pain, swelling and redness. There may also be a collection of pus which may or may not discharge through the wound. Most infections of the skin are caused by Streptococcal and Staphylococcal families of bacteria. Following water related disasters the organisms that cause skin and wound infections are more varied. In addition to the usual causes, other bacteria including *Aeromonas* and *Vibrio* species may cause infections. When wounds are contaminated with environmental debris *Clostridium* bacteria can cause serious infection (see section on tetanus below). A diagnostic test that is relatively simple to perform in the field is a Gram stain which can help determine which type of bacteria is causing a wound infection. Wounds should be kept clean and whenever practical kept covered. Pus complicating wounds should be drained and any foreign material should be removed. Antiseptic solutions can be used to reduce the bacteria on the surface of a wound but they do not treat deeper infection. Antibiotics effective against skin lesions include amoxicillin, flucloxacillin (particularly for wounds with pus) and trimethoprim-sulfamethoxazole.

### Scabies

Scabies is a skin infection caused by a microscopic mite called *Sarcoptes scabiei*. Infection is more common and often more severe in tropical regions, particularly in crowded conditions. The mites transfer between people with prolonged direct skin contact and less commonly by freshly contaminated clothes or bed sheets. The mite burrows under the skin causing an intense itch which is often worse at night. The infection causes a red lumpy rash and sometimes a fine inflamed line can be seen where the mites have burrowed (Figure 2). Secondary bacterial skin infection can occur when a person scratches the affected area. The rash is often found around the buttocks, wrists, ankles and between the fingers and toes as well as in the skin folds of the elbows, armpit and genitals. Diagnosis is made by identifying the mite under a low power microscope, but this is not always necessary if a person has characteristic symptoms. Creams used to treat scabies include permethrin and benzyl benzoate. In children less than 2 months of age these creams are not considered

safe and crotamiton cream can be used. A repeat treatment is necessary after one week as none of the creams are active against the scabies eggs. It is recommended that all members of the household be treated at the same time. Clothes, towels and linen should be washed in hot soapy water and left in the sun to dry. Mattresses and pillows should also be put into the sun and sprayed with surface spray when available. The itch may continue for one to two weeks after treatment. For further images and information see: [www.cdc.gov/parasites/scabies/](http://www.cdc.gov/parasites/scabies/)



Photo of typical nodular scabies rash affected the hand. Photo courtesy of Dr Bart Currie, Menzies School of Health Research, Darwin.

## Others

### Pneumonia

Pneumonia is an infection of the lung tissue. When a person has pneumonia the lung tissue fills with pus and fluid making breathing difficult and painful. It is the most common cause of death in children less than 5 years of age, killing more children each year than AIDS, malaria and tuberculosis combined. It can also cause severe illness in adults, particularly the elderly and those infected with HIV. It is one of the main causes of death in displaced populations. Pneumonia is most commonly caused by bacterial infection (*Streptococcus pneumoniae* and *Haemophilus influenzae*) and by viruses (respiratory syncytial virus, measles and influenza). The illness usually comes on over a few days and when the illness is particularly prolonged unusual causes, including tuberculosis and whooping cough, should be considered. The symptoms of pneumonia include rapid or difficult breathing, cough, fever, loss of appetite and wheezing. Important clinical signs that correlate with

the severity of pneumonia include the breathing rate and indrawing of the lower chest wall with breathing. Those skilled with the use of a stethoscope can detect abnormal breathing sounds in individuals with pneumonia. Diagnosis is often made on the symptoms and clinical signs. A chest x-ray when available can be useful (Figure 4). Treatment includes maintaining fluid intake, providing paracetamol for fever and pain relief and oxygen for patients with difficulty breathing. Antibiotics can usually be given by mouth so long as vomiting and diarrhoea is not prominent. Antibiotics with activity against *S. pneumonia*, the common bacterial cause of pneumonia, include amoxicillin, trimethoprim-sulfamethoxazole and erythromycin. The WHO Manual for the Health Care of Children in Emergencies outline clear and practical guidelines for the assessment and treatment of pneumonia in children. There are vaccines available for common causes of pneumonia including *Streptococcus pneumoniae*, *Haemophilus influenzae*, measles and whooping cough.

### Leptospirosis

Leptospirosis is a bacterial infection that humans acquire from animals. The leptospira bacteria are found in the kidneys of many domestic and wild animals. Humans become infected when they have contact with water, wet soil or vegetation that is contaminated with the urine of infected animals (most commonly rats). Cuts or grazes on the exposed skin increased the risk of infection. Leptospirosis outbreaks have been reported after flood disasters. About 10 days after exposure to the bacteria a person becomes unwell with fever, headaches, muscle pains and reddened eyes. Most people have only mild symptoms, but sometimes infected people will go on to develop more severe disease including jaundice, kidney failure, bleeding into the skin, breathing difficulties, confusion and occasionally meningitis. Diagnosis usually requires a specialised laboratory with specific methods including culturing of blood or urine and serological tests. Antibiotics with activity against leptospira include penicillin and doxycycline. For further information see: [www.cdc.gov/leptospirosis/](http://www.cdc.gov/leptospirosis/)

### Tetanus

Tetanus is an infection caused by the toxin producing bacteria *Clostridium tetani* and is sometimes referred to as 'lock jaw'. The bacteria are ubiquitous in the environment, particularly in dust and soil. A person becomes infected when bacterial spores from the environment enter wounds. In the case of neonatal tetanus the cut umbilical cord is the usual site infected with the bacteria. Early symptoms of tetanus in adults include painful muscle spasms that begin in the jaw and subsequently cause stiffening of the neck, shoulder and back muscles. Other symptoms include violent generalised muscle spasms, seizures and breathing difficulty. A baby with tetanus presents between 1 and 10 days after birth with irritability, difficulty feeding and floppiness of the body. Symptoms progress to muscle spasms which can cause severe arching of the back. Treatment of tetanus may include antitoxin, antibiotics and surgical treatment of the infected area. Tetanus is a preventable illness as there is an effective vaccine. For further information see: [www.who.int/topics/tetanus/en/](http://www.who.int/topics/tetanus/en/)

### HIV

The Human Immunodeficiency Virus (HIV) is a virus that affects the ability of the immune system to fight infections. In recent years the number of people in Asia living with HIV has not increased and only Thailand has a prevalence of close to 1%. In Africa the prevalence of HIV is much higher. The risk factors for HIV infection in Asia are similar to Australia and include men who have sex with men, intravenous drug users and sex workers and their clients. HIV can be passed on by breast feeding, unprotected sexual contact and any procedure or injury that brings infected blood into contact with the deeper tissues of another person. People with HIV develop a febrile illness in the weeks following infection, but then remain well for many years in most cases. HIV is diagnosed by a blood test that requires a specialised laboratory. A person with HIV is more likely to become ill with other infections, including with pathogens that would not usually cause disease in a person with a functioning immune system. Illnesses that HIV people are more likely to suffer are tuberculosis, pneumonias, skin disease and diarrhoea. Disruption of HIV medicine is a major factor contributing to virus resistance. It would rarely be appropriate to start HIV medication in the disaster response setting unless there were close links with national treating bodies. However, efforts should be made to support individuals to continue their HIV medications. Further information regarding HIV can be found at: [www.who.int/hiv/en/](http://www.who.int/hiv/en/)

## Further reading

This overview of infectious diseases one may encounter in the tropics is not complete. The Centre for Disease Control in the US has an excellent website that provides information on most tropical infectious diseases available at: [www.cdc.gov/az/w.html](http://www.cdc.gov/az/w.html)

Detailed Australian treatment guidelines for infectious diseases which outline treatment doses and duration are available in: Therapeutic Guidelines: Antibiotic. Version 14, 2010. [www.tg.org.au/](http://www.tg.org.au/)

The WHO Manual for the Health Care of Children in Emergencies is a key resource which provides up to date guidelines for the management of all major illnesses affecting children in emergencies. It provides flow charts and clear management plans including relevant medication doses. A free copy can be downloaded at: [http://whqlibdoc.who.int/publications/2008/9789241596879\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241596879_eng.pdf)



# Use of Rapid Detection Test (RTDs) for Malaria



**WHO recommends that “malaria case management be based on parasite-based diagnosis in all cases, with the exception of young children in areas of high transmission and where lack of resources or need for urgent response temporarily limits its application.** The use of antigen-detecting rapid diagnostic tests (RDTs) forms a vital part of this strategy, providing the possibility of parasite-based diagnosis in areas where good quality microscopy can not be maintained.”

Of the 247 million developing clinical malaria and one million deaths yearly, few have any formal testing carried out. Cheap, easy to use and sensitive/specific Rapid detection tests are improving this problem. AusAID/AusMAT/ADF deployment during the Pakistan floods in late 2010 performed over 6,000 RDTs in 48 days (in all those presenting with fever), with an RDT positivity rate of between 30 and 60% daily (mean 55%). RDT positivity rates in endemic regions are normally less than 30%, and escalation of malaria prevention and treatment measures were enacted after trends and daily results were provided to the WHO and Pakistan Ministry for health.

RDTs require one to two drops of blood from a finger prick, and use basic, heat stable reagents and a simple plastic slide with several wells for addition of fluids. Results are available in 15 minutes, allowing mass testing to work. Multiple companies produce RDTs, some more expensive than others. The most useful give results for both *P. Vivax* and *P. Falciparum*, and have sensitivity and specificity rates in the high 90's. Costs vary but can be as low as one dollar per test for well validated RDTs (upto \$15-20). Local medical advice should be sought, or through experts in CDC, or regional malaria research centres, on RDT usage. Examples of this include advice from the malarial institute in Kabul to the Australian team, that regional *P. Vivax* antigen levels were low, giving false negative results with RDTs despite clinical disease. RDTs were also able to diagnose a serious escalation of *P. Falciparum* rate from 20% to 50% of positive tests (n=30-80 patients daily)

Due to the large number of products available, and the importance of RDTs in the global fight against malaria, the WHO have collated many scientific papers, performed structured reviews, and provide on-line teaching for clinic staff on the usage of RDTs.

Website; <http://www.wpro.who.int/sites/rdt/home.htm>

Most useful review, including product information and comparison for most available RDTs; [http://www.wpro.who.int/internet/resources.ashx/RDT/docs/pdf\\_version/OMS-FINDRapportMalaria200900514v25.pdf](http://www.wpro.who.int/internet/resources.ashx/RDT/docs/pdf_version/OMS-FINDRapportMalaria200900514v25.pdf)

# Communicable Disease Outbreak



## Communicable disease outbreaks

### References

World Health Organization (2005) *Communicable disease control in emergencies: a field manual* edited by M.A. Connolly (is on WHO website)

Connolly M.A., Gayer M, Ryan M.J., Spiegel P, Salama P, Heymann D.L., *Communicable diseases in complex emergencies: impact and challenges Lancet* 2004; 364 (9449): 1974-1983

Gayer M., Legros D, Formenty P, Connolly M.A., *Conflict and emerging infectious diseases Emerg Infect Dis.* 2007 Nov; 13 (11). Available from <http://www.cdc.gov/EID/content/13/11/1625.htm>

Disease control web: [www.who.int/diseasecontrol\\_emergencies](http://www.who.int/diseasecontrol_emergencies)

In emergencies the cluster lead for health is the World Health Organization (WHO) and is responsible for preparation and response to increased numbers of cases of an infectious disease. "A disease outbreak is an occurrence of an outbreak of disease in excess of what would normally be expected in a defined community, geographical area or season" (WHO)

The fundamental principles of disease control in emergencies are:

- Rapid assessment to identify main threats and set priorities;
- Prevention of communicable diseases by improving/maintaining physical environment and good living conditions;
- Surveillance/early warning system to facilitate early detection and prompt response to outbreaks;
- Outbreak control through preparedness and rapid response; and
- Disease management using adequately trained staff, appropriate treatment and standard protocols.

### Major diseases with epidemic potential in emergency situations

- Cholera
- Meningococcal disease
- Measles
- Shigellosis

In certain geographical areas the following may have to be included:

- Malaria
- Louse-borne typhus
- Yellow fever

- Trypanosomiasis
- Visceral or cutaneous leishmaniasis
- Viral haemorrhagic fevers
- Relapsing fever
- Typhoid
- Hepatitis A and E

### Steps in managing a communicable disease outbreak are:

- Prepare
  - Health coordination meetings
  - Surveillance system and reporting weekly/daily to Ministry of Health and WHO
  - Outbreak response plan for each disease: resources, skills and activities required
  - Stockpiles: test kits, appropriate antimicrobials, intravenous fluids, vaccines
  - Contingency plans for isolation/referral
  - Laboratory support
- Detect
  - Case definition
  - Clinical confirmation
  - Report case at health meeting
  - The earlier the detection and response, the greater the reduction of disease burden
- Respond
  - Confirm
  - Investigate
  - Control
- Evaluate
  - Assess appropriateness and effectiveness of interventions

### Epidemic thresholds

**ONE** suspected case of the following diseases represents a potential outbreak and requires immediate investigation:

- Cholera
- Measles
- Typhus
- Plague
- Yellow fever
- Viral haemorrhagic fever

An increase in the number of cases above a given threshold (or number/1000 population) of the following diseases indicate a potential outbreak and require immediate investigation:

- Malaria
- Shigellosis
- Visceral leishmaniasis
- Meningococcal meningitis
- Human African trypanosomiasis
- Others (e.g. typhoid fever, hepatitis A)

### Thresholds

A disease becomes an epidemic when there is an increase (often sudden) in the number of cases of a disease above what is normally expected in that population in that area.

Expected thresholds for particular diseases for given countries are widely available and information should be sought prior to deployment. The Ministry of Health in the affected country are often a reliable source for the collection of this information otherwise consult WHO.

### Case Definitions

It is essential case definitions are clearly stated and easy to use and are measured in a standard manner by different users. A clear and concise definition of what is a significant case ensures the same entity in different groups is being measured. It is essential background information for the country/area in which a team works is available and that all team members are briefed on what are the most likely infectious disease outbreaks prior to deployment. Case definitions are widely available in the WHO field manual ([www.who.int/diseasecontrol\\_emergencies/en/](http://www.who.int/diseasecontrol_emergencies/en/)) as well as other sources such as the Centre for Disease Control.

### Outbreak Reporting

The team reporting an outbreak of an infectious disease must collect the following information:

- Define the extent of the outbreak:
  - When did the cases occur – onset
  - Where do they live
  - Who are they
- Measure the severity of the outbreak:
  - How many
  - How many suffered complications
  - How many died

### Infectious diseases with the greatest burden

Infectious diseases with the greatest burden for morbidity and mortality in emergencies and conflict setting are:

- Pneumonia – leading cause of death in children <5
- Malaria where endemic – estimated 7.5 million clinical cases/year, 35,000 deaths/year
- Measles
- Diarrhoeal disease
- Tuberculosis and HIV/AIDS are increasingly important

Threat increases in emergencies due to:

- Increased incidence of endemic diseases
- Increased risk of epidemics
- Drug resistance
- Emerging diseases
- Eradication and elimination efforts threatened

### Infectious disease threat after natural disasters

The infectious disease threat depends on the following:

- Type of disaster/geographical area/level of development of the disaster affected region
- Most deaths occur in the immediate aftermath due to drowning or trauma
- Infectious diseases are caused mostly by secondary effects and NOT by the primary trauma
- May be an increase in epidemic diseases such as cholera, meningitis and endemic diseases such as malaria, acute respiratory infections
- Natural disasters rarely cause large scale epidemics unless population displacement and overcrowding

### Risk factors for infectious disease

- Loss of water/sanitation/power supplies
- Overcrowding
- Environmental changes increasing vector breeding sites
- Food shortages/malnutrition/health status
- Disruption/destruction of health services

### Which diseases

- Waterborne diseases (dysentery, cholera, typhoid, hepatitis, leptospirosis)
- Vector borne diseases (malaria, dengue, scrub typhus)
- Foodborne diseases (cholera, dysentery, typhoid, hepatitis)
- Disease related to overcrowding (measles, meningitis, influenza, pneumonia, also water and vector borne diseases)
- Tetanus post injury

### Dead bodies

There is no evidence that dead bodies pose a risk of disease outbreaks after natural disaster. Most agents do not survive long in the human body after death. Victims of natural disaster usually die from trauma and are unlikely to have “outbreak causing” symptoms. The source of acute is more likely to come from survivors. Handlers of dead bodies must however observe universal precautions.

## DISEASE EARLY WARNING SYSTEM

### References

Rahim M., Kazi B.M., Bile K.M., Munir M., and Khan A.R. The impact of the disease early warning system in responding to natural disasters and conflict crises in Pakistan. *Eastern Mediterranean Health Journal* Vol 16 Supplement 2010 accessed via [http://www.emro.who.int/publications/emhj/16\\_Sup/article15.htm](http://www.emro.who.int/publications/emhj/16_Sup/article15.htm)

[http://www.emro.who.int/afghanistan/pdf/dews\\_2008\\_2013.pdf](http://www.emro.who.int/afghanistan/pdf/dews_2008_2013.pdf)

The disease early warning system (DEWS) was introduced in the immediate aftermath of the 2005 Pakistan earthquake. DEWS is a mechanism which offers early detection of potential outbreaks of disease thus providing the opportunity for early response and containment.

### Objective:

To reduce morbidity and mortality by early detection and response to infectious disease outbreaks.

### Process:

Record infectious disease cases daily and respond to alerts. Chart and assess data weekly and respond to alerts. Investigate suspected outbreaks and take action to control them.

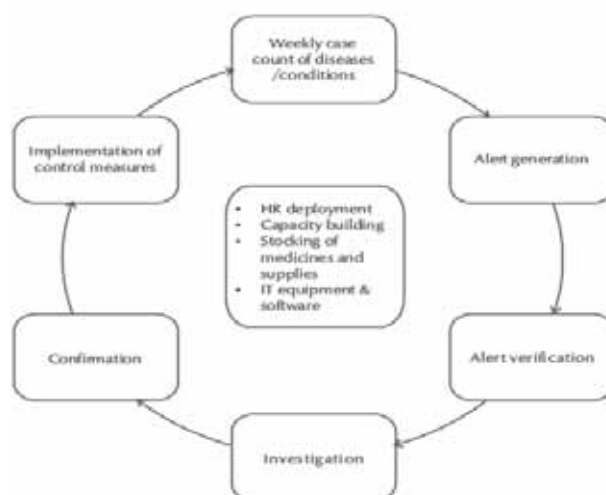
### DEWS in practice

The efficiency of DEWS is dependant upon ongoing surveillance, adequate reporting and rapid and appropriate intervention.

Diagnostic thresholds for alerts and outbreaks relevant to identified disease are agreed and implemented into the DEWS surveillance network. The following is an example of 2 diagnostic thresholds implemented in Pakistan.

Thresholds		
Disease/Condition	Alerts	Outbreaks
Acute respiratory infection	Twice the average number of cases of the previous three weeks for a given location	Clustering of cases in a single location above the threshold
Acute watery diarrhoea (suspected cholera)	One suspected case	A confirmed case, or a cluster of three or more suspected cases in a single locality.

Below is an example of the DEWS framework implement in Pakistan.



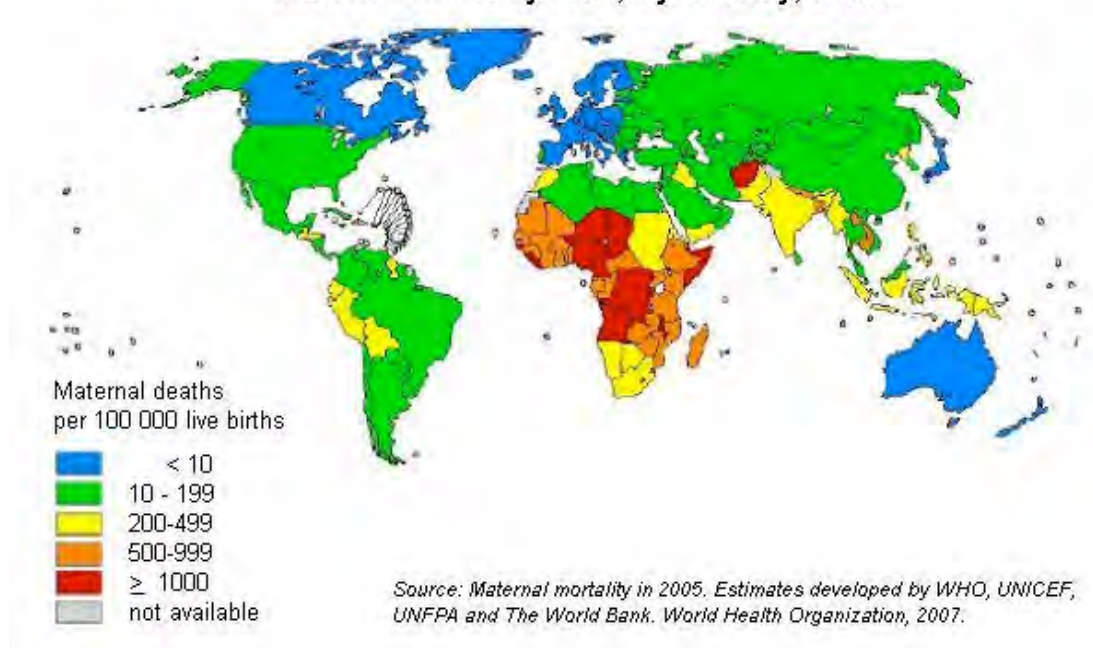
### Conclusion

Disease surveillance systems are essential for detecting disease outbreak and thus reducing the burden of morbidity and mortality in disaster affected populations. In order to achieve the overall aim, there must be close collaboration with the Ministry of Health of the affected country and the health cluster partners to ensure the system is effective, technically sound and viable.

# Maternal and Neonatal Health in Disasters.

While maternal mortality is a common cause of death among women of reproductive age living in resource-poor settings, the stressful living conditions of displaced women make delivering a child even more difficult and potentially life threatening. A useful resource that provides step-by-step approaches to integrate emergency obstetric care (EmOC) into humanitarian programming is the Field friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs.

Maternal mortality ratio, by country, 2005



# Preventing Excess Maternal and Neonatal Mortality and Morbidity

The central element of an organisation's "security architecture" is the definition of responsibilities and (decision-making) powers.

## Background: Before the crisis

All women and babies need maternity care in pregnancy, childbirth and after delivery to ensure optimal pregnancy outcomes. However, around the world, one third of births take place at home without the assistance of a skilled attendant.

*WHO strongly advocates for "skilled care at every birth" to reduce the global burden of 536 000 maternal deaths, 3 million stillbirths and 3.7 million newborn deaths each year.*

Countries measure the proportion of deliveries assisted by skilled attendants frequently since it is one of the indicators of progress towards Millennium Development Goal 5, which aims to improve maternal health.

Every minute, at least one woman dies from complications related to pregnancy or childbirth – that means 529 000 women a year. In addition, for every woman who dies in childbirth, around 20 more suffer injury, infection or disease – approximately 10 million women each year. (WHO).

Many countries with high maternal mortality rates (MMR) and low coverage of skilled care at birth, lack human resources for maternal and newborn health, especially at primary care level and primary referral facilities. This is further hampered by the lack of a long-term human resources development plan. Specifically, there is a need to pay attention to the following issues.

- There is a need, first, to ensure sufficient numbers of skilled attendants recruited and deployed at community level with necessary support.
- These skilled attendants should function as part of a primary health centre providing services at community level.
- At the same time, there is a need to equip sufficient numbers of health care providers with obstetric, anaesthetic and paediatric skills and support services at the nearest hospital – as a primary referral facility – for managing complications and health problems in women and their newborns.
- Retaining those employed and keeping them motivated is crucial in hardship areas which may need special incentives and recruitment of local people.
- In addition, issues of ethnicity, culture and language require special attention.

## Variation in definition of a skilled attendant at community level.

There is a lack of consistency across countries in terms of education and accreditation of skilled attendants at community level. There are different cadres of midwifery workers with varying time-spans of basic training ranging from 6 to 18 months after different levels of basic education (primary, junior or high school). There is an urgent need for countries to define the core competencies that different types of human resources should possess.

## Delegation of authority in health care practice.

Skilled attendants at community level are often most restricted in their tasks. Some countries are recognizing the need to address this problem. Indonesia, for example, has given community midwives the responsibility of providing first aid management of obstetric and newborn complications.

In India, recently, there has been a notable change in policy to allow auxiliary nurse-midwives (ANMs) to practice some selected life-saving skills. Issues related to upgrading of staff skills, supervision and support in carrying out the new tasks, how staff will be assisted to maintain their competency levels, and how to change the current pre-service curriculum are being discussed in order to arrive at a consensus.

*There should be a comprehensive, long-term plan for human resources development, especially in countries with a high MMR and low level of skilled care at birth.*

## Inadequate health sector financing

Almost all countries in the south east Asian region face a serious lack of investment in health services generally and in maternal and newborn health in particular. Health investment from public sources in most countries is still low, commonly below 5% of GDP. (WHO)

There is an urgent need for governments to make higher investments in health, especially for activities at primary health care level, and for ensuring quality of its referral back-up. Inadequate health financing has caused people primarily to pay out of pocket for accessing care, making ill-health one of the major drivers of poverty.

Health benefit schemes or insurance must include care during pregnancy, childbirth and post-natal period and for early newborn care. They should also include coverage for

the management of maternal complications and newborn problems. In addition, these packages should provide screening and treatment of diseases, such as malaria, TB, HIV/AIDS and underlying conditions, i.e. diabetes and anaemia in pregnant women.

Decentralization in health care settings is increasingly seen throughout the South East Asian Region. While it has improved the situation in some areas, it may become a potential threat to prioritization and adequate resource mobilization for skilled care at birth. Indonesia, for example, has seen some of its provinces failing to invest in funding for community midwives. (WHO)

### Need for a pro-poor approach and equitable deployment of human resources

Coverage with skilled care at birth is unevenly distributed in the countries of the south east Asian region. A sufficient number of skilled attendants need to be deployed close to the community they serve; this is particularly important for the poor and disadvantaged populations.

Data from the Demographic and Health Survey (DHS) in India, for example, showed that less than 10% of women in the poorest quintile utilize skilled care at birth, while more than 80% of those in the highest quintile utilize skilled care. Other countries also showed similar disparities.

Life-saving and emergency referral back up care of good quality should always be available free at the point of use, especially for the poor. Sometimes cost recovery and insurance schemes exclude the poor and do not cover costs of obstetric emergencies and other health problems in pregnancy. However, the south east Asian region does have a number of examples of pro-poor innovative finance schemes.

- The Self-Employed Women's Association (SEWA) in the state of Gujarat, India, has an insurance scheme which works on very low premium and insures its women employees and which includes maternity care and management of complications.
- Thailand has included maternal and newborn care in the 30 Baht health care scheme that has been implemented all over the country.
- In Indonesia, there is a government-funded safety net programme for poor pregnant women and promotion of a community saving scheme "tabulin" for childbirth.
- Bangladesh is adopting the pro-poor approach, as reflected in its Poverty Reduction Strategy Paper (PRSP).

Midwifery in most countries of the Region is not seen as a profession. Neither is it recognized that midwives or those who practise midwifery require "specialist" type of pre-service training. Midwifery is often integrated into the basic nursing curricula where the time spent on developing midwifery competencies is frequently too short. In some instances, this has led to nursing subjects and specialization taking precedence over development of midwifery competencies.

Having generic, low level or multipurpose health care workers to provide skilled care at birth, especially in the community, may sound theoretically useful. However, it can pose problems when trying to maintain standards and competency levels where having the necessary specific competency for dealing with pregnancy and birth-related complications is critical.

Additionally, very few countries have an established mechanism for licensing midwifery practice. Few have a proper functioning accreditation system to ensure that institutions prepare practitioners for safe midwifery practice. Without such licensing and accreditation systems, it is unlikely that midwifery will acquire the status of a profession, and thus will never be as attractive as other occupations. This has serious implications for recruitment of entrants with the necessary educational background.

Sri Lanka has made midwifery an attractive and well-respected profession since the early period of its efforts to reduce MMR. Both Sri Lanka and Thailand had introduced a strong licensing and accreditation system in order to ensure that midwives, who were licensed, were truly competent. The current scenario in some countries becomes a vicious cycle of low status of midwifery personnel; poor recruitment; low morale which leads to poor quality of care, lack of empowerment; and, finally, low utilization of services.

### Complications

Five direct complications account for more than 70% of maternal deaths:

- Haemorrhage
- Infection
- Unsafe abortion
- Eclampsia (very high blood pressure leading to seizures)
- Obstructed labour

Maternal death – causes and main interventions		
Causes of maternal death	%	Proven interventions
Postpartum Haemorrhage	25%	Treat anaemia in pregnancy. Skilled attendant at birth: prevent/ treat bleeding with correct drugs, replace fluid loss by IV drip/ transfusion if severe.
Sepsis	15%	Skilled attendant at birth: clean practices, antibiotics if infection arises.
Unsafe Abortion	13%	Skilled attendant: give antibiotics, empty uterus, replace fluids if needed, counsel and provide family planning.
Eclampsia	12%	Detect in pregnancy; refer to doctor or hospital. Treat eclampsia with appropriate anticonvulsive magnesium sulphate; refer unconscious woman for supervised, urgent delivery.
Obstructed Labour	8%	Detect in time, refer for operative delivery.
Other Direct Obstetric Causes	8%	Refer ectopic pregnancy for operation.

Stillbirths – causes and main interventions		
Causes of stillbirths	%	Proven interventions
Birth Asphyxia and trauma	40%	Skilled attendant at birth. Effective management of obstetric complications.
Other known causes (pregnancy complications, maternal diseases, malaria, malformations)	25%	Pregnancy care. Presumptive treatment for endemic diseases, effective management of pregnancy complications.
Congenital Syphilis	8%	Maternal syphilis screening and treatment of positives.
Unknown causes	27%	

(WHO Packages of interventions for family planning, safe abortion care, maternal, newborn and child health)

While these are the main causes of maternal death, unavailable, inaccessible, unaffordable, or poor quality care is fundamentally responsible. They are detrimental to social development and wellbeing, as some one million children are left motherless each year. These children are 10 times more likely to die within two years of their mothers' death. (WHO)

## Practice

Women need not die in childbirth. Young woman should be afforded the information and support needed to control her reproductive health, help her through a pregnancy, and care for her and her newborn well into childhood.

It is well understood that the vast majority of maternal deaths could be prevented if women had access to quality family planning services, skilled care during pregnancy, childbirth and the first month after delivery, or post-abortion care services and where permissible, safe abortion services.

15% of pregnancies and childbirths need emergency obstetric care because of risks that are difficult to predict. A working health system with skilled personnel is key to saving these women's lives. (WHO | Packages of interventions for

family planning, safe abortion care, maternal, newborn and child health)

## WHO recommends:

- All children receive immunizations by their first birthday. Starting at six months against:
  - Polio,
  - Tuberculosis,
  - Diphtheria,
  - Tetanus,
  - Whooping cough,
  - Measles,
  - Hepatitis B and
  - Haemophilus influenzae type B
- Couples wait at least two years from one birth to the time a woman attempts to become pregnant again.
- Infants be fed freshly-prepared, nutrient-rich food while continuing to be breastfed for up to two years.

## During the Emergency (Conflict or Natural Disaster)

Ensuring clean deliveries and access to emergency obstetric care in the first few days of a crisis are a priority because these actions will save lives and prevent illness.

### MISP

The Minimum Initial Service Package (MISP) for Reproductive Health (RH) is a set of priority activities to be implemented during the early stages of an emergency (conflict or natural disaster).

The MISP is a standard in the 2011 revision of the Sphere Humanitarian Charter and Minimum Standards in Disaster Response. The components of the MISP form a minimum requirement and comprehensive RH services should be provided as soon as the situation allows.

The MISP is not just kits of equipment and supplies; it is a set of activities that must be implemented in a coordinated manner by appropriately trained staff at the beginning of a crisis.

It can be implemented without a new needs assessment since documented evidence already justifies its use. The MISP prevents excess maternal and neonatal mortality and morbidity, reduces HIV transmission, prevents and manages the consequences of sexual violence and includes planning for the provision of comprehensive RH services.

When implemented at the onset of an emergency, the MISP saves lives and prevents illness, especially among women and girls. Neglecting RH in emergencies has serious consequences: preventable maternal and infant deaths, sexual violence and subsequent unwanted pregnancies and unsafe abortions; and the spread of HIV.

The Reality of Implementing the MISP in Indonesia 56  
The Women's Commission conducted an assessment of the MISP in tsunami-affected areas of Aceh, Indonesia in February 2005.

While slightly more than half of humanitarian workers interviewed had actually heard of the MISP, only one of 25 people could accurately describe its overall goal, objectives and priority activities.

Coordination of the MISP was led by UNFPA, which fielded a designated RH focal point in Banda Aceh within one week of the tsunami and initiated working group meetings among the numerous local and international organizations, as well as the Indonesian health authorities.

Women and girls in focus groups expressed concern with the lack of privacy and security in some settings and, in some camps, men and women shared latrines. No MOH personnel and few organizations were able to state that they had a sexual violence protocol in place to respond to the clinical needs of rape survivors.

MOH and WHO representatives reported that health workers failed to practice universal precautions, such as cleaning, disinfection and sterilization of medical supplies to prevent the spread of infections, including HIV/AIDS. Most supplies to support the MISP, such as clean delivery kits and midwife kits for health centers, were available to international agencies within or shortly after the first month of the emergency. The need to plan for comprehensive RH services as part of the MISP, including ordering RH supplies, was evident in the demand that women affected by the tsunami had for contraceptive supplies. The demand was quickly addressed through collaborative efforts of donors, the National Family Planning Coordinating Board (BKKBN) and UNFPA. (MISP Learning Module pg41).

### Why is the MISP a priority?

While resources should not be diverted from dealing with other major health threats, implementing the MISP is essential to reducing mortality and morbidity experienced particularly by women and girls. There are multiple competing health priorities in an emergency, such as addressing diarrhoea, measles, acute respiratory infections, malaria and malnutrition, but specific aspects of RH, as expressed in the MISP, also must be addressed. Rather than trying to implement a broad range of RH activities, limiting the scope of RH in the emergency phase to the MISP ensures focused attention on essential actions in emergencies where human and material resources are scarce.

### What are the possible consequences of ignoring the MISP in an emergency setting?

The lives of the displaced, particularly women and girls, are put at risk when the MISP is not implemented. For example, women and girls can be placed at risk of sexual violence when attempting to access food, firewood, water and latrines.

Their shelter may not be adequate to protect them from intruders or they may be placed in a housing situation that deprives them of their privacy. Those in power may exploit vulnerable women and girls by withholding access to essential goods in exchange for sex.

Not observing universal precautions in a health care setting may allow the transmission of HIV to patients or health workers. Without a referral system in place to transfer patients

## Challenges and Solutions

1. Sometimes a lack of understanding and/or prioritization of RH by humanitarian actors can make coordination difficult. How can one counteract such apathy and dismissal of RH issues?

In the short term, one could point to the fact that the MISP is a Sphere standard and is thus an internationally recognized, universal minimum standard in disaster response to which each humanitarian agency is obligated to adhere. One could emphasize that it is a lifesaving intervention. From a longer-term perspective, agencies should be encouraged—based on the Sphere standard—to prioritize RH in their emergency preparedness planning. One could also encourage staff to complete the MISP module as well as use the module to educate and advocate to relevant agency staff and others about the importance of implementing the MISP.

2. At the beginning of an emergency, UNFPA and other specialist agencies may not yet be operational in the field. Security may be poor and capacity of staff may be very weak. In such a setting, the reality of trying to adequately implement all elements of the MISP can be very challenging. In what ways can an individual, small group or agency address this problem?

If your agency is assuming responsibility in the health sector, it should ensure the MISP is included in its response. Your agency or another agency could volunteer to establish regular meetings to coordinate implementation of the MISP. Contacting UNFPA in Geneva or New York could also help to identify in-country support.

[www.who.int/reproductive-health/publications/interagency\\_manual\\_on\\_RH\\_in\\_refugee\\_situations/full\\_text.pdf](http://www.who.int/reproductive-health/publications/interagency_manual_on_RH_in_refugee_situations/full_text.pdf)

The RH Kits for Crisis Situations booklet is available at [www.rhrc.org/pdf/rhrkit.pdf](http://www.rhrc.org/pdf/rhrkit.pdf).

in need of emergency obstetric care services (e.g., cesarean section) to an equipped health facility, women may die or suffer long-term injuries (e.g., obstetric fistula).

## Who is responsible for implementing the MISP?

Humanitarian workers are responsible for ensuring that MISP priority activities are implemented. MISP activities are not limited to reproductive health staff or even the general health sector. The MISP cuts across all sectors in addition to health, including food security, water and sanitation services and shelter. Humanitarian workers should however report concerns to the cluster lead within their area of expertise – i.e. where humanitarian workers are involved in health initiatives, concerns should be reported to the cluster lead for health which is WHO.

## Coordination of the MISP

In any emergency situation the host government has ultimate responsibility for its subjects. Where the affected country has a UN presence before the crisis, the UNDP is the lead agency and will have in place, a resident coordinator who has the responsibility for day to day operations.

When a humanitarian crisis occurs and emergency relief is requested, the UN Office for the Coordination of Humanitarian Affairs (OCHA) appoints a humanitarian coordinator who has the in-country responsibility to set up and coordinate a humanitarian response. The humanitarian coordinator reports directly to the Emergency Relief Coordinator in Geneva who has overall responsibility for the international response.

The humanitarian coordinator is advised by cluster leads. The cluster leads are responsible for coordinating and implementing the response in a manner which best utilises available resources and avoids duplicating services. For example the World Health Organisation has the overall responsibility for coordinating and implementing the health response, World Food Program is the cluster lead for food aid. Reproductive health and MISP activities should be coordinated by cluster leads and in consultation with local, national and international respondents.

Evidence has shown that where there is no clear delegation of RH activities, they are typically overridden by other emergency concerns such as food distribution, water and shelter. Through the cluster lead, the RH coordinator has the task of making RH a priority in order to facilitate the implementation of the MISP.

## MISP Objective

### Prevent excess neonatal and maternal mortality and morbidity by:

- providing clean delivery kits to visibly pregnant women or birth attendants to promote clean deliveries;
- providing midwife delivery kits (UNICEF 48 or equivalent) to facilitate clean and safe deliveries at the health facility;
- initiating the establishment of a referral system to manage obstetric emergencies.

### Why is preventing neonatal and maternal morbidity and mortality a priority?

In any displaced population, approximately 4 percent of the total population will be pregnant at a given time.

Of these pregnant women, 15 percent will experience an unpredictable obstetric complication, such as obstructed or prolonged labor, pre-eclampsia or eclampsia, sepsis, ruptured uterus, ectopic pregnancy or complications of abortion.

In the early phase of an emergency, births will often take place outside the health facility without the assistance of trained health personnel.

Without access to emergency obstetric services, many women will die or suffer long-term health consequences that are preventable (for example, obstetric fistula).

### How can we ensure that delivery complications are dealt with efficiently at the health center level?

Fifteen percent of women will develop a potentially life-threatening complication during pregnancy or at the time of delivery. At the primary health care level, basic EmOC 53 should be available for these women 24 hours per day, seven days per week. Therefore, it is important to provide midwives and other skilled birth attendants at the primary health center level with materials and drugs to safely conduct deliveries, to deal with complications and to stabilize women prior to transport to the referral level. Supplies to address obstetric emergencies are included in the Interagency RH Kits and can be ordered through UNFPA.

### How many deliveries require a cesarean section (c-section)?

According to the UN Process Indicators of Emergency Obstetric Services, 5 to 15 percent of all deliveries require a c-section.

These women, and other women suffering from obstetric emergencies, such as those requiring blood transfusion and

surgery, may need to be referred to a hospital that is capable of performing comprehensive EmOC. Obstetric complications that cannot be managed at the health center should be stabilized and transported to the referral hospital.

Estimates based on a population of 20,000 with a CBR of 4%	
Expected number birth in a 3-month period	20,000 x 0.4 (CBR) x .25 = 2000
Pregnant women who will face complications at delivery	15% = 300
Complicated deliveries that require a c-section	5-15% = 10-30

Three months are 25 percent (.25) of one year.

Basic emergency obstetric care functions, performed in a health center without an operating theatre, include: assisted vaginal delivery, manual removal of the placenta

and retained products to prevent infection, and administering antibiotics to treat infection and drugs to prevent or treat bleeding, convulsions and high blood pressure.

Comprehensive EmOC services require an operating theater and are usually provided in a district hospital. These include all the functions of a basic emergency facility, plus the ability to perform surgery (c-section) to manage obstructed labor and to provide safe blood transfusion to respond to hemorrhages.

### When should a referral system for obstetric emergencies be made available?

As soon as possible, a referral system, including the means of communication and transport, that supports the management of obstetric complications must be available for use by the displaced population 24 hours a day, seven days a week.

The referral system should ensure that women with complications of pregnancy or delivery are referred from the community to a primary health care facility where basic EmOC is available and to a facility with comprehensive EmOC services, if necessary.

### **Is it better to support an already existing referral facility or set up new one?**

Where feasible, a local referral facility (e.g., district hospital) should be used and supported with personnel, medical equipment and supplies as needed to meet the needs of the displaced population.

If this is not feasible because of the distance or the inability of the host facility to meet the increased demand, then an appropriate emergency referral facility for the displaced population could be established. In either case, it will be necessary to coordinate with local health authorities concerning the policies, procedures and practices to be followed in the referral facility. The protocols of the country should be followed, although some variation may have to be negotiated.

### **What are the 24/7 requirements of an effective referral system?**

A referral system should have transport at all times. For example, if the NGO staff leave the camp and take the vehicle or ambulance with them, a communication system must be established so that if a woman goes into labor and experiences complications, such as obstructed labor, she can get to the health care facility.

It may be necessary to negotiate with camp security personnel to allow the transport of emergency patients at night. In addition, a qualified medical person who can address obstetric complications and perform a c-section if necessary must be available at the referral facility at all times.

Finally, the referral facility must have qualified staff, medical equipment and supplies to cope with the extra demands put on it by the displaced population.

### **Which type of activity related to maternal care is not a priority in a crisis?**

Most maternal deaths occur from complications during or after delivery. The majority of these complications cannot be predicted earlier in pregnancy. Of all pregnant women in whom a health problem is identified during antenatal care, most will not develop a life-threatening complication during or after delivery.

Therefore, although providing antenatal care and training midwives are appropriate activities once all the components of the MISP are implemented and the crisis phase is over, these interventions are not vital and could divert attention from the more urgent need of access to quality EmOC in the emergency phase.

It is not necessary to train TBAs and midwives before providing them with clean delivery kits as these kits should reach pregnant women without delay.

Organizing discussions with TBAs and midwives to exchange information and provide supplies to the community can be done early in an emergency. However, training existing TBAs and/or midwives on clean and safe deliveries should wait until a more stable phase has been reached.

Note that WHO no longer recommends training new TBAs, but rather recommends informing all women in the community about danger signs during delivery and providing a professional training curriculum for village midwives.

## **Neonatal Care**

Approximately two-thirds of infant deaths occur within the first 28 days. The majority of these deaths are preventable by initiating essential actions that can be taken by health care workers, mothers or other community members:

WHO, Perinatal and Neonatal Mortality: Global, Regional and Country Estimates, 2001.

60 Moore, J. and J. McDermott, Every Newborn's Health: Recommendations for Care for All Newborns, Save the Children US, 2004.

### **Immediate care after birth**

- Be sure that attendants use gloves or wash hands with soap and water before the delivery and before tying and cutting the cord.
- Keep delivery room warm and ensure baby is dried and warmly wrapped immediately after birth.
- Keep the head covered. Delay bathing for at least six hours.
- Use a clean (preferably sterile) instrument to cut the umbilical cord, and check frequently for bleeding.
- Keep the baby with the mother to ensure warmth and frequent breastfeeding.
- Pay attention to frequent hand washing by anyone handling the baby.
- Clean baby's eyes immediately after birth, and if prophylaxis is country policy, instill drops or ointment.
- Encourage Kangaroo Mother Care.
- Help mother with the first (within one hour)

## Continuing postnatal care

- Keep the baby with the mother. Avoid putting two babies in the same cot.
- Clean the cord with soap and water and keep it dry. Do not cover the cord with any bandage or cloth.
- Tell the mother what danger signs to look for in the condition of the cord and in her baby. Be sure she knows when and where to go for help.
- Teach the mother how to keep the baby warm.
- Take the baby to the health center at six weeks for immunizations.
- Advise the mother to give her child nothing but breast milk for the first six months and to continue breastfeeding up to two years or longer.



## What causes women to die from obstetric complications?

Often women experience delays in accessing life-saving care that cost them their lives. The situations that hinder women from seeking care can be divided into three categories

("the three delays"):

- delay in deciding to seek care;
- delay in reaching care due to transportation difficulties; and
- delay in having appropriate care available at the facility once reached.

Therefore, after EmOC services are in place, the immediate focus should be on preventing delays in timely access to good quality EmOC for women suffering from emergency obstetric complications.

## Managing the Premature infant with Kangaroo Mother Care

Definition: A universally available and biologically sound method of care for all newborns, but in particular for premature babies, with three components ...

- 1 Skin-to-skin Contact
- 2 Exclusive breastfeeding
- 3 Support to the mother infant dyad.

Skin-to-skin contact is between the baby front and the mother's chest. The more skin-to-skin, the better. For comfort a small nappy is fine, and for warmth a cap may be used. Skin-to-skin contact should ideally start at birth, but is helpful at any time. It should ideally be continuous day and night, but even shorter periods are still helpful.

Exclusive breastfeeding means that for an average mother, expressing from the breasts or direct suckling by the baby is all that is needed. For very premature babies, supply of some essential nutrients may be indicated.

Support to the dyad means that whatever is needed for the medical, emotional, psychological and physical well being of mother and baby is provided to them, without separating them. This might mean adding ultramodern equipment if available, or purely intense psychological support in contexts with no resources.



Sr Agneta Jurisoo studied what little literature was available on KMC during 1987. The following year she and Dr Bergman arrived at a small mission hospital in Zimbabwe, where premature births were common. There were no incubators, poor transport over great distances, and overloaded referral centres: only one of ten premature babies survived.

In the absence of incubators, they started a care plan in which the mother became the incubator. Instead of waiting for the baby to “stabilise”, the mother was used to stabilise premature infants immediately after birth. It was immediately clear this was highly effective, no matter how small or how premature, stabilisation took a mere six hours. With this care, now five of ten very low birth weight babies survived.

#### **This work has been published:**

The “kangaroo-method” for treating low birth weight babies in a developing country.

Tropical Doctor, April 1994, 24: 57-60.

Babies need feeding: when very premature this was usually given through a nasogastric tube, but always mothers own milk was given.

Intravenous lines were only used for resuscitation.

Babies were kept skin-to-skin 24 hours a day.

By putting the head-end of the bed at 30 degrees, the baby is the best angle, and mother can’t overlay the baby. Mothers and babies are comfortable and secure in KMC. But the mother needs psychological support to keep it up!

## **Birth Bundles**

www.maternova.net. Rapid prototyping for a new kind of midwifery kit to save women’s lives in childbirth.

Minimum Initial Service Package (MISP) for Reproductive Health in 42 Crisis Situations.

The creation of birthing bundles – or care packages is seen as an additional method to decrease mortality through the provision of essential items needed for birthing and the care of the newborn for the first few hours after birth.

#### **What basic materials can help pregnant women have a clean birth in an emergency?**

All displaced populations will include women who are in the later stages of pregnancy and who will therefore deliver during the emergency phase; the crude birth rate (CBR) is estimated at 4 percent.

Simple, clean delivery packages for home use should be made available to all visibly pregnant women. These are packages that the women themselves or TBAs can use to help women when they are giving birth. The packages contain very basic materials: one sheet of plastic, two pieces of string, one clean (new and wrapped in its original paper) razor blade, one bar of soap, a pair of gloves and a cotton cloth.

#### **What is the best way to get clean delivery kits?**

Because these materials are often easily obtained locally, it is possible to assemble these packages on-site.

In fact, it may be possible to contract with a local NGO to produce the kits, which could provide an income generation project for local women.

However, clean delivery kits can be ordered from UNFPA.<sup>51</sup> Sometimes this may be a quicker alternative, and the sooner the materials are available, the better it is for pregnant women.

In addition, contacting UNFPA at the start of a crisis to establish a relationship and to determine the availability of MISP supplies will likely facilitate better emergency preparedness.

#### **Making kits for remote skilled birth attendants**

Making a pack for remote skilled birth attendants requires thinking outside a typical health kit, because some solutions to life-threatening issues lie outside the medical field. In many low-resource settings, drugs and medical personnel are in short supply, but so are key things like light and power.

Providing the lowest cost tools to allow frontline midwives and nurses to perform in what are often difficult circumstances will assist in safer deliveries for both mother and child.

Birthing Bundles come in a variety of forms relevant to the community that they are created to the skill level of the attendant.

The development of kits should include items that have been validated through experience, such as the inclusion of solar-powered headlamps in the kits provided to Kenyan attendants. This item was included due to need to free their hands to do deliveries, after repeated stories of midwives holding unsanitary flashlights in their mouths, in an attempt to aid deliveries in the dark.

- Mobile phones are critical for the safety of the health provider, for calling ahead to other facilities when needing to refer a woman in crisis and for getting backup from supervisors. Kenyan packs include the provision of a mobile phone charger that works through a windable crank because of the lack of power availability in remote locations.
- The obstetric pack should also include a reminder flow chart on key clinical protocol designed to prevent

postpartum, hemorrhage, the leading cause of maternal death.

- The pack should be designed to fold out like a toiletry kit so that the tools are accessible and the reminder card displayed on the back of the pack.
- Even more basic, include a simple silicone cup that allows the measurement of blood loss, prompting health workers to refer when a woman gets near a critical point of blood loss.
- WHO Colour Scale to detect anemia
- The inclusion of mosquito nets to protect the mother and newborn from malaria carrying mosquito's

The distribution of these packs should be through health workers who spend time in low-income settings where there is a higher likelihood of the bundles being used by skilled attendants.

### Good practice

If the situation permits, assembling clean delivery packages locally may be a good opportunity to identify and organize TBAs and to talk with them about referring women suffering from obstetric complications or requiring medical care for rape. TBAs can be organized to make up the simple packages and then distribute them to visibly pregnant women.

Because TBAs are part of the displaced population, they most likely already know which women are close to their delivery times and are in need of the materials, and may also know which women and girls have survived rape.



Remote - Skilled Birthing Bundle. Maternova obstetric Kit

## Traditional Birthing Attendant's (TBA)

The following includes extracts from WHO

Dietsch E, The experience of being a midwife: Relationships with skilled birth attendants. Rural and Remote Health 10 (online), 2010:1481 available from: <http://www.rrh.org.au>

*While the WHO requires the implementation of skilled attendants for pregnant women the traditional birth attendant remains a significant person for many women who are unable to access a skilled care.*

Traditional Birth Attendants (TBA's) are often generally older women who are well respected by their communities. Many are illiterate and have learnt their skills through working with other Traditional Birth Attendants in an informal apprenticeship. In locations where referral is feasible, TBAs can save lives through identifying risks and conducting required preventive measure before arrival at the referral site.

Most TBAs considered themselves as private practitioners who responded to requests for service and received some compensation, mostly in kind. The focus of their work is to assist women during delivery and immediately post-partum. Frequently their assistance also included helping with household chores.

A recent survey of TBA's in Africa where access to skilled attendants is very low found the following;

- The majority of the TBAs interviewed resided in poor rural areas, very distant from health facilities.
- They often served as a bridge with the formal health system, sometimes accompanying women to health facilities.
- Cases reviewed showed that TBAs can make an impact in preventing maternal and neonatal infections.
- They can prevent post-partum sepsis by applying the "three cleans" during delivery and following placenta management procedures.
- They also contribute to decreasing maternal and neonatal deaths due to tetanus by referring women for tetanus toxoid immunization and by conducting an aseptic delivery.

Most TBA's go to the woman's house to deliver although some arrange a delivery area in their own house or compound. The primary theme that TBA's consistently identified when interviewed, is that the basis for being a TBA is being in relationships with others which forms part of their identity and also informs how they work with other health professionals.

Relationships of TBA's includes:

- The woman
- The family
- The community and
- Relationships with other health providers.

Where a community relies on the services of TBA's, due to limited health care options an inclusive approach that respects relationships within that community is a preferred. Skilled attendants should work with the TBA to foster a positive working relationship that is likely to result in better outcomes for women and children of that community.

Collaborative practice has the potential to be life-saving for birthing women. It has been argued that the Maternal Neonatal Mortality Rates will be reduced when social factors such as gender inequity, poverty and its associated infrastructural deficits are addressed and when TBA's are treated as colleagues and potential lifesavers, rather than unskilled, under performers

The experience of being a traditional midwife: relationships with skilled birth attendants. Rural and Remote Health 10 (online), 2010: 1481.



## Sexual Violence

### How do we manage the consequence of sexual violence and respond appropriately to survivors?

- Ensure a standard medical response to sexual violence survivors, including the option of emergency contraception, preventive treatment for STIs, post-exposure prophylaxis for prevention of transmission of HIV, and tetanus and hepatitis B vaccinations and wound care as appropriate.
- Ensure privacy and confidentiality of the survivor.
- Ensure the presence of same-sex, same-language health worker or chaperone and, if the survivor wishes, a friend or family member, present for any medical examination.
- Ensure the physical safety of the survivor immediately following an incident of sexual violence.
- Ensure the displaced population is informed of the availability and location of services for sexual violence survivors.
- Ensure the availability of appropriate, culturally appropriate psychosocial support.
- Ensure that locations where incidents of sexual violence have occurred are identified and documented and relevant preventive measures are established. A useful resource that provides guidance to health care providers for medical management after rape of women, men and children is Clinical Management of Rape Survivors: A guide to the development of protocols for use in refugee and internally displaced person situations. [www.rhrc.org/pdf/Clinical\\_Management\\_2005\\_rev.pdf](http://www.rhrc.org/pdf/Clinical_Management_2005_rev.pdf)

### What is sexual violence?

Sexual violence is any non-consented action of a sexual nature, including rape and sexual exploitation among other acts. Sexual violence is a subset of the broader category of gender-based violence (GBV). GBV is an umbrella term for any harm that is perpetrated against a person's will that results from power inequities that are based on gender roles. Violence may be physical, sexual, psychological, economic or socio-cultural.

The focus of addressing sexual violence in the MISP is the prevention of rape, provision of medical care for rape survivors and ensuring the availability of essential psychosocial services. Once a situation stabilizes and all components of the MISP have been implemented, attention can be given to preventing the wider array of violence issues, including domestic violence, early and/or forced marriage, female genital mutilation/cutting, forced sterilization or

pregnancy, forced or coerced prostitution, trafficking of women, girls and boys and additional forms of GBV.

### Who is responsible for preventing and managing incidents of sexual violence?

A multi-sectoral team approach is required to prevent and respond appropriately to sexual violence. A committee or task force should be formed to design, implement and evaluate sexual violence programming at the field level. The purview of the task force should encompass all technical sectors and all geographic areas.

Representatives of the displaced community, UNHCR, UN partners, NGOs and government authorities should be members of this task force. Each member of the task force, including displaced women and girls, representing relevant sectors/partners (such as protection, health, education, community services, security/police, site planning, etc.) should identify her/his role and responsibilities in preventing and responding to sexual violence.

### The Reality of Implementing the MISP in Pakistan

The Women's Commission conducted a year-long MISP assessment in Pakistan from 2002 to 2003 to advocate for improved RH services for Afghan refugees who had fled their country from the bombings following the September 11 attacks on the United States. Most staff had not received refresher training and lacked proper equipment and supervision to adhere to universal precautions to prevent the spread of HIV. Condoms were available in most settings but were not always free. Prevention and management of sexual violence went largely unaddressed. Emergency obstetric care was available, but many women did not have the means to access services due to high transportation costs. The assessment revealed that while isolated efforts had been made to improve the quantity and quality of RH care for Afghan refugees, many programs were limited to traditional maternal and child health services, and the quality of RH care was a significant concern.

### Who is impacted most by sexual violence?

Most reported cases of sexual violence among displaced people—and in most settings around the world—involve male perpetrators committing violent acts against females.<sup>24</sup> However, men and boys may also be at risk of sexual violence, particularly when they are subjected to detention

or torture. While all women in situations of conflict are susceptible to sexual violence, female adolescents are exceptionally vulnerable as they are often targeted for sexual exploitation and rape. In addition, systematic sexual violence, even if exclusively perpetrated against women and girls, often affects and undermines the entire community, including the fathers, brothers, husbands and sons of the survivor.

### **Who are the perpetrators of sexual violence?**

Perpetrators may be others who have been displaced by the conflict or disaster; members of other clans, villages, religious groups or ethnic groups; military personnel; rebel forces; humanitarian workers from UN or NGO agencies; members of the host population; or family members. Rape may be used as a strategy of war to intimidate and traumatize a population, in which case the perpetrators are enemy combatants; perpetrators of opportunistic rape can be anyone acting with impunity in the climate of lawlessness that accompanies armed conflict.

### **When does sexual violence occur?**

Sexual violence can happen during all phases of displacement: prior to fleeing one's home area, during flight, while in the country of asylum and during repatriation and reintegration. In addition, sexual and domestic violence frequently escalates in displaced settings as normal social structures are disrupted. Immediate prevention and response measures must be adapted to suit these different circumstances.

### **What are some situations that put women and girls at risk of sexual violence?**

It has been shown that women without their own personal documentation for collecting food rations or shelter materials are vulnerable because they are dependent on males for their daily survival and may be forced to provide sexual favors to obtain these essential items. It also has been demonstrated that when men (fellow displaced persons or humanitarian actors) are responsible for distributing food and other essential goods, women may be subject to sexual exploitation, that is, they may be forced to perform sexual favors for men in order to obtain their survival needs.

Women and girls may have to travel to remote distribution points for food, firewood for cooking fuel and water. Their living quarters may be far from latrines and washing facilities. Their sleeping quarters may also be unlocked and unprotected. Lighting may be poor. Male and female latrines and washing facilities may not be separate. All of these circumstances leave women vulnerable to attack or abuse.

Lack of police protection and lawlessness also contribute to an increase in sexual violence. Police officers, military personnel, humanitarian workers, camp administrators or other government officers may themselves be involved in acts of abuse or exploitation. If there are no independent organizations, such as UNHCR or NGOs, to ensure personal security within a camp, the number of incidents often increases. It is important that female protection officers are available since often women and girls are more comfortable reporting protection concerns and incidents of violence to another woman.

## **Reducing the transmission of HIV**

The relationship between conflict and vulnerability to STIs and HIV is complex.

Displaced populations in crisis situations are especially vulnerable to STIs and

HIV. STIs, including HIV, have the potential to thrive under crisis conditions where access to means of prevention, treatment and care are limited. However, new findings from conflict settings also show that in some circumstances, where displaced people have been isolated and are less mobile, HIV prevalence rates are lower than those of neighboring countries. An important resource that outlines the set of minimum multi-sectoral interventions to prevent and respond to HIV in emergency situations is the Inter-agency Standing Committee Guidelines for HIV/AIDS Interventions in Emergency Settings. A reference matrix of these multi-sectoral guidelines is also available.

<http://www.humanitarianinfo.org/iasc/>

# Medication used on AusMAT deployment

Medication, under the Sphere guidelines, is generally provided free to an affected population post disaster. It should be appropriately packaged and labelled in either local language, and/or with pictorial symbols of amount, timing and duration of doses. A global initiative in the ethical supply and donation of medication to developing countries and those affected by disaster has been formulated by major international organizations and is published by PAHO.

Drug donations, even in emergency situations, may cause problems rather than being helpful if they do not comply with specific principles and guidelines.



Some countries (e.g. Indonesia post the 2004 Tsunami) describe a second tsunami of unwanted aid, including medications, often half used, expired, unsorted and in foreign languages. The sorting of such medications is impossible, particularly in a crisis, and a significant impost of cost and effort was required to safely dispose of the tons of medications received.

### Core principles for drug donation:

- All donations should benefit the recipient
- Respect for the wishes and authority of the recipient
- There should not be a double standard in quality
- Effective communication between the donor and the recipient.

### Guidelines for drug donations:

- All drug donations should be based on an expressed need and be relevant to the disease pattern in the recipient country.
- All drugs should be approved for use in the recipient country.
- The presentation, strength and formulation of donated drug should, as much as possible, be similar to those commonly used in the recipient country.
- All donated drugs should be obtained from a reliable source and comply with quality standards in both: donor and recipient countries.
- No drug should be donated that have been issued to patients and then returned to a pharmacy or elsewhere.
- After arrival in the recipient country all donated drugs should have a remaining shelf-life of at least one year.
- All drugs should be labeled in a language that is easy understood by health professionals in the recipient country.
- Donated drugs should be presented in larger quantity units and hospital packs.
- All drug donations should be packed in accordance with international shipping regulations (named by INN, dosage form, quantity, batch number, expiry date, volume, weight and any special storage conditions).
- Recipients should be informed of all drug donations that are being considered, prepared or actually underway.
- In the recipient country the declared value of a drug donation should be based upon the wholesale price of its generic equivalent in the recipient country (except for patented drug for which there is no generic equivalent).
- Cost of international and local transport, warehousing, port clearance and appropriate storage and handling should be paid by the donor agency, unless specifically agreed otherwise with the recipient in advance.

### Recommendations For Donors:

Drug donations should complement national efforts and meet the country needs. Always consult the official list made by the national authority (or the disaster coordinator) for information on WHAT medicines are needed for that particular country. To donate pharmaceutical products relevant to the disaster or emergency situation may not be enough reason to send them to the country. The country may have them in stock or they may not comply with locally agreed drug policies and standard treatment guidelines. Donations of inappropriate medicines can divert attention from health personnel in sorting, classifying, labeling and, most important, in destroying them.

Whenever possible, donate medicines already classified (in their boxes), preferably by therapeutic groups.

Pharmaceutical forms as well as presentation are important. To reduce shipments cost and facilitate logistics, whenever possible does not donate drug syrup and mixtures packed in glass containers. (Except for those preparations that must be packed in that kind of containers).

### Recommendations For the Recipient Country:

In emergency situations, it is common to have many organizations involved in receiving and distributing international donations (mainly NGO's). It is wise to have an official unit to coordinate them or at least to have access to information on what drugs are being received and where (i.e. health centers) they are being sent.

Provide international donors with a list of needed drugs and inform them of updates.

Include in the list of needed drugs all necessary devices for administering them such as syringes and needles.

In making the list of needed drugs, make a specific provision for controlled medicines and follows the WHO guidelines (WHO/PSA/96.17).

Even though drug donations guidelines are to be followed by donors and recipients, be prepared to receive drugs that are not needed, expired or near the expiration date. Have a special team to deal with those cases.

For more information on donations of drugs and medical equipment visit <http://www.drugdonations.org>.

### Counterfeit drugs

Poor standards of drug manufacture, unknown efficacy, or attempted counterfeiting of expensive drugs, is well recognized in developing countries. Extreme examples of this occurred in China in the manufacture of Artemether like drugs, including fake hologram markings designed to deter counterfeiters, faithfully reproduced.

Newton et al, Lancet 2001; 357:1948, describe 38% of shop bought “artesunate” drug in Cambodia, Laos, Myanmar (Burma), Thailand and Vietnam contained no artesunate.

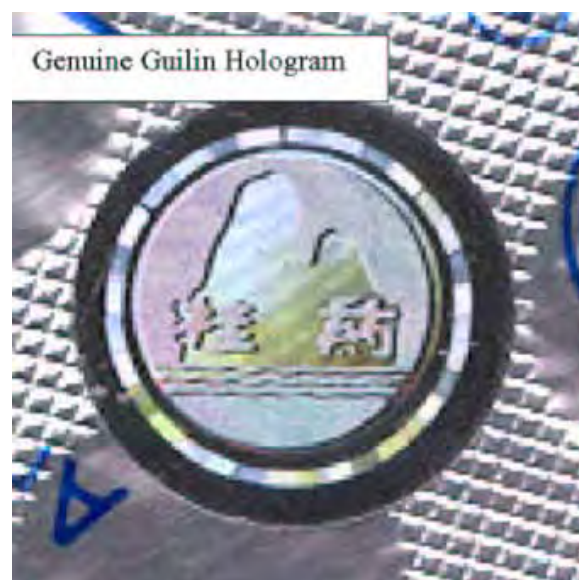
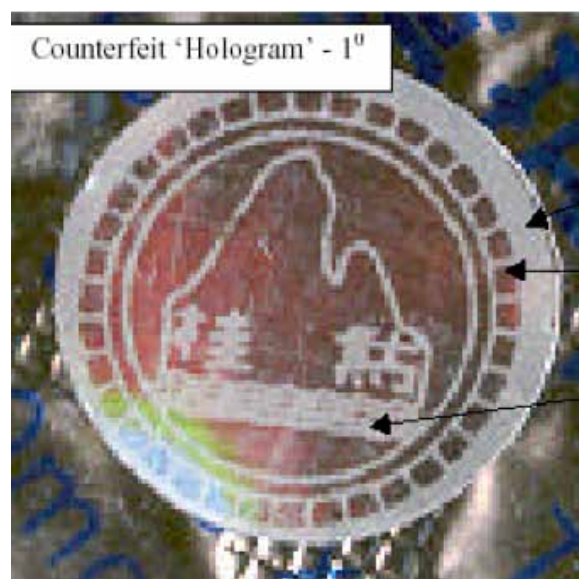
If sourcing drugs within country, reputable dealers must be found, without affecting the local supply or price adversely. Regional malarial research centers can assist in testing locally sourced critical malarial medication like artesunate in a matter of days to weeks. Consideration of transport of enough medication for initial assistance, and strong logistics support from companies or organizations accustomed to working in that region and in times of crisis is recommended.

### Interagency emergency health kit (IEHK)

AusMAT teams may be provided an IEHK to use for humanitarian relief efforts in a none trauma situation (e.g. Pakistan floods 2010). A single kit has enough medicines and medical devices to manage the basic health needs of 10,000 people for 3 months. Each kit contains a basic health unit, designed for use by a primary healthcare worker, and is modularized into 10 equal boxes, each with enough to treat 1,000 people, making distribution easy. The basic kit also includes an optional module for uncomplicated malaria.

There is a supplementary unit, containing medicine and medical devices to be administered by professional healthcare workers and doctors only. The combined weight of basic and supplementary kit is just over 1,000kg. Kits have been modified since their initial design, with the latest version available since 2010. The contents can be found at [http://www.missionpharma.com/media\(540,1033\)/IEHK\\_brochure.pdf](http://www.missionpharma.com/media(540,1033)/IEHK_brochure.pdf)

Note this kit is not suitable for AusMAT responses to large scale injury, or levels of care beyond basic humanitarian relief. It provides no resuscitation capacity of note, beyond simple intravenous fluid and antibiotics. Supplementation of this equipment with resuscitation and other medication and equipment for staff medical care is mandatory.



# Malnutrition

(Protein Energy Malnutrition & Micronutrient Deficiencies)

## INTRODUCTION

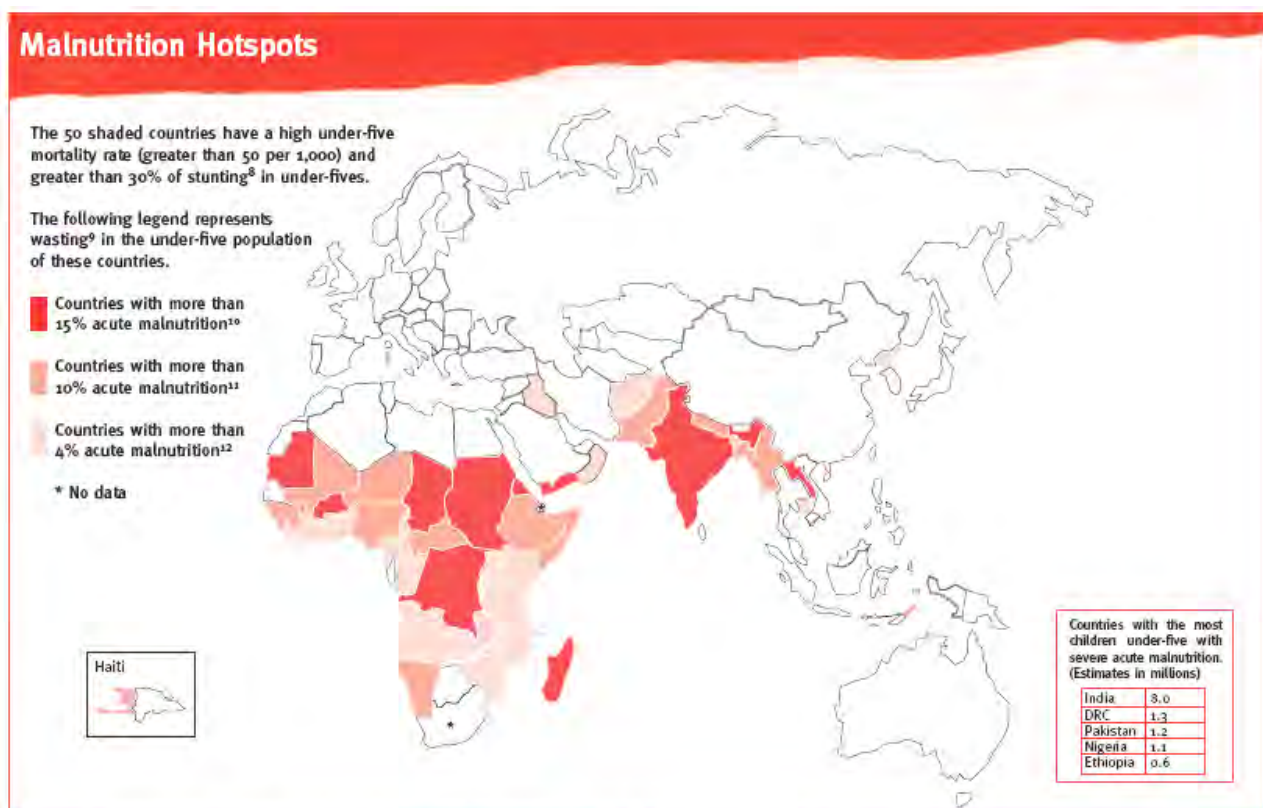
Malnutrition is a global problem and is still one of the most common causes of morbidity and mortality in the paediatric population worldwide. In the developing countries, it is commonly a result of inadequate food supply due to a combination of factors. These can be socio-economic or environmental factors like natural disasters. According to the World Health Organization (WHO), 49% of the 10.4 million deaths occurring in children younger than 5 years in developing countries are associated with malnutrition.



# Protein Energy Malnutrition

## EPIDEMIOLOGY

Approximately 50 million children under the age of 5 years have malnutrition, and half of the children who die before the age of 5 years are undernourished (Fig. below). Though it is a global problem, 80% of the malnourished children live in Asia, 15% in Africa, and 5% in Latin America. (1) In spite of all the interventions and programmes aimed to reduce global malnutrition, a staggering 94 million children would be malnourished by 2020 with South Asia continuing to be the region with the highest prevalence. (2)



<sup>8</sup> Stunting – Growth retardation, indicated by low height for age (height for age  $< -2$  Z according to WHO 2005 Growth Standards).

<sup>9</sup> Wasting – Emaciation or thinness as measured by low weight for one's height (weight for height  $< -2$  Z according to WHO 2005 Growth Standards).

<sup>10</sup> Burkina Faso, Chad, Democratic Republic of Congo, Eritrea, India, Lao People's Democratic Republic, Madagascar, Mauritania, Sudan, Yemen.

<sup>11</sup> Bangladesh, Central Africa Republic, Comoros, Ethiopia, Guinea, Guinea Bissau, Haiti, Mali, Myanmar, Namibia, Nepal, Niger, Nigeria, Pakistan, Sierra Leone, Somalia, Timor-Leste, Togo.

<sup>12</sup> Afghanistan, Angola, Benin, Burundi, Cambodia, Cameroon, Republic of Congo, Côte d'Ivoire, Equatorial Guinea, Ghana, Iraq, Kenya, Democratic People's Republic of Korea, Liberia, Malawi, Mozambique, Rwanda, Tanzania, Uganda, Zambia, Zimbabwe.

Sources for map: Population Reference Bureau 2007 World Population Data. WHO Analyses of national nutritional surveys done 2001-2006.

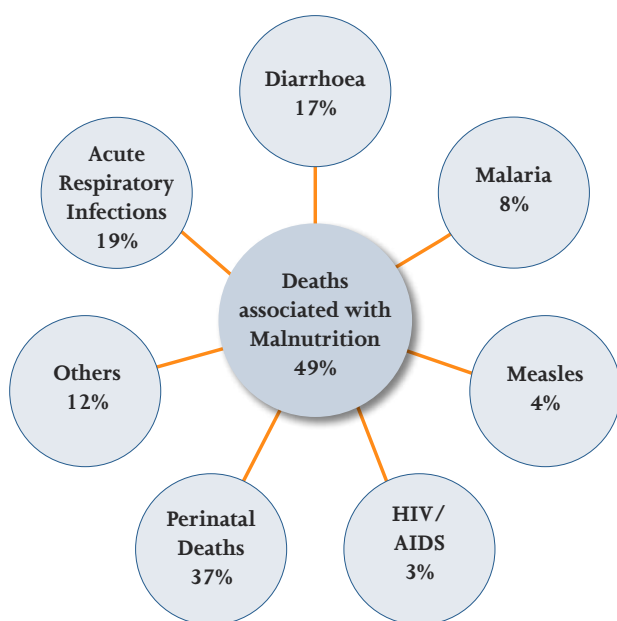
UNICEF – The State of the World's Children 2008

## THE PROBLEM

Malnutrition increases the risk of mortality due to illnesses like diarrhoea, pneumonia, malaria or measles that are commonly seen in developing countries.

In fact more than 50% of all childhood deaths are attributed to malnutrition. In addition to this risk, malnutrition also leads to impaired physical and mental development. These are evident even in those who recover from it and have far reaching effects on the community at large.

### CAUSES OF DEATH IN CHILDREN UNDER 5 YEARS OF AGE.



The groups most vulnerable to malnutrition are pregnant women, lactating women and young children.

In the setting of natural disasters, there can be displacement of people from their homes. This coupled with the poor availability of nutrition and an increase in communicable diseases proves disastrous for the vulnerable group mentioned above. Existing malnutrition worsens and those who have previously been borderline, go into a state of acute malnutrition. This further increases the risk of death from communicable diseases, especially if the displacement is long term, as would happen in extensive floods, earthquake or wars.

Thus diagnosis and treatment of malnutrition in children becomes a very important and vital part of the relief work

during natural disasters. Prompt and simple measures go a long way in saving precious lives as well as prevent the long term ramifications for the child, the family and the nation in a broader sense.

## DEFINITION

In the recent past there has been significant evidence to suggest that micronutrient deficiencies play an important role in causing malnutrition. Based on this concept, malnutrition can be said to have two broad constituents namely- Protein Energy Malnutrition (PEM) and micronutrient deficiencies.

In children, malnutrition is defined by measurements that are 2 standard deviations below the normal weight for age (underweight), height for age (stunting) and weight for height (wasting). Wasting indicates recent weight loss and stunting, chronic weight loss. (3)

The World Health Organization (WHO) defines malnutrition as “the cellular imbalance between the supply of nutrients and energy and the body’s demand for them to ensure growth, maintenance, and specific functions.”

PEM can be classified further into:

- Marasmus (means withering or wasting). It involves inadequate intake of protein and calories and is characterized by emaciation.
- Kwashiorkor (means ‘the sickness of the weaning’). It refers to an inadequate protein intake but with a reasonable caloric (energy) intake. The characteristic feature of kwashiorkor is oedema, which is absent in marasmus.
- Marasmus-kwashiorkor is used for those with mixed features.

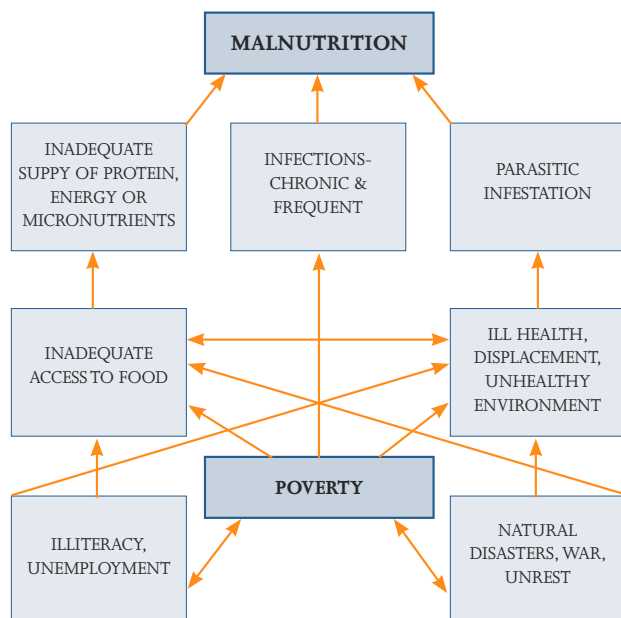
Malnutrition should be viewed as more than just a macronutrient deficiency (carbohydrates, fats & proteins). In fact micronutrient deficiencies are proposed to play a major role in the cause of malnutrition. Micronutrients are as essential for life as macronutrients. However they are distinct as they are required only in tiny amounts. The common micronutrients are key vitamins and minerals. The important ones are Vitamin A, Iron, Zinc and Iodine. Most people in developing countries are deficient in more than one micronutrient and more than 2 billion people worldwide are estimated to be micronutrient deficient. This increases their risk of succumbing to the common illnesses they might encounter.

The need for micronutrients increases during infections to help combat them. However, infections suppress the appetite making it difficult to meet that demand. This understanding has led to the practice of micronutrient replacement along with protein and energy supplementation in the treatment of malnutrition.

## CAUSES OF MALNUTRITION

Marasmus is more frequent in children less than 5 years of age, because this period is characterized by increased energy needs and increased susceptibility to viral and bacterial infections. Weaning, which also occurs during this period, is often complicated by factors such as drought, famine, illiteracy, unemployment and its implications. Poor hygiene and inadequate access to clean drinking water and other public health issues also contribute to it. This makes it a high risk period for malnutrition to occur. (see flow chart below)

### CAUSES OF MALNUTRITION- DIRECT AND INDIRECT



**Nutrition:** In many developing countries, food variety is limited and results in mineral and vitamin insufficiencies (micronutrient deficiencies). This can cause frequent infections and anorexia, decreasing the total energy intake and lead to malnutrition.

**Infections:** Measles, diarrhoeal diseases, pertussis and other acute respiratory infections are some of the common infections that often trigger or aggravate malnutrition. HIV

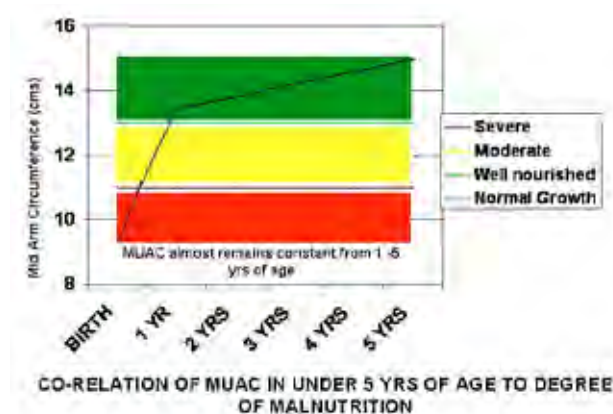
also plays a significant role in some countries. It is clear that several other factors also contribute to malnutrition. Therefore, a comprehensive approach is required to tackle the problem.

## CLINICAL FINDINGS AND ASSESSMENT (5)

Clinical assessment of a child with malnutrition includes a thorough examination and measurement of height, weight and Mid Upper Arm Circumference (MUAC).

These measurements should be plotted on appropriate growth charts. In the setting of a relief camp, the WHO growth charts are extremely helpful and adequate. If the child is 3 SD score (Standard Deviation score) below normal, a diagnosis of severe malnutrition can be made. The child can be said to have moderate malnutrition if the weight is in the range of 2 and 3 SD score below normal.

Assessment of fat and muscle mass loss can be clinically performed by measuring the MUAC (see image below). MUAC is a simple, low-cost, objective method of assessing nutritional status. It is also the most useful tool in large epidemiological surveys.



Because arm circumference is relatively constant in healthy children aged 1-5 years, it is a fair representation of the general assessment of nutritional status and is a good predictor of mortality. In a disaster setting where rapid assessment is required, it is a very important screening tool. The MUAC can be measured by using the plasticized paper tapes which are part of the WHO kit. In case they are not available, you can use twine. Colour the twine (with permanent markers) red from 0 to 110mm, yellow from 110 to 120 mm and green from 120 mm and upwards.

### Measurement of MUAC:

- Measure on the left arm, at the midpoint between the tip of the shoulder to the elbow.
- With the arm hanging straight down, wrap a MUAC tape around the arm at the midpoint mark.
- Measure to the nearest 1 mm
- A measurement in the green zone means the child is properly nourished
- A measurement in the yellow zone means that the child is at risk of malnutrition
- A measurement in the red zone means that the child is acutely malnourished

\*DO NOT MISS THE OPPORTUNITY TO MEASURE THE LACTATING MOTHER'S MUAC.

Significant if less than 210 mms.



### Clinical signs in Marasmus

- The child appears emaciated
- Marked loss of subcutaneous fat and muscle wasting.
- The skin is dry, wrinkled, and loose.
- Triangular facies secondary to a loss of buccal fat pads.
- Fine, brittle and sparse hair.
- Fissures and cracks in the nails.

### Clinical signs in Kwashiorkor

- Failure to thrive
- Oedema, can be bilateral pedal or generalized oedema.
- Moon facies
- Potbelly, and might have an enlarged liver.
- Some of the children have characteristic skin changes.
  - The skin becomes dark, dry, and then splits when stretched.
  - The underlying pale areas between the cracks give the appearance that is classically described as 'crazy pavement dermatosis'. (4)
- The hair is dry, lusterless and can have depigmentation. If periods of poor nutrition are interspersed with good nutrition, alternating bands of pale and dark hair (the flag sign), may occur.



### In addition check for the following danger signs

- Hypothermia or fever
- Severe pallor
- Signs of shock: cold hands and feet, weak radial pulse, prolonged central capillary refill time and drowsiness.
- Respiratory rate and effort of breathing to look for signs of pneumonia or heart failure
- Eye changes of vitamin A deficiency
- Ears, mouth, throat for evidence of infection
- Skin infection or purpura (bleeding spots on skin)



## INVESTIGATION

In a relief camp very few tests may be available and the following will prove useful.

- Blood glucose
- Peripheral blood smear
- Haemoglobin
- Examination and culture of urine specimen
- Examination of faeces by microscopy (for signs of infection and parasitic infestation)
- Chest X-ray
- Skin test for tuberculosis

## PRINCIPLES IN TREATMENT

Treatment plans should be made according to the severity of malnutrition and the available resources. Mild & moderately malnourished children should be managed at home, whereas all severely malnourished children should ideally be admitted to a hospital for the initial phase of treatment.

Managing malnutrition in a disaster situation or a refugee camp poses its own challenges.

- Health workers in disaster situations and refugee camps may be faced with having to manage a large number of severely malnourished children at the facility itself.
- This might require that a therapeutic feeding centre be established (WHO guideline).
- If not, they should be referred to NGOs who deal specially with malnourished children.
- The identified cases should have detailed contact information( remember mobile phones)
- In spite of this they may be lost to follow up as contact details could be inaccurate
- The NGOs might be overwhelmed themselves and precious time could be lost.
- Hence those children being sent home for follow up by NGOs should be commenced on domiciliary treatment with appropriate diet and vitamin supplementation on discharge.

(Details of how to set up a feeding centre, is available on the WHO website).

### Medical Care

Wherever possible, severely malnourished children should be referred to hospital as mortality is very high during the initial treatment phase. Successful initial management requires frequent, careful clinical evaluation which is not always possible in the setting of a disaster response camp.

### For the others:

- Correct dehydration if present.
- Treat infections with appropriate antibiotics
- Administer anti-helminthics (deworm).
- Commence on daily multivitamin and Zinc.
- Supply macronutrients by dietary therapy.
- Milk-based formulas are the treatment of choice.
- At the beginning of dietary treatment, patients should be demand-fed.
- After 1 week, intake rates should approach 175 kcal/kg and 4 g/kg of protein for children.
- Iron supplement can be commenced after the second week and continued for 3 months.

## DIET SUPPLEMENTS

### F-75 and F-100 solution

The WHO has formulated two types of diet supplements called the F-75 and the F-100 solutions. They contain 75cal/100ml and 100 cal/100ml respectively. The F-75 is for the first week and the F-100 is for use from the second week.

Ingredient	F-75	F-100
Dry skimmed milk or Fresh cows milk	25 g 300ml	80 g 300ml
Sugar	70 g	50 g
Cereal Flour	35 g	-
Vegetable Oil	27 g	60 g
Mineral mix	20 ml	20 ml
Vitamin Mix	140 mg	140 mg
Water to make	1000 ml	1000ml

### Ready to Use Therapeutic Foods (RUTF)

- RUTF is a homogenous mixture of lipid-rich and water-soluble foods.
  - High Energy Biscuits
  - Plumpy'nut (peanut based paste, with a peanut butter like consistency and quite tasty)
- They are high-energy products (similar to the F-100) and contain minerals and vitamins.
- Appropriate for treating moderate to severely malnourished children.
- Very useful to have in stock as they make home based treatment very easy.

- The mother can be given a weeks supply of the RUTF and the child can be followed up on a weekly basis to check progress.
- The recommended dose is usually 2-3 packets/day.
- The ones that do not show weight gain or loss in oedema should be investigated for underlying infections or referred to the hospital for in-patient treatment.

### High Calorie Cereal Milk (HCCM)

The medical services may not have the resources or the expertise to run a nutritional centre nor have any of the RUTFs. It is important to know this simple HCCM formula to teach the mothers who can prepare it even in relief camps or tents.

100 ml milk  
1 tsp rice/ wheat flour  
1 tsp sugar  
1 tsp oil

Heat the oil, roast the flour in it, add the milk and sugar to make a gruel.

Advice the mothers to administer this to the child 4-6 times a day and increase the volume gradually after a week and continue to do this till the RTUFs become available.

In addition to this do not forget to administer multivitamin supplements, with special attention to Vit. A.

### CONCLUSION

Malnutrition continues to be a big threat worldwide. A good structured approach to assess and treat these children will go a long way in making it possible to decrease it's incidence significantly by 2020.

### BIBLIOGRAPHY

1. Fisberg M, Nobrega FJ. Disturbios da nutricao. Revinter. 1998;140-4.
2. Akram a Khan, Nazli Bano and Abdus Salam. Child Malnutrition: An overview of trends, issues and policy prescriptions. Vikalpa. Vol. 31.Nov4. Oct-Dec 2006. 81-89
3. Muller and Krawinkel. Malnutrition and health in developing countries. CMAJ. Aug. 2, 2005;173(3) pg 279-286
4. Latham MC. The dermatosis of kwashiorkor in young children. Seminars in Dermatology 1991;4:270-2.
5. Zubin Grover. Protein Energy Malnutrition. Pediatr Clin N Am 56(2009) 1055-1068



## Micronutrient Deficiency

Micronutrient deficiency can be an important form of malnutrition both in settings of chronic under-resourcing or acute crisis. The important micronutrient deficiencies are Vitamin A, Iron, Zinc and Iodine. Vitamin C, niacin, thiamine and riboflavin deficiencies can also occur as a result of acute food shortage.<sup>1</sup> Clinical detection is important in order that individuals receive treatment (direct assessment) and also at a population level (indirect assessment) for determination of their risk of a particular deficiency and strategies so that serious clinical signs can be prevented. Vitamin A deficiency is an example where xerophthalmia (drying and softening of the cornea) can result in blindness or damage to vision, a risk even after beginning treatment. Early supplementation with vitamin A in a group having one or two affected children may prevent symptoms in the rest of the group.

Certain groups are more at risk of some deficiencies, e.g. iron in children under 5 and women of child-bearing age, especially pregnant or lactating.

Care is also needed not to over-dose as some micronutrients are toxic in excess (e.g. Vitamin A can cause liver damage).

“Following the publication of two studies evaluating the impact of iron and zinc supplementation on childhood mortality and severe morbidity in Nepal and Zanzibar, WHO and UNICEF published a Joint Statement to emphasize the fact that iron and folic acid supplementation should be targeted only to those children who are anaemic and at risk of iron deficiency. They should receive concurrent protection from malaria and other infectious diseases through prevention and effective case management.”<sup>2</sup>

Diagnosis of iodine deficiency could be made in the context of information about soil quality in the area, a high prevalence of goitre in adults or children.

Specific details of micronutrient deficiency signs, doses for supplementation, toxic effects and precautions are available on sites such as WHO (Child and Adolescent Health and Development) and United Nations Standing Committee on Nutrition (UNSCN).<sup>1</sup> This resource also has references to software for population based nutritional assessments.

Role of parasites in micronutrient deficiency.

According to one article, “Parasitic infections are thought to contribute to child malnutrition and micronutrient deficiency through subtle reduction in digestion and absorption, chronic inflammation and loss of nutrients. Parasites may affect the intake of food; its subsequent digestion and

absorption, metabolism and the maintenance of nutrient pools. The most important parasites related to nutritional status are intestinal parasites especially soil transmitted helminthes, *Giardia duodenalis*, *Entamoeba histolytica*, and other parasites such as the coccidia, *Schistosoma* sp. and malarial parasites.”<sup>3</sup> Malarial parasites contribute to anaemia, with iron deficiency or inherited haemoglobin variations as additional causes.

Diagnosis can best be made on stool microscopy by experienced technicians, although empirical treatment can be given on a population basis on suspicion confirmed by a few positive specimens. Standard treatment regimens apply with care in children and pregnancy.

### Other References:

1. United Nations Standing Committee on Nutrition (UNSCN) Harmonised Training Package [http://www.unscn.org/en/gnc\\_http/](http://www.unscn.org/en/gnc_http/)
2. SCN Food & Nutrition Resource Portal [http://www.unscn.org/en/resource\\_portal/](http://www.unscn.org/en/resource_portal/)
3. [www.sphereproject.org/component/option,com\\_docman/task,doc\\_download/gid,8/Itemid,203/lang,english/](http://www.sphereproject.org/component/option,com_docman/task,doc_download/gid,8/Itemid,203/lang,english/) 5. Food Security, Nutrition and Food aid.
4. [www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001379/](http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001379/) Beriberi
5. [www.merckmanuals.com/professional/sec01/ch004/ch004h.html](http://www.merckmanuals.com/professional/sec01/ch004/ch004h.html)

<sup>1</sup> [www.unscn.org/layout/modules/resources/files/MicronutrientsSup.pdf](http://www.unscn.org/layout/modules/resources/files/MicronutrientsSup.pdf)

Includes tables of symptoms, signs, investigations and daily requirements.

<sup>2</sup> [www.unscn.org/layout/modules/resources/files/iron\\_supplementation.pdf](http://www.unscn.org/layout/modules/resources/files/iron_supplementation.pdf) on SCN Food & Nutrition Resource Portal

<sup>3</sup> *Med J Malaysia*. 2004 Jun;59(2):284-93 Intestinal parasitic infections and micronutrient deficiency: a review. Hesham MS, Edariah AB, Norhayati M. Available at [http://www.e-mjm.org/2004/v59n2/Intestinal\\_Parasitic\\_Infections.pdf](http://www.e-mjm.org/2004/v59n2/Intestinal_Parasitic_Infections.pdf)

**Table of clinical signs of micronutrient deficiency**

Nutrient/ sign	sign	symptom	syndrome	
Vitamin A	xerophthalmia, ulceration, scarring Bitot's spots	night blindness		Excess intake is hepatotoxic
Riboflavin (Vitamin B2)	angular stomatitis lesions of mucosa of the mouth sore throat glossitis conjunctivitis seborrheic dermatitis			With other deficiencies: thiamin, vitamin C, and vitamin D  Low milk consumption, chronic diarrhoea in children. May have anemia.
Niacin (Vitamin B3)	dermatitis		pellagra	
Pyridoxine (Vitamin B6)	angular stomatitis peripheral neuropathy seizures		pellagra-like syndrome	Can be associated protein- energy malnutrition, malabsorption, alcoholism, drugs (anticonvulsants, isoniazid, steroids). May have anemia.
	sign	symptom	syndrome	
Zinc	angular stomatitis		acrodermatitis	
Thiamine (Vitamin B1)	Increased heart rate Swelling of the lower leg	Shortness of breath causing waking at night or with activity	Wet beriberi (cardio-myopathy)	Cardiovascular
	Difficulty walking Loss of muscle function or lower leg paralysis Mental confusion/ speech difficulties Strange eye movements (nystagmus) Vomiting	Loss of feeling in hands and feet Pain Tingling	Dry beriberi Wernicke- Korsakoff syndrome	Nervous system
Iodine	Goitre Oedema Poor development	tiredness	hypothyroidism	
Vitamin C	irritable Poor weight gain impaired bone growth bleeding	pain on moving loss of appetite.	scurvy	anemia may occur
Iron	Pale, poor concentration	Tiredness	may be anaemia	Excess intake is hepatotoxic. Infants: Consider delaying treatment until infection controlled

Refs: 1, 7.



Bitot's spots in Vitamin A deficiency. From:  
<http://sonorandeserteye.blogspot.com/2011/02/vitamin-deficiency.html>



Pellagra dermatitis. From: <http://www.rcsi-alumni.com/dermaatlas/catalog.php?id=259>



Zinc deficiency dermatitis. From:  
<http://www.dermaamin.com/site/atlas-of-dermatology/25-z/505-zinc-deficiency-.html>

# Management of the deceased



### *Management of the deceased is NOT the primary task of AusMAT whose role is to provide care for the living.*

However AusMAT need to be aware of the management of the deceased to ensure that their operations are consistent with international best practice and integrate effectively with local government and health services as well as other responding agencies.

#### **The issues to consider are:**

- Who has responsibility for the dead?
- What is the infection risk from dead bodies?
- What protection should be used when handling the dead?
- How should dead bodies be stored?

The Pan American Health Organisation (PAHO) has produced an excellent Field Manual on this topic and should be used as the reference point.

Morgan, Oliver-ed. Management of dead bodies after disasters: a field manual for first responders. Washington, D.C: PAHO, © 2006. ISBN 92 75 12630 5

This manual is available at [www.paho.org/disasters](http://www.paho.org/disasters) (click on Publications Catalog)

A copy will also be available during deployment for reference while sections have been reproduced below with the kind permission of the authors.

It is also worth noting the following comment from the authors: "Throughout this manual we have used the term "dead bodies" instead of the more respectful and technically correct term "human remains," because the term "dead bodies" is less ambiguous for readers whose first language is not English."

### **Who has responsibility for the dead?**

The following has been reproduced in part from Chapter 2 Coordination and Chapter 7 Information Management.

Reproduced in part from Chapter 4 Infectious Disease Risks and Chapter 4 Body Recovery.

Reproduced in part from Chapter 4 Body Recovery, Chapter 5 Storage of Dead Bodies, Chapter 6 Identification of Dead Bodies, Chapter 8 Long Term Storage and Disposal of Dead Bodies, and Chapter 10 Support to Families and Relatives.

### **Overview**

- State authorities bear primary responsibility for the proper handling of information about the dead and missing in disasters.
- A large amount of information is collected about the dead and missing, even after relatively small disasters.
- Necessary resources (human, technical, and financial) for information management must be provided.

### **Organizational arrangements**

Information centers should be established at regional and/or local levels.

- Local centers act as focal points for collection and consolidation of information on the dead and for attending to the public. They are particularly necessary for receiving tracing requests, leaving photographs and information about the missing, and for the release of information on persons found or identified.
- A national system for management and coordination of information should centralize all information on the dead and missing in disasters.
- Tracing services of the International Committee of the Red Cross and National Red Cross/Red Crescent Societies may assist in this task.
- Data should flow in both directions between the national and local level.

#### **Effective coordination**

- As soon as possible, and in accordance with existing disaster preparedness plans, identify an agency and name a person to serve as a local coordinator with full authority and responsibility for the management of dead bodies (e.g., local Governor, Police Chief, Military Commander, Mayor).
- The selection of Medical or Hospital Directors as coordinators should be discouraged as their primary responsibility is the care of the living and injured.
- Establish a team, within the Emergency Operations Center, to coordinate management of the dead.
- As soon as possible, name a person as a national or regional coordinator and provide him or her with the appropriate authority for the management of dead bodies (e.g. Minister, Governor, Police Chief, Military Commander, Mayor).

## What are the risks from handling dead bodies?

### Overview

- After most natural disasters there is fear that dead bodies will cause epidemics.
- This belief is wrongly promoted by the media, as well as some medical and disaster professionals.
- Dead bodies do not cause epidemics after natural disasters.
- The political pressure brought about by these rumors causes authorities to use unnecessary measures such as rapid mass burials and spraying so-called “disinfectants.”
- The consequences of mismanagement of the dead include mental distress and legal problems for relatives of the victims.

The surviving population is much more likely to spread disease.

### Infections and dead bodies

- Victims of natural disasters are normally killed by injury, drowning, or fire— not by disease.
- At the time of death, victims are not likely to be sick with epidemic-causing infections (i.e., plague, cholera, typhoid, and anthrax).
- A few victims will have chronic blood infections (hepatitis or HIV), tuberculosis, or diarrheal disease.
- Most infectious organisms do not survive beyond 48 hours in a dead body. An exception is HIV, which has been found six days postmortem.

### Risk to the public

- The risk to the public is negligible because they do not touch dead bodies.
- There is the potential (but as yet undocumented) risk of drinking water supplies contaminated by fecal material released from dead bodies.

### Risk to body handlers

- Individuals handling human remains have a small risk through contact with blood and feces (bodies often leak feces after death) from the following:
  - Hepatitis B and C
  - HIV
  - Tuberculosis
  - Diarrheal disease
- Body recovery teams work in hazardous environments (e.g., collapsed buildings and debris) and may also be at risk of injury and tetanus (transmitted via soil).

## What protection should be used when handling the dead?

### Safety precautions for body handlers:

Basic hygiene protects workers from exposure to diseases spread by blood and certain body fluids. Workers should use the following precautions:

- Use gloves and boots, if available.
- Wash hands with soap and water after handling bodies and before eating.
- Avoid wiping face or mouth with hands.
- Wash and disinfect all equipment, clothes, and vehicles used for transportation of bodies.
- Face masks are unnecessary, but should be provided if requested to avoid anxiety.
- The recovery of bodies from confined, unventilated spaces should be approached with caution. After several days of decomposition, potentially hazardous toxic gases can build-up. Time should be allowed for fresh air to ventilate confined spaces.
- Recovery teams often work among debris or collapsed buildings. First-aid and medical treatment should be available in case of injury.
- Tetanus may be a particular problem in unvaccinated workers. Local medical teams should be on the alert for tetanus prone injuries.

## How should dead bodies be stored?

### Overview

- Recovery of bodies should not interrupt other interventions aimed at helping survivors.
- Rapid retrieval is a priority because it aids identification and reduces the psychological burden on survivors.
- Within 12 to 48 hours in hot climates, decomposition will be too advanced to allow facial recognition.
- Cold storage slows the rate of decomposition and preserves the body for identification.
- A dead body should only be released when identification is certain and should only be released by the responsible authority, which must also provide documentation of the release.
- All identified dead bodies should be released to relatives or their communities for disposal according to local custom and practice.
- Long-term storage will be required for remaining unidentified bodies.

### Methods and procedures for body recovery

- Bodies should be placed in body bags. If these are unavailable, use plastic sheets, shrouds, bed sheets, or other locally available material.
- Body parts (e.g., limbs) should be treated as individual bodies. Recovery teams should not attempt to match the body parts at the disaster scene.
- Body recovery teams work most effectively in two groups: one to take bodies to a nearby collection point and a second to take them to identification or storage areas.
- Personal belongings, jewelry, and documents should not be separated from the corresponding remains during recovery, but only during the identification phase. This is mandatory.
- Stretchers, body bags, and flatbed trucks or tractor-trailers can be used to transport bodies. Ambulances should not be used for this purpose as they are best used to help the living.

### Storage options

- Whichever storage option is used, each body or body part should be kept in a body bag or wrapped in a sheet before storage.
- Waterproof labels (e.g., paper in sealed plastic) with a unique identification number should be used. Do not write identification numbers on bodies or body bags/sheets as they are erased easily during storage.
- Refrigeration
- Refrigeration between 2°C and 4°C is the best option.
- Refrigerated transport containers used by commercial shipping companies can be used to store up to 50 bodies.
- Enough containers are seldom available at the disaster site and alternative storage options should be used until refrigeration becomes available.

### Temporary burial

- Temporary burial provides a good option for immediate storage where no other method is available, or where longer term temporary storage is needed.
- Temperature underground is lower than at the surface, thereby providing natural refrigeration.
- Temporary burial sites should be constructed in the following way to help ensure future location and recovery of bodies:
  - Use individual burials for a small number of bodies and trench burial for larger numbers.
  - Burial should be 1.5m deep and at least 200m from drinking water sources
  - Leave 0.4m between bodies.
  - Lay bodies in one layer only (not on top of each other).
  - Clearly mark each body and mark their positions at ground level.

### Dry ice

- Dry ice [carbon dioxide (CO<sub>2</sub>) frozen at -78.5°C] may be suitable for short-term storage.
- Dry ice should not be placed on top of the bodies, even when wrapped, because it damages the body.
- Build a low wall of dry ice (i.e., 0.5m high) around groups of about 20 bodies and cover with a plastic sheet, tarpaulin, or tent.

- About 10 kg of dry ice per body, per day is needed, depending on outside temperature.
- Dry ice must be handled carefully as it causes “cold burns” if touched without proper gloves.
- When dry ice melts it produces carbon dioxide gas, which is toxic. Closed rooms or buildings should be avoided when using dry ice in preference to areas with good natural ventilation.

#### **Ice**

- The use of ice (frozen water) should be avoided where possible because:
- In hot climates ice melts quickly and large quantities are needed.
- Melting ice produces large quantities of dirty waste water that may cause concern about
- diarrheal disease. Disposal of this waste water creates additional management issues.
- The water may damage bodies and personal belongings (e.g., identity cards).

#### **Method of disposal/Long-term storage**

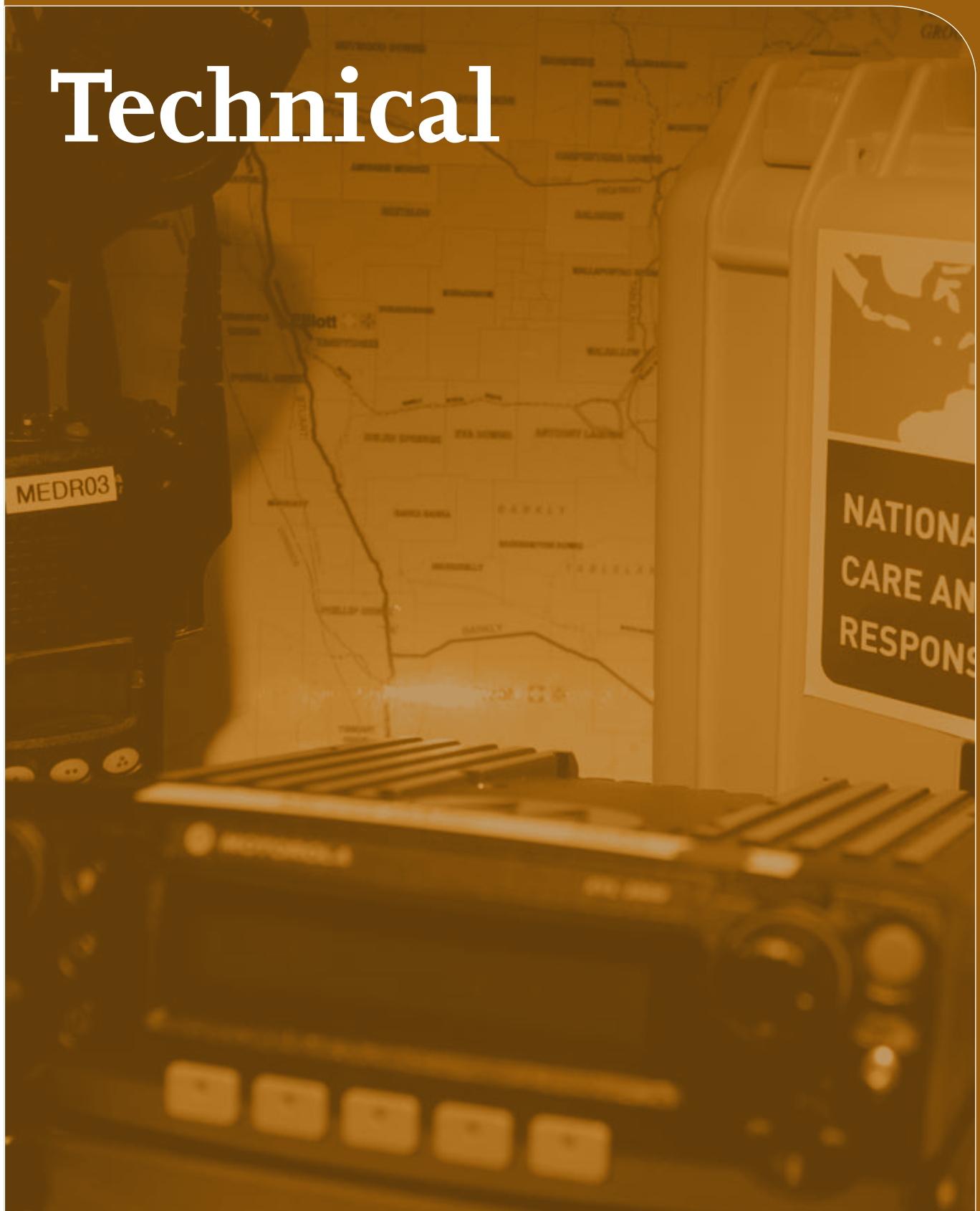
- Burial is the most practical method as it preserves evidence for future forensic investigation, if required.
- Cremation of unidentified bodies should be avoided for several reasons:
  - Cremation will destroy evidence for any future identification.
  - Large amounts of fuel are needed (usually wood).
  - Achieving complete incineration is difficult, often resulting in partially incinerated remains that have to be buried.
  - It is logistically difficult to arrange for the cremation of a large number of dead bodies.

### **Cultural and religious aspects**

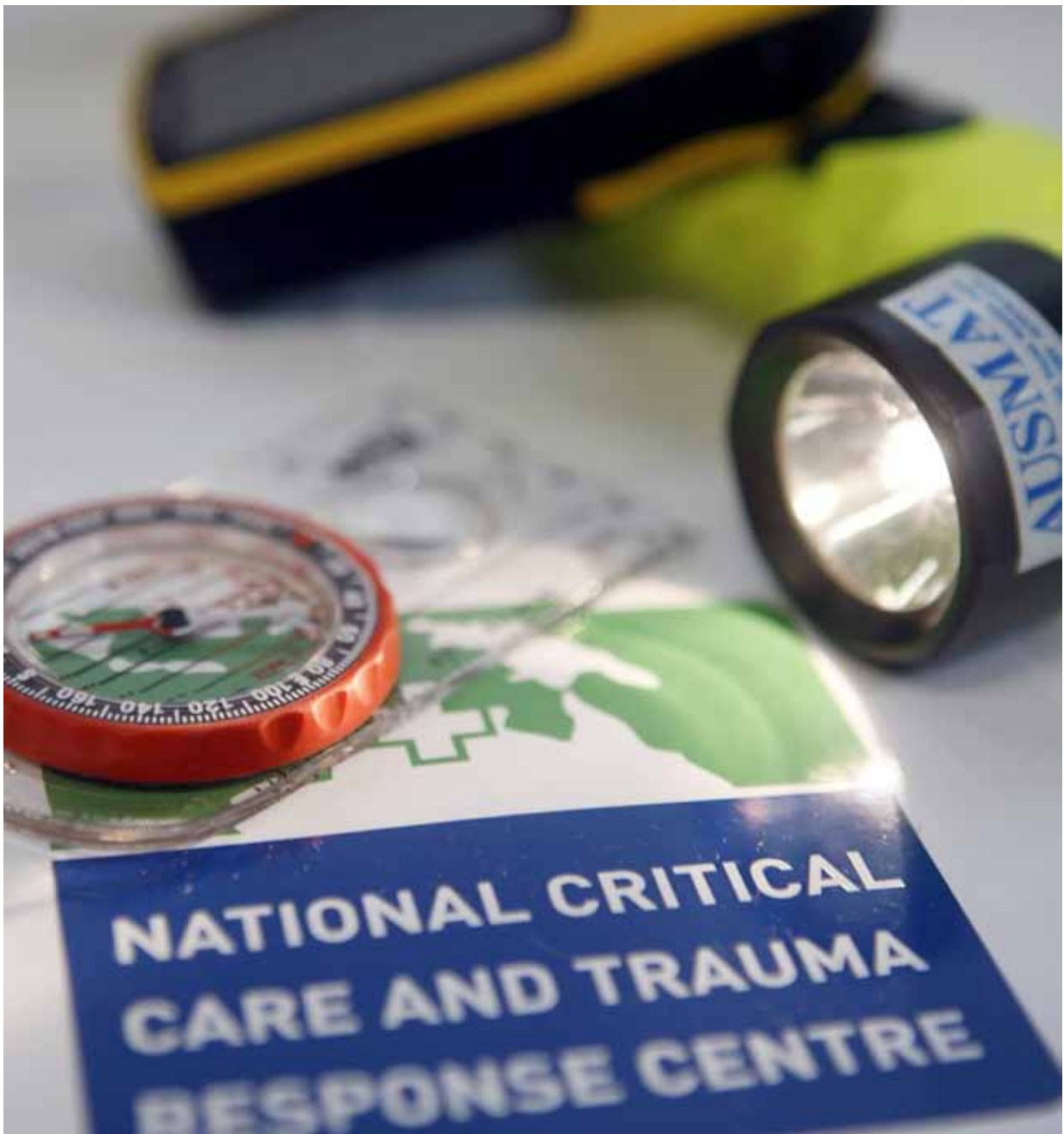
- The overwhelming desire of relatives from all religions and cultures is to identify their loved ones.
- Advice and assistance from religious and community leaders should be sought to improve understanding and acceptance of the recovery, management, and identification of the dead bodies.
- Undignified handling and disposal of dead bodies may further traumatize relatives and should be avoided at all times. Careful and ethical management of dead bodies, including disposal, should be ensured, including respect for religious and cultural sensitivities.



# Technical



# LOGISTICS



## Equipment for AusMAT Deployment

The success of any field operations will rely on the equipment selected and its safe, efficient and effective operation. It is the intent of this chapter to provide a brief overview of equipment and requirements to support an AusMAT unit.

AusMAT logisticians must not depend on external power and water supplies. Forward treatment facilities, field hospitals and base camps will not function without a reliable power and water supply.

### Preparedness

Response times and the success of field operations will rely heavily on the level and quality of preparation. Equipment must always be stored in a state of readiness; it must be checked and operated regularly. This includes testing in the field, software updates and compatibility with other teams. AusMAT teams must develop plans and policies to ensure this. Compliance with general transport and aviation regulations and the preparation of equipment manifests and weights is essential. AusMAT equipment must be clearly identifiable and distinguishable from other agencies.

Logisticians must be familiar with the equipment they are deployed with.

Contingencies must be well established to cope with equipment failures in the field. Consideration should be given to strategically located equipment cache/s.

### Response

Consideration must be given to the likelihood of response across various mediums of travel.

- Can equipment travel by vehicle, light or military aircraft, is it safe to fly, can the equipment be moved manually onsite.
- Does the equipment meet or exceed the operational needs of AusMAT in the field.
- Equipment must be stored in way that is scaleable respective to the size of the response team, equipment stowage should enhance the rapid response of teams.

### Recovery

Logisticians must remain focussed on the safety and functionality of the AusMAT unit through out the emergency response or the beginning phase of recovery. Logisticians must consider local communities when establishing field hospitals/bases and ensure there are no adverse effects of that community or environment as a result of these temporary structures and staff during or post deployment. Consideration must be given to community infrastructure during planning processes. Gifting equipment or expanding operations into affected communities is the responsibility of the mission leader (AusAID).

## Generating Power On Scene

### AusMAT Forward/Needs Assessment Team

In a scenario where a rapid lightweight (1-4 person) AusMAT response is required, it may not be practicable to transport fuel powered generators. Consideration must be given to alternate sources such as 12/24/240v invertors, rechargeable batteries and flexible solar panels. Basic calculations will be required to estimate power usage requirements pre-deployment. Logisticians should consider;

- the type of batteries used, some aviation transport restrictions apply,
- consider selecting equipment to suit batteries sizes, thus limiting multiple battery sizes required by teams.

Low voltage invertors are now readily available to the general public, they function by converting electricity from 12/24v vehicles into limited 240v household voltages. Ideal for low voltage electronic equipment, invertors generally can produce between 50 to 2000 watts of power for a limited time. The bigger the wattage the heavier the unit. An example of power consumption ranges from 1 to 2 watt for mobile phone and camera batteries, 85 watts for a laptops and 600 watts for a power drill. A charged 12v (car battery) is required to power an invertor.

The majority of Australian electronic and electrical equipment will carry a label identifying equipment power consumption; alternatively an electrician can supply this. Some labelling may be expressed in Amps.

### Basic power conversion formula;

**Voltage x Amps = Watts.**

**Eg. 240 volts x 5 amps = 1200 watts**

**1000 Watts = 1Kva**

### AusMAT Rapid Response Health Team

In a scenario where a AusMAT rapid response or full AusMAT health team (15-40 person) is deployed, transportation of more reliable electricity generation and lighting may be required. Generator type and size will depend on team requirements which should be calculated prior to deployment during the preparation process.

### Generator Type

Generators have differing fuel requirements and voltages. Differing fuel types include petrol and diesel systems. Petrol generators are significantly lighter than diesel models but are generally limited in Kva output and consume more fuel than diesel systems. Petrol generators are generally limited to 5 to 6 Kva, where diesel generators may extend through to 3000 Kva. Generators can supply electricity at single phase for light demand or 3 phase for heavy demand. AusMAT Logisticians must calculate the best suited system of power generation during the preparation phase, well before any disaster presents. Many systems now incorporate sine wave electricity generation suitable for sensitive electronic equipment.

A rapid response team that is travel weight restricted should consider lightweight petrol generators. Systems that can be parallel connected to boost Kva from a single point should also be considered. Generators that are not reliant on heavy lift equipment are preferred.

There are several safety considerations AusMAT personnel should be aware of when using a generator.

Always read the owners manual before operating portable generators.

- Never operate an internal combustion engine inside a building or any other enclosed area.
- The generator needs a minimum of 1 to 2 metres of spacing on all sides (including above).
- A generator needs an unlimited supply of fresh air for proper cooling during operation. Generators should be placed downwind of personnel and air intakes.
- Since combustion engines create carbon monoxide, good ventilation is critical.
- Keep the generator dry and always operate it on a level surface. Unless specified otherwise, generators will malfunction and become dangerous when exposed to wet conditions.
- Ensure the generator is off and cool before refuelling. Fuel spilled on hot engine parts could ignite.

- Store fuel for the generator in an approved safety container. Use the type of fuel (2 Stroke / 4 Stroke/Diesel) recommended in the instructions or on the label on the generator.

It is very important that you never attempt to feed power from your portable generator into a wall outlet. This is commonly called back feeding and can electrocute personnel working on electrical grid systems within the community.

When operating from generator power it is essential to prioritise equipment to be powered. This is to ensure that generators are not overloaded unnecessarily.

Caution should be taken when using non-inverter / sine wave type generators as damage can occur to modern electronic equipment (Eg, medical equipment, computers, televisions, monitors)

### OPERATE THE GENERATOR IN THE OPEN

- ⦿ Operate in open space.
- ⦿ Aim exhaust outlet AWAY from working areas.
- ⦿ Keep the area around the generator unobstructed for cooling and exhaust.

### OPERATE IN DRY CONDITIONS

- ⦿ Avoid operating the generator in rain or snow.
- ⦿ Avoid operating the generator near a pool.
- ⦿ Avoid operating the generator near a sprinkler system.
- ⦿ Avoid operating the generator with wet hands, feet or clothing.

### OPERATE ON FIRM, LEVEL SURFACES

- ⦿ Operate on a level surface.
- ⦿ Operate on a firm surface.
- ⦿ Operate away from dusty or sandy conditions.
- ⦿ Operate in dry conditions.

### GENERATOR READINESS

- ⦿ Exercise the generator monthly under load
- ⦿ Keep battery charged
- ⦿ Keep fuel tank filled with fresh fuel

## Power Distribution



Power cords and distribution boards must meet or exceed Australian standards before use. Purchase good quality electrical equipment from a reputable manufacturer.

Extension cords must comply with local state and territory testing standards.

Extension cords must be completely uncoiled before use, this will reduce the possibility of heat generation and fire.

Extension cords must not be placed in high pedestrian traffic areas without proper safety measures to reduce wear and trip hazards.

Extension cords used in wet conditions must be fitted with approved weather proof connections.

Ensure electrical plugs are fully inserted, electrical fittings poorly fitted produce a significant fire hazard

Power distribution boards should contain some type of overload or surge protection.

Double adaptors must not be used in a distribution board.

Main power distribution boards should incorporate a RCD (residual current protection devices).

RCD must be checked regularly to ensure that it is operating correctly by the use of the 'test' button.

## Tool Kit Requirements

Every rapid deployment should include the capability of basic repairs and assembly of equipment. More prolonged deployments will require more specific equipment to the trades and qualifications deployed.

Basic hand tool may include but not limited by the following:

- Combination of Pliers
- Combination Spanner Set
- Screwdriver Set
- Socket Set
- Stanley Knife
- Cable Ties
- Hammers
- Hand Saws
- Electrical Tape
- Punch set
- Adjustable Shifters

Additional equipment may be required based on each deployment. Additional hand tools should complement the basic list to provided basic mechanical and electrical support when deployed. Additional power tools and technical equipment may be required when the likelihood of construction or ongoing maintenance may be required in austere environments.



# Field Hospitals





## WHO-PAHO

### Guidelines for the Use of Foreign Field Hospitals in the Aftermath of Sudden-Impact Disasters Area on Emergency Preparedness and Disaster Relief Pan American Health Organization

International meeting  
Hospitals in Disasters—Handle with Care  
San Salvador, El Salvador, 8–10 July 2003

Both natural and complex disasters may produce a massive number of casualties that outstrip the ability of the local health care system to provide the required care. Damage to the health care infrastructure will further compromise the delivery of health services.

As a consequence, affected and collaborating countries are anxious to find ways to provide immediate medical care to victims. An obvious solution would seem to be the dispatch of mobile field hospitals to the stricken area.

In complex disasters (civil conflicts and wars), field hospitals—civilian or military—have been used with notable success. However, the experience in the aftermath of natural disasters in developing countries has proven to be less satisfactory in terms of effectiveness and cost.

These perceived shortcomings prompted the World Health Organization (WHO) and the Pan American Health Organization (PAHO) to convene a meeting of experts to review guidelines regarding the dispatch or donation of foreign field hospitals (FFH) to areas in which a disaster has compromised the delivery of health services, particularly in developing countries.

Systematic and independent evaluation of FFH used in disasters will be required to further refine the following recommendations.

#### Definition

For the purpose of these guidelines, a field hospital is defined as a mobile, self-contained, self-sufficient health care facility capable of rapid deployment and expansion or contraction to meet immediate emergency requirements for a specified period of time.

The field hospital may be temporarily dispatched with personnel or donated without personnel.

It is understood that: field hospitals are deployed only: (a) following an appropriate declaration of emergency and a request from the health authorities of the affected country;

(b) when they are integrated into the local health services system; and (c) when the respective roles and responsibilities for their installation and operational sustainment have been clearly defined.

#### Uses for Foreign Field Hospitals

Field hospitals may be used to substitute or complement medical systems in the aftermath of sudden-impact events that produce disasters for three distinct purposes:

1. Provide early emergency medical care (including Advanced Trauma Life Support—ATLS). This period lasts only up to 48 hours following the onset of an event.
2. Provide follow-up care for trauma cases, emergencies, routine health care and routine emergencies (from day 3 to day 15).
3. Act as a temporary facility to substitute damaged installations pending final repair or reconstruction (usually from the second month to two years or more).

The FFH should meet some essential requirements to ensure that it benefits the affected population. Ideally, it should also meet some additional (optional) criteria.

The World Health Organization (WHO) and the Pan American Health Organization (PAHO) suggest the following “essential requirements” and “additional (or optional) criteria” for each intended purpose.

#### Early Emergency Medical Care (First 48 Hours)

##### Essential requirements:

- Be operational on site within 24 hours after the impact of disaster

The interval must begin from the time of occurrence of the mass casualties and not, as usually advertised by donors, from the time the request is acted upon by the assisting country or organization. This is an essential medical requirement for life-saving response and is not an administrative condition that can be waived.

- Be entirely self-sufficient

In the early phase, FFH should be able to operate with a minimum of support/utilities from the affected community. At the least, they should have sufficient power generating capacity and medical supplies and equipment to operate independently for the first 48 hours. The staff should require minimal or no support (food, accommodation, etc.) from the host community.

- Offer comparable or higher standards of medical care than were available in the affected country prior to the precipitating event

The medical personnel should be qualified and have prior experience in managing mass casualties (including the concept of triage) and in treating victims with acute, multiple injuries.

### Optional criteria:

- Be familiar with the health situation and culture of the affected country

Sharing the same language and culture or being familiar with the health systems and level of technology of the affected country are highly desirable even in the immediate aftermath of a natural disaster (first two days).

In practice, those medical facilities that are available within the first 24 hours most likely will come from the closest neighbors who share the same language and culture.

Issues that must be clarified before accepting/requesting a field hospital for early emergency trauma/medical care (first 48 hours).



Questions both parties (recipient and donor) should ask:

Questions	Comments
When can the FFH actually and effectively start assessing and treating victims?	If not within 24 hours of the impact, consider accepting this facility using the criteria for secondary care and routine emergencies (3–15 days).  Beware of vague answers or misleading statements that indicate that the hospital can be “activated” or mobilized within, for example, 6 hours. What you need to know is when it can be operational on site.
Is the hospital fully self-sufficient (including power and water)? For how long?	Only self-sufficient hospitals should be accepted.
Type of equipment and services available? Number of beds? Stabilization and transfer of patients only? Full operating room capacity? General anesthesia? Blood bank and laboratory?	The reply will tell you what you can reasonably expect in terms of performance and services.
Type of medical staff available? Number, qualifications and seniority? Prior experience in mass casualty management?	Medical staff inexperienced in disasters, too junior or from a specialty unrelated to trauma/ medical emergencies are not as useful as emergency physicians and trauma surgeons from a busy trauma department.
How long can the FFH stay?	Longer is not necessarily better. FFH staff unfamiliar with local culture and health services quickly outlive their usefulness (and welcome).  Needs change after a few days, as should the profile of the assisting medical staff.
What is the most appropriate location for installation of this FFH?	This depends on medical needs (identified by recipient country), logistical imperatives (roads, infrastructure) and access by victims. Generally, FFH are better placed in the proximity of a local health facility (even if it is out of service).



### Follow-up Trauma and Medical Care Day 3 to Day 15

Following the first 48 hours when provision of acute care does save lives, the health services are progressively overwhelmed by the need for secondary or maintenance care for the trauma victims as well as the demand resulting from the rapid emergence of normal emergencies or routine medical care. The health facilities may not be fully operational and staff will urgently need some rest and time to care for possible personal losses.

When the local health installations remain functional, this need of external assistance is better met by medical brigades or teams from within the country or from culturally compatible neighbors rather than by expensive or bulky FFH.

The primary role of the FFH is to temporarily fill the gaps in emergency medical assistance resulting either from the large number of casualties or the inability of the local health services to respond to normal emergencies. The duration of the FFH operations should usually not exceed 15 days but can be extended at the specific request of the affected country.

Essential requirements:

- Be fully operational within 3–5 days

Early arrival at the site is no longer a matter of life or death as almost all victims will have received acute care from the local health workers and the few FH or medical teams from outside the disaster affected area who were able to arrive in time to provide effective medical care.

A few hours may not make a significant difference after the first 24 hours, so hasty decision-making by the recipient government is counterproductive. Nevertheless, in order to assist with the provision of health care that meets immediate needs of the affected community, such field hospitals must be operational within three to five days following the impact.

- Minimal need for support from the local communities

The FFH must be self-sufficient (staff, medicines, equipment and supplies, orthopedic surgery and minor interventions, anesthesia, external consultation and accommodation of the FFH staff). Water and power may be restored at least for critical facilities in the community affected. The FFH may reasonably expect to receive some support from the local authorities. However, due to the expected unreliability of these services, the FFH should be able to provide its own source of energy and water when necessary.

- Basic knowledge of the health situation and language, and respect for the culture

The FFH personnel is expected to initiate or continue to provide services after the initial acute care phase (first 48 hours) and must be able to communicate with the patients, the local authorities and colleagues in the health services. The staff should have some familiarity with endemic local pathology. Some of the staff should speak the local language or interpreters must be provided.

Medical personnel utterly unfamiliar with the environment have proven to be not only of limited utility but often have turned out to be a burden and a source of contention for the host community.

- Availability of selected specialties

The FFH must include health professionals in areas other than orthopedics, such as general surgery, anesthesiology, internal medicine, gynecology and obstetrics, and pediatrics with the paramedical and support staff to meet the type and variety of services they will be called on to provide. The equipment and facilities should allow assessment and treatment of all patients regardless of age or gender.

- Sustainability (appropriate technology)

The bulk of the assistance from the FFH may consist of external consultations and routine (non-disaster related) hospital care. FFH do not stay for extended periods of time and the local health workers are expected to assume full function within a few weeks after the precipitating event.

The quality and sophistication of the care provided by the FFH must be sustainable by the local health services once the FFH has departed. Short-lived availability of higher technological care (diagnosis, medicines, etc.) often raises unrealistic expectations from the population and leaves the local health services in a weakened position.

- Evaluation of the cost-effectiveness and cost-benefit associated with the use of the FFH

Setting up a field hospital is an expensive undertaking. A detailed agreement between the recipient and donor must be made specifying who will be responsible for costs associated with shipment, site preparation, maintenance, operational costs, staffing, etc. Donors sometimes expect the host country to cover local expenses involved in operating a field hospital (e.g., utilities, fuel, and other support), but local health services are not usually able to meet these costs.

Optional criteria:

- Cultural similarity

Familiarity with and a respect of the local culture and language are essential requirements. Ideally, the staff should share the same language and culture. Dissimilarity of culture and language has resulted in misunderstandings between the external helpers and the local staff.<sup>1</sup>

- Broad range of medical disciplines

The FFH should include a broad range of clinicians and public health professionals. Epidemiologists, hygiene/sanitation experts and mental health experts have proven to be valuable assets.

Questions	Comments
When can the FFH actually and effectively start assessing and treating victims?	If not within five days of the impact, postpone the decision until you have completed a detailed assessment of the needs and residual health capacity.  Beware of vague answers or misleading statements. What you need to know is when it can be operational on site.
Is the hospital self-sufficient? For how long? What may be required from the host community: prepared site with drainage, water, power (specs?), interpreters, food, and accommodation for staff? When?	Normally, only self-sufficient hospitals should be accepted. However, after 48 hours, you should know where basic utilities (power, water, etc.) are available and can be provided.  The reply will assist you in deciding where to locate this FFH: near a partly functional hospital or one that is totally destroyed or out of service.

<sup>1</sup> In most instances, the time of the medical staff of a FFH is dedicated increasingly to providing external (ambulatory) consultations to outpatients. The total number of consultations will far exceed the normal rate for reasons not necessarily associated with the disaster but rather with poverty or poor coverage of the health services. Increase in demand for services can be attributed to:

- Prestige of foreign doctors;
- Availability of new diagnosis, treatment or medicines;
- Unformulated wish for second opinions on minor ailments; and/or
- Economic incentives (absence of a token fee for consultations or medicines).

The short duration of this otherwise valuable assistance leaves the local staff in a debilitated and uncomfortable position. Statistics on numbers of consultations during this period also tend to exaggerate the impact of the disaster and the relevance of the FFH.

What are the financial implications for the host community or health services?	Who will pay for the utilities, fuel and other support? Exemption of VAT and other taxes? This is a sensitive issue but must be answered as completely as possible. Many FFH from less wealthy countries expect the host country to cover all local expenses. Local health services are usually unable to do so.
Type of equipment and services available? Number and type of beds? Trauma care only? Surgical capacity for most emergencies (including geriatric, obstetric and pediatric)? Diagnostic facilities (lab, Xray)?	The reply will tell you what you can reasonably expect in terms of performance and services.  Keep in mind that in large part the demand will be for routine emergencies and chronic care of a general population.

Issues to clarify before accepting/requesting a field hospital for follow-up care (day 3 to day 15).

Questions the recipient government should ask:

Questions	Comments
Will your stock of medicines be sufficient for the anticipated duration of the mission and the local health situation? Is your logistical unit able to provide you with the required supplies?	Beware that some groups may use medicines that are expired or not registered in the country (refer to WHO guidelines on donations).
Are you familiar with and willing to follow the Ministry of Health or WHO treatment guidelines observed in the country?	Share any relevant standard treatment schedules or guidelines the Ministry of Health may have issued. The treatment offered by FFH should be similar to that normally provided in the host country (e.g., oral rehydration therapy, standard TB drugs, etc.).
Medical staff: Number, qualification and seniority? Language and culture? Insurance and liability coverage?	The staff should include professionals able to provide general care for the most common problems in the country: diarrhea; acute respiratory infection; endemic diseases; geriatric, obstetric or pediatric emergencies, etc.
Will the medical staff be available and equipped for visits to outreach areas?	The use of FFH personnel and resources to visit neighboring communities that do not have access to health facilities is a definite asset.

# Radio Communication



PROWORD	MEANING
<b>ACKNOWLEDGE</b>	Confirm that you have received my message and will comply.
<b>AFFIRMATIVE</b>	Yes/Correct.
<b>NEGATIVE</b>	No/Incorrect.
<b>ALL AFTER</b>	Everything that you (I) transmitted after ... (Keyword).
<b>ALL BEFORE</b>	Everything that you (I) transmitted before ... (Keyword).
<b>CORRECT (THAT IS CORRECT)</b>	What you have transmitted is correct.
<b>CORRECT (THAT IS CORRECT)</b>	A. An error has been made in this transmission. It will continue with the last word (group) correctly transmitted.  B. An error has been made in this transmission. Correct version is ...  C. That which follows is a correct version in answer to your request for clarification.
<b>WRONG</b>	Your last transmission was incorrect. The correct version is ...
<b>DISREGARD THIS TRANSMISSION –OUT</b>	This transmission is an error. Disregard it. This proword shall not be used to cancel any message that has already been completely transmitted and for which receipt or acknowledgement has been received.
<b>DO NOT ANSWER- OUT</b>	Stations called are not to answer this call, acknowledge this message, or otherwise to transmit in connection with this transmission.
<b>SILENCE-SILENCE-SILENCE!</b>	Cease all transmissions on this net immediately. Will be maintained until lifted.

PROWORD	MEANING
<b>SILENCE LIFTED</b>	Silence is lifted. The net is free for traffic.
<b>END OF MESSAGE – OVER (OUT)</b>	This concludes the message just transmitted (and the message instructions pertaining to a formal message).
<b>END OF TEXT</b>	The textual part of a formal message ends. Stand by for the message instructions immediately following.
<b>FETCH ...!</b>	I wish to speak on the radio to that person.
<b>...SPEAKING</b>	Requested person is now using the radio himself
<b>FIGURES</b>	Numerals or numbers will follow. (This proword is not used with the call signs, time definitions, grid references, bearings, distances, etc., especially in fixed-form reports).
<b>FROM</b>	A. This is ...  B. The originator of this formal message is indicated by the address designation immediately following.
<b>TO</b>	The addressees whose designations will immediately follow are to take action on this formal message.
<b>THIS IS</b>	This transmission is from the station whose designation immediately follows.
<b>OVER</b>	This is the end of my turn of transmitting. A message is expected. Go ahead.
<b>THROUGH ME</b>	I am in contact with the station you are calling; I can act as a relay station.
<b>MESSAGE PASSED TO</b>	Your message has been passed to

PROWORD	MEANING
<b>ROGER</b>	I have received your last transmission satisfactorily.
<b>ROGER SO FAR</b>	Have you received this part of my message satisfactorily?
<b>WILCO</b>	I have received your message, understand it, and will comply. (To be used only by the addressee). ROGER and WILCO are never used together.
<b>UNKNOWN STATION</b>	The identity of the station calling or with whom I am attempting to establish communication is unknown.
<b>VERIFY</b>	Verify entire message (or portions indicated) with the originator and send correct version. To be used only at discretion of or by the addressee to which the questioned message was directed.
<b>I VERIFY</b>	That which follows has been verified at your request and is repeated. To be used only as a reply to VERIFY.
<b>WAIT (WAIT-WAIT)</b>	I must pause for a few seconds.
<b>WAIT-OUT</b>	I must pause for more than a few seconds, and will call you again when ready.
<b>WORD AFTER</b>	The word of the message to which I make reference is that which follows
<b>WORD BEFORE</b>	The word of the message to which I make reference is that which precedes
<b>WORD TWICE</b>	Communication is difficult. Transmit(ing) each phrase (group) twice. This proword can be used as an order, request or as information.
<b>OUT</b>	This is the end of my transmission to you. No answer or acknowledgement is expected.

PROWORD	MEANING
<b>OUT TO YOU</b>	Do not answer, I have nothing more for you, I shall now call another station on the net.
<b>READ BACK</b>	Repeat the entire following transmission back to me exactly as received.
<b>I READ AGAIN</b>	The following is my reply to your request to read back.
<b>SAY AGAIN</b>	A. Repeat all of your last transmission. B. Followed by ALL AFTER, ALL BEFORE, WORD AFTER, WORD BEFORE, etc. means: Repeat ... (portion indicated).
<b>I SAY AGAIN</b>	I am repeating my transmission or portion indicated.
<b>SEND</b>	Go ahead with your transmission.
<b>SEND YOUR MESSAGE</b>	Go ahead, transmit; I am ready to copy.
<b>SPEAK SLOWER</b>	Reduce the speed of your transmission.
<b>I SPELL</b>	I shall spell the next word, group or equivalent phonetically. (Not used when transmitting coded groups only).
<b>RELAY TO</b>	Transmit the following message to all addressees or to the address designation immediately following.
<b>RELAY THROUGH</b>	Send this message by way of call sign

### RADIO COMMUNICATIONS, PHONETIC ALPHABET

Letter	Phonetic equivalent
A	Alpha
B	Bravo
C	Charlie
D	Delta
E	Echo
F	Fox-trot
G	Golf
H	Hotel
I	India
J	Juliet
K	Kilo
L	Lima
M	Mike
N	November
O	Oscar
P	Papa
Q	Quebec
R	Romeo
S	Sierra
T	Tango
U	Uniform
W	Whiskey
X	X-Ray
Y	Yankee
Z	Zulu

### Establishing Radio Communications Protocol in Field Situations

Communications via radios e.g. devices operating on HF, UHF or VHF frequencies are subject to certain constraints, including physical (distance), technical (compatibility) and legal (government regulation) among others. Physical constraints mean that in some situations, and without additional technical support, your communications may be limited to a distance of from only a few kilometres to a total of 100 kilometres. Technical constraints mean that if you are operating on one radio system (HF), you will be unable to communicate with someone operating on another (VHF). Legal constraints may mean that you need prior government authorization to even operate a radio system and even if you do, the communications may be monitored by the authorities.

With the introduction of increasingly inexpensive satellite phone technologies into many field emergency situations, it is more common that staff arriving new to a field situation will expect to be able to establish phone-based, two-way communications and will not be experienced with establishing or operating an efficient radio protocol. Understanding the above constraints and adopting a simple but comprehensive protocol for communications via radios can be an important safety feature in any field situation.

#### Basic Principles of Radio Protocol

There are three basic, but fundamental principles to follow when establishing a radio communication protocol for a field situation.

1. Alphanumeric call signs (Alpha, Bravo, Charlie Zero, One, Two)
2. Call signs are location and function specific
3. Transmission in English (in some cases French) only
1. Alphanumeric call signs: the use of the alphanumerical system to designate call signs for individuals ensures that all users are utilizing simple, number and letter-based identifiers for staff on the same radio network. The system ensures simple, multi-syllable identifiers that are easily pronounced by speakers of most languages.

2. Location- and function-specific call signs: When identifier call signs are based on an individual's name, this may lead to confusion when two staff arrive at a duty station with names that begin with the same letter. Similarly, when someone is replaced in an operation and the call signs are based on names rather than functions, other users on the radio network will not quickly be able to communicate with the new replacement as they will be unfamiliar with the call sign identifier. Finally, it is much easier to "decode" call signs that are based on personal names, which can compromise individual security. Use location first, then function when establishing a radio protocol.
3. Transmission in English or French: it is generally acceptable to use local languages only on unregulated, open (or "simplex") frequencies, and then only when the users understand that these frequencies are the least secure communications means available. UN standards require that the dominant UN language of the operation, either English or French, be used on official radio frequencies.

### Establishing a Radio Call-Sign System

1. Location: choose a letter from a location name  
Islamabad = India  
Kandahar = Kilo  
Peshawar = Papa
2. Function: choose a letter from the organisation name:  
UNHCR = "HOTEL"  
Red Cross = "ROMEO"  
IOM = "INDIA"
3. Function: choose a number to denote responsibility  
Head of Office = 1 ("Wun")  
Deputy Head of Office = 1.1 ("Wun Wun")  
Logistics = 4 ("fo-wer")  
Admin = 6 ("seeks")

It is important to emphasise that the Indicators used for call signs are assigned in a cascading format, from location, to function (organisation) and function (responsibility). This enables a coherent, logical framework that can be expanded as new organizations are added to the network, and more staff are added to each organization. Actual radio protocols in field situations may vary in some way from the above, but will always follow a logical framework that is both simple and coherent for proper field communications.

### Radio Maintenance and Use Advice

The following advice applies to using your VHF (walkie-talkie) radio. It is purposely kept as simple as possible, and should be valid in most field situations. Following these procedures will help you get the best performance (and best security) from your radio system.

### Communication Range

Communication range for VHF radios is largely dependant on having a line-of-sight or near line-of-sight path between your antenna and the antenna of the station you want to talk to. If you are having trouble with weak signals, try some of these tricks:

Hold the radio over your head (antenna is higher).

Climb to a location that is higher, or that has fewer obstructions between you the station you are talking to.

Move the radio around the immediate area. It is common for a spot just a few feet away to work much better (or sometimes worse).

Ask any other station that hears you to try to relay your call to the base station or the person you need to communicate with.

### Squelch Setting

The squelch control on your radio quiets the background noise when there is no signal to receive. It should be adjusted to the point where the noise just quiets. If the control is turned beyond this point, it will actually reduce the sensitivity of the radio. Many newer radios do not have a user controlled squelch control. This style of radio will have a MONITOR pushbutton on the side of the radio to unsquelch the radio for test purposes (to set volume level for example).

### Battery Life

Battery life for hand held radios mainly depends on how many minutes the radio is used in the transmit mode. A typical radio using a high capacity (larger, heavier) battery will usually be specified by the manufacturer to operate on a 5-5-90 duty cycle for an 8 hour day (5% transmit time, 5% receive time, 90% standby time). To maximize battery life, minimize transmit time. Consider these examples:

- 5% of an 8-hour day is 24 minutes of transmit time.
- If the radio transmits for only 12 minutes, the battery "day" becomes 16 to 20 hours.
- If the radio transmits for 30 minutes, the battery "day" becomes only 4 hours.
- Keep radio transmissions brief. Let the base station do the talking.

### COMMON COMMUNICATIONS EQUIPMENT AND TERMINOLOGY

**Codan (Manufacturer's name)**

High frequency radio system using voice communication, commonly used in vehicles

**DAMA – Demand Assigned Multiple Access**

Satellite (VSAT) system which allows multiple lines of telephone, fax and data to be transmitted via satellite

**DTS – Digital Transmission System**

A successor to PACTOR, allowing the transmission of e-mail messages by radio

**HF – High Frequency**

Range of frequency if radio waves used for long distance radio communication

**INMARSAT – International Mobile Satellite Organization (originally called International Maritime Satellite Organisation)**

Phone system which provides global phone, fax and data transmission via satellite

**Pactor – Packetised Telex Over Radio**

System whereby printed messages can be sent by radio

**SATCOM – Satellite Communications**

Generic term for any satellite communications system

**SATCOM A, B, C, M, Mini-M – Refers specifically to INMARSAT terminals used by UNHCR**

Telephone system used for voice, fax and data communications. The equipment comes in various sizes, from suitcase size to small laptop size, and with varying capabilities from simple telex to video conferencing.

**SITA – Société Internationale de Telecommunications Aéronautiques**

An organisation which provides a global communications network for airline reservations and ticketing. It can also provide a communications network for non-airline customers (e.g. UNHCR)

**UHF – Ultra High Frequency (Higher than VHF)**

Range of frequency of radio waves used for short distance radio communication

**VSAT – Very Small Aperture Terminal**

Satellite system which allows multiple lines of telephone, fax and data to be transmitted via geo stationary satellite

**VHF – Very High Frequency**

Radio waves used for short distance radio communications (e.g. handsets for walkie-talkies)

**VHF Repeater – Very High Frequency Repeater**

Equipment used to extend the range of VHF short distance radio communications to a range of 20 to 80 km, depending on the topography

**Radio Checks**

When you are issued a radio, you will be assigned a channel and a call-sign to use. As you leave your home office or base, but before you get too far away, make a test call to the communications or security officer. "Hotel, this is Charlie Seven on channel 2". This test will help ensure that you are on the correct channel, have the volume and squelch set properly, and have a working radio.

If you leave the city or office area, it also is a good idea to make a second test call once you are 1 kilometer away from base. Some radio faults (bad antenna connection, weak battery) will not be evident when tested close to the base station.

**Call Signs**

Be sure you have a listing of the call signs and standard channel uses for your radio network. It will be important to memorize the call-signs you need. When you arrive at the office or are given a radio, make sure you have a prepared card or pocket reference with the call signs you will need.

**Scheduled Calls**

One way to extend battery life in certain situations is the SCHEDULED CALL. Leave the radio OFF most of the time. (Clear this with you security officer - as the situation may require full-time monitoring for security reasons) By prior arrangement with your base station or security officer, turn it on every hour and monitor for 10 minutes for a call. Do not place a call if you are not called (transmitting uses 50 to 100 times as much battery power as monitoring).

**Battery Issues**

Rechargeable batteries are damaged each time they are left on to the point where the battery is fully discharged. Check, then double-check that your radio is OFF when you are done with it. Check your team-mate's radio. Have him or her check yours.

# Navigation

This short discussion of map basics is based on information found on the “WorldWeb Travel Guide” and “Reading Topographic Maps”. See the original on-line articles @ [www.discoveralberta.com/Articles/WildernessNavigation/8-16.html](http://www.discoveralberta.com/Articles/WildernessNavigation/8-16.html), [www.map-reading.com](http://www.map-reading.com)



### Maps

Maps are two dimensional representations of three dimensional features. It is a flat drawing of a changing world. Topographical maps are the standard map for most navigating.

### Scale

Scale is a representation of the size of a feature on the map relative to the size of the real thing. For example, a lake measuring 1 centimeter on a map with a scale of 1 to 50,000, would represent an actual lake 50,000 centimeters or 0.5 kilometers wide. Whether you measure in inches, feet, centimeters, or thumb nails, the relationship is still the same. A stream 2 1/2 thumb nails long on a 1:100,000 scale map represents an actual stream 250,000 thumb nails long. (When working with scales, the metric system is definitely the one to use.)

### Common Map Scales and Their Uses:

- 1:50,000 Used by hikers, ski tourers, backpackers, hunters on foot, Good detail for travelling on foot in intricate terrain.
- 1:100,000 Used by hikers, ski tourers, and backpackers on longer trips in more moderate terrain. Less detail but still useful for selecting appropriate routes on longer trips
- 1:250,000 An overview of large and extensive back country trips on foot or ski, may be used for off road motorized travel , canoeists. Limited detail with no information regarding micro-terrain features need for ground travel. May be suitable for river or ocean trips with small craft
- 1:500,000 Paddlers travelling extended distances (200 kilometres or more), general views of very large terrain features. Large areas covered with limited detail
- 1:1,000,000 Overview maps of very large tours or expeditions. This is approaching the detail of a large road map.

### Contour Lines

A contour line is continuous line of the same elevation around the edge of a feature. Think of it as the edging trim along each layer of a wedding cake. Each line gives an outline of what a feature looks like at regular intervals of elevation. The closer together the lines are, the steeper the slope. For example the close gathering of contour lines on Mt.

Wrongagain represents a steep slope. The spread out contour lines indicate a more gentle slope. The contour lines are at 100 foot intervals, that is each line represents an outline of the mountain 100 feet higher than the line below it. Contour intervals will vary with maps, and it is important to check the interval to interpret the map.

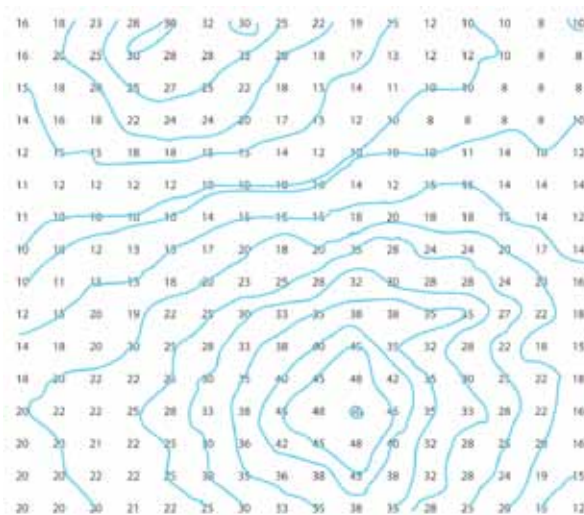
To understand the shape of the mountain it is helpful to use the contour lines to build an image of the feature, either in your mind or to draft out a profile on paper. Here is a profile of Mt. Wrongagain.

The mountain has two peaks, with the higher summit on the left. The lower slopes are moderate, becoming very steep towards the summits.

Because the contour lines are at 100 foot intervals we can only estimate what the terrain between each contour looks like. An 80 foot cliff could easily hide between contours and not be recorded on the map. With this in mind it is good to remember that while these maps are generally very good, there is still room for the odd surprise.

One of the most difficult things to interpret on a contour map is a sense of elevation, ridges, and valleys. Here are a few tips. Water always flows down through valleys or gullies, never ridges.

Creeks begin at higher elevations and flow down to lower elevations where they join to form larger but fewer rivers. When contours form a bulge that points from a lower elevation to a higher elevation, it is a gully, valley, or bowl. When contours form a bulge from higher elevations to lower elevations it is a ridge.



## Map Coordinates

There are two primary methods for recording a point on a map, the latitude & longitude system, and various grid systems, including military grid systems.

### 1. Longitude and Latitude

This is the traditional system for global positioning. Longitude is a series of imaginary lines radiating from the North and South poles. There are 360 degrees of longitude. Latitude is a series of belts that circle the Earth. The equator is 0 degrees, and the north pole is 90 degrees north latitude. The border between western Canada and the United States is exactly 49 degrees north latitude. For both latitude and longitude, every degree is broken down into 60 minutes. Each minute is further broken down into 60 seconds.

Longitude and latitude measurements are located along side the grid measurements, but are printed in black. Longitude is located at the top and bottom of the map. The longitude for Mt. Snowdome, for example, is 117 degrees 18 minutes 55 seconds or 117°18'55". Latitude is determined with the scale on the side of the map; 52°11'22" N. The N represents north, because the same reference is used in the southern hemisphere. The north south designation may be deleted from latitude if it is clearly understood that you are referring to the northern hemisphere. If there is any doubt add the N designation to prevent ending up somewhere in Chile. So Mt. Snowdome is located 117°18'55" 52°11'22" N.

The grid system is generally much easier to use and is fairly standard for guide books and reference points used by guides, foresters, and land rescues. Most aircraft navigate with longitude and latitude and most GPS units give coordinates as longitude and latitude. This makes it important to know both systems. For general travel and route finding the grid is probably a better system. If sending word out for a rescue to police, military forces, or civil defence and rescue units, the grid system is generally the preferred system. When communicating directly to an aircraft give longitude and latitude. If using a GPS be prepared to use both systems.

### 2. Grid systems

The grid system is based on the light blue grids printed on most topographical maps. On a 1:50,000 scale map, the grid is 1000 metres square. Along the outside of the map on the top and bottom are a series of numbers called the Easting. The first light blue number will be accumulated distance in metres from 0 on the grid. On the Columbia Icefield map

it begins at 467000 metres east. The number increases by 1000 metres with each additional grid east. Mt. Snowdome is located between 478000 and 47900 E. Using a ruler and knowing by the scale that 2 millimetres equals 100 metres; the grid reference is 478400 E. The same method is used to determine the northing, 5781750 N.

This coordinate is expressed in several ways:

- 478400 E, 5781750 N Full description 478400, 5781750 Easting first, Northing second
- 478400, 781750 The million metre reference is dropped from the northing (often used in guide books)

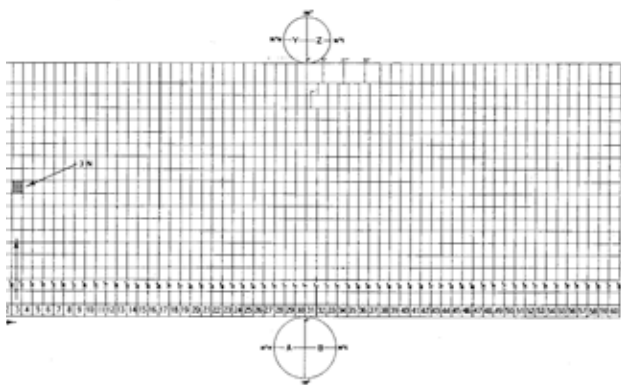
The grid system is quick simple and very accurate.

### The United States Army Military Grid Reference System

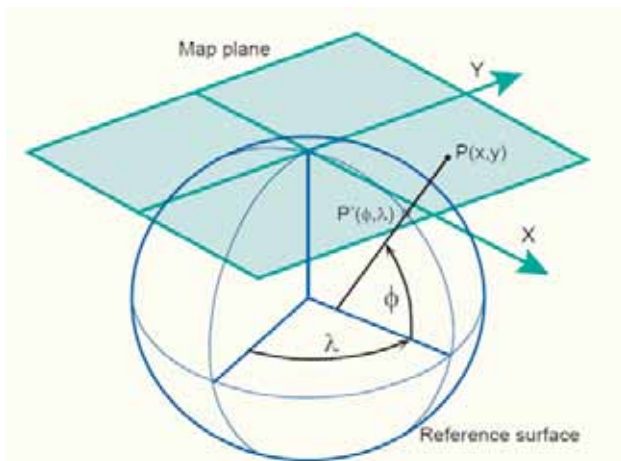
This grid reference system is designated for use with the UTM and UPS grids. The coordinate value of points in these grids could contain as many as 15 digits if numerals alone were used. The US military grid reference system reduces the length of written coordinates by substituting single letters for several numbers. Using the UTM and the UPS grids, it is possible for the location of a point (identified by numbers alone) to be in many different places on the surface of the earth. With the use of the military grid reference system, there is no possibility of this happening.

**Grid Zone Designation.** The world is divided into 60 grid zones, which are large, regularly shaped geographic areas, each of which is given a unique identification called the grid zone designation.

- 1) UTM Grid. The first major breakdown is the division of each zone into areas 6° wide by 8° high and 6° wide by 12° high. Remember, for the transverse Mercator projection, the earth's surface between 80° S and 84° N is divided into 60 N-S zones, each 6° wide. These zones are numbered from west to east, 1 through 60, starting at the 180° meridian. This surface is divided into 20 east-west rows in which 19 are 8° high and 1 row at the extreme north is 12° high. These rows are then lettered, from south to north, C through X (I and O were omitted). Any 6° by 8° zone or 6° by 12° zone is identified by giving the number and letter of the grid zone and row in which it lies. These are read RIGHT and UP so the number is always written before the letter. This combination of zone number and row letter constitutes the grid zone designation. Columbus lies in zone 16 and row S, or in grid zone designation 16S (see figure below)

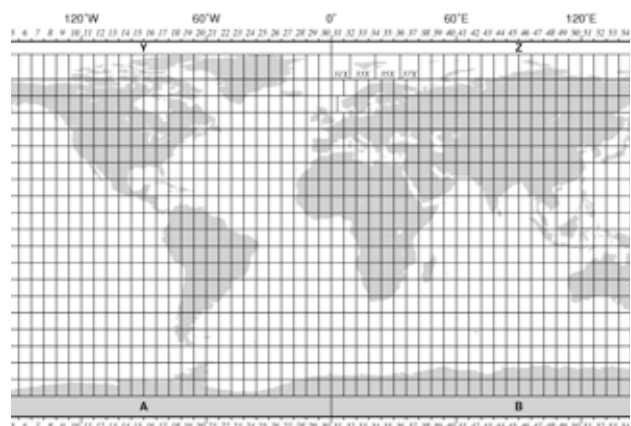


- 2) UPS Grid. The remaining letters of the alphabet, A, B, Y, and Z, are used for the UPS grids. Each polar area is divided into two zones separated by the 0-180° meridian. In the south polar area, the letter A is the grid zone designation for the area west of the 0-180° meridian, and B for the area to the east. In the north polar area, Y is the grid zone designation for the western area and Z for the eastern area (see figure below).



- b. squares that are identified by the combination of two alphabetical letters. This identification is unique within the area

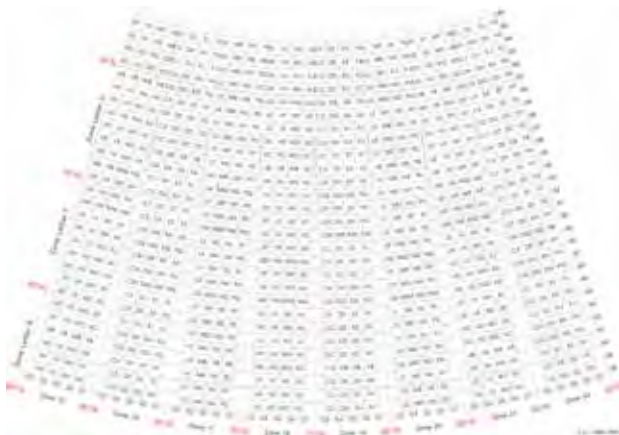
100,000-Meter Square. Between 84° N and 80° S, each 6° by 8° or 6° by 12° zone is covered by 100,000-meter covered by the grid zone designation. The first letter is the column designation; the second letter is the row designation (See figure below). The north and south polar areas are also divided into 100,000-meter squares by columns and rows. The 100,000-meter square identification letters are located in the grid reference box in the lower margin of the map.



### Grid zone designation and 100,000-meter square identification.

- c. Grid Coordinates. We have now divided the earth's surface into 6° by 8° quadrangles, and covered these with 100,000-meter squares. The military grid reference of a point consists of the numbers and letters indicating in which of these areas the point lies, plus the coordinates locating the point to the desired position within the 100,000-meter square. The next step is to tie in the coordinates of the point with the larger areas. To do this, you must understand the following.

1) Grid Lines. The regularly spaced lines that make the UTM and the UPS grid on any large-scale maps are divisions of the 100,000-meter square; the lines are spaced at 10,000- or 1,000-meter intervals (see figure below). Each of these lines is labeled at both ends of the map with its false easting or false northing value, showing its relation to the origin of the zone. Two digits of the values are printed in large type, and these same two digits appear at intervals along the grid lines on the face of the map. These are called the principal digits, and represent the 10,000 and 1,000 digits of the grid value. They are of major importance to the map reader because they are the numbers he will use most often for referencing points. The smaller digits complete the UTM grid designation.



## Grid lines

EXAMPLE: The first grid line north of the south-west corner of the Columbus map is labeled 3570000m N. This means its false northing (distance north of the equator) is 3,570,000 meters. The principal digits, 70, identify the line for referencing points in the northerly direction. The smaller digits, 35, are part of the false coordinates and are rarely used. The last three digits, 000, of the value are omitted. Therefore, the first grid line east of the south-west corner is labeled 689000m E. The principal digits, 89, identify the line for referencing points in the easterly direction (figure below).

## Columbus map, southwest corner.

(2) squares. Normally, the size of one of these grid squares on large-scale maps is 1,000 meters (1 kilometer).

Grid Squares. The north-south and east-west grid lines intersect at 90°, forming grid

## Reading 2.4.2 Some FAQs about the Global Positioning System (GPS)

These short descriptive answers to frequently asked questions about GPS were collected from the website of the US Federal Aviation Administration (<http://gps.faa.gov/FAQ/faq-gps-text.htm>), [www.map-reading.com](http://www.map-reading.com), and other sources.

### Q. What is GPS?

A. The GPS is a satellite-based, radio navigational system. It consists of a constellation with 24 active satellites that interfaces with a ground-, air-, or sea-based receiver. Each satellite transmits data that enables the GPS receiver to provide precise position and time to the user. The GPS receivers come in several configurations, hand-held, vehicular-mounted, aircraft-mounted, and watercraft-mounted.

GPS consists of three segments: space, control, and user.

The Space Segment, consists of 24 operational satellites in six 12-hour orbits 20,200 km (10,900 ml) above the earth at an inclination angle of 55 degrees. The satellites are spaced in orbit so that at any time a minimum of 4 satellites will be in view to users anywhere in the world. The satellites continuously broadcast a low power, one way position and time signal to users throughout the world. There are currently 29 satellites in orbit, or five spares, which assures the availability of 24 operational satellites.

The Control Segment consists of a master control station in Colorado Springs, Colorado, with five monitor stations and three control up-link stations located throughout the world. Monitor stations track all GPS satellites in view and collect ranging information from the satellite broadcasts. This information is then sent back to the master control station, which computes extremely precise satellite orbits. The data is then formatted into updated navigation messages for each satellite. The updated information is transmitted to each satellite via the control up-link stations, which also transmit and receive satellite control and monitoring signals.

The User Segment consists of the receivers, processors, and antennas that allow land, sea, or airborne operators to receive the GPS satellite broadcasts and compute their precise position, velocity and time.

### **Q. How many GPS satellites are there?**

**A.** The GPS system, at full Operational Capability (FOC), was designed for a minimum of 24 Satellites, 4 in each orbital plane. This produces the design probability that at least 4 satellites will be in view to users worldwide, over any 24-hour period, with a Position Dilution Of Precision (PDOP) of six or less, at least 99.9 percent of the time. The exact number of satellites operating at any one particular time varies based on the number of satellite outages and operational spares on orbit. For the current status of the GPS constellation, please visit <http://tycho.usno.navy.mil/gpscurr.html>

### **Q. How is GPS used?**

**A.** GPS receivers collect signals from satellites in view. They display the user's position, velocity, and time, as needed for their marine, terrestrial, or aeronautical applications. Some display additional data, such as distance and bearing to selected waypoints or digital charts.

The GPS concept of operation is based upon satellite ranging. Users determine their position by measuring their distance from the group of satellites in space. The satellites act as precise reference points.

Each GPS satellite transmits an accurate position and time signal. The user's receiver measures the time delay for the signal to reach the receiver, which is the direct measure of the apparent range (called a "pseudorange") to the satellite. Measurements collected simultaneously from four satellites are processed to solve for the three dimensions of position (latitude, longitude, and altitude) and time.

Position measurements are in the worldwide WGS-84 geodetic reference system, and time is with respect to a worldwide common U.S. Naval Observatory Time (USNO) reference.

For accurate three-dimensional data, the receiver must track four or more satellites. Most GPS receivers provide the user with the number of satellites that it is tracking, and whether or not the signals are good. Some receivers can be manually switched to track only three satellites if the user knows his altitude. This method provides the user with accurate data much faster than that provided by tracking four or more satellites. Each type receiver has a number of mode keys that have a variety of functions. To better understand how your specific GPS receiver operates, refer to the operators' manual.

### **Q. Who uses GPS?**

**A.** GPS is used to support land, sea, and airborne navigation, surveying, geophysical exploration, mapping and geodesy, vehicle location systems, farming, transportation systems, and a wide variety of other additional applications. Telecommunication infrastructure applications include network timing and enhanced 911 for cellular users. Global delivery of precise and common time to fixed and mobile users is one of the most important, but least appreciated functions of GPS.

### **Q. What's the status of the GPS?**

**A.** The Global Positioning System reached Full Operational Capability (FOC) July 17, 1995. Per U.S. Policy and Law, the GPS Standard Positioning Service is available to civil users worldwide for their peaceful transportation, scientific, and other uses free of direct user charges.

### **Q. How Accurate is the GPS?**

**A.** The GPS can locate the position of the user accurately to within 21 meters, 95 percent of the time. However, the GPS has been known to accurately locate the position of the user within 8 to 10 meters. It can determine the distance and direction from the user to a programmed location or the distance between two programmed locations called waypoints. It provides exact date and time for the time zone in which the user is located.

**Q. How compatible are different GPS devices and systems?**

**A.** All GPS receivers have primarily the same function, but the input and control keys vary between the different receivers. The GPS can reference and format position coordinates in any of the following systems:

Degrees, Minutes, Seconds (DMS): Latitude/longitude-based system with position expressed in degrees, minutes, and seconds.

Degrees, Minutes (DM): Latitude/longitude-based system with position expressed in degrees and minutes.

Universal Traverse Mercator (UTM): Grid zone system with the northing and easting position expressed in meters.

Military Grid Reference System (MGRS): Grid zone/grid square system with coordinates of position expressed in meters.

**Q. What is the Standard Positioning Service?**

**A.** GPS provides two levels of service: A Standard Positioning Service (SPS) for general civil use and an U.S. allies. The SPS is the standard specified level of positioning and timing accuracy that is available, without restrictions, to any user on a continuous worldwide basis.

SPS provides accuracies (for position, the accuracy with respect to geographic or geodetic coordinates of the Earth) within:

100 meters (2 drms) horizontal, 156 meters (2 Sigma) vertical, 300 meters (99.99% prob.) horizontal, 340 nanoseconds time (95% prob.).

SPS Coverage is continuous and worldwide, with a position dilution of precision (PDOP) of 6 or less.

These accuracy's reflect the last signal specification in the Federal Radio navigation Plan, the signal specification is in the process of being revised to reflect the accuracy obtained with Selective Availability (SA) turned off.

**Q. What is Selective Availability (SA)?**

**A.** SA was a technique to reduce the accuracy of unaugmented, single-receiver GPS measurements. This was accomplished by altering (or "dithering") the GPS satellite clock signals, and by modifying orbital elements of the broadcast navigation message. These alterations were done in a coded fashion, and could be removed by authorized

users. This alteration caused horizontal positional errors on the order of 100 meters (95%), and varied in a manner that prevented rapid averaging of positional data.

**Q. Why was SA Necessary?**

**A.** SA was used to protect the security interests of the U.S. and its allies by globally denying the full accuracy of the civil system to potential adversaries.

**Q. What is the status of Selective Availability (SA)?**

**A.** By order of the President of the United States, the use of Selective Availability was discontinued on May 1, 2000.

**Q. Will SA ever be turned back on?**

**A.** It is not the intent of the U.S. to ever use SA again. To ensure that potential adversaries do not use GPS, the military is dedicated to the development and deployment of regional denial capabilities in lieu of global degradation through SA.

### Reading 2.4.3. Locating A Point Using The US Army Military Grid Reference System (MGRS)

This reference is from the Survival IQ Handbook, see [www.survivaliq.com](http://www.survivaliq.com) for more information on this topic.

There is only one rule to remember when reading or reporting grid coordinates—always read to the RIGHT and then UP. The first half of the reported set of coordinate digits represents the left-to-right (easting) grid label, and the second half represents the label as read from the bottom to top (northing). The grid coordinates may represent the location to the nearest 10-, 100-, or 1,000-meter increment.

- a. Grid Zone. The number 16 (example below) locates a point within zone 16, which is an area 6° wide and extends between 80° S latitude and 84° N latitude.
- b. Grid Zone Designation. The number and letter combination, 16S, further locates a point within the grid zone designation 16S, which is a quadrangle 6° wide by 8° high. There are 19 of these quads in zone 16. Quad X, which is located between 72° N and 84° N latitude, is 12° high.

- c. 100,000-Meter Square Identification. The addition of two more letters locates a point within the 100,000-meter grid square. Thus 16SGL (Figure 2.4.3.A) locates the point within the 100,000-meter square GL in the grid zone designation 16S. For information on the lettering system of 100,000-meter squares, see TM 5-241-1.
- d. 10,000-Meter Square. The breakdown of the US Army military grid reference system continues as each side of the 100,000-meter square is divided into 10 equal parts. This division produces lines that are 10,000 meters apart. Thus the coordinates 16SGL08 would locate a point as shown in Figure 2.4.3.A. The 10,000-meter grid lines appear as index (heavier) grid lines on maps at 1:100,000 and larger.



**Figure 2.4.3.A. The 10,000-meter grid square.**

- e. 1,000-Meter Square. To obtain 1,000-meter squares, each side of the 10,000-meter square is divided into 10 equal parts. This division appears on large-scale maps as the actual grid lines; they are 1,000 meters apart. On the Columbus map, using coordinates 16SGL0182, the easting 01 and the northing 82 gives the location of the southwest corner of grid square 0182 or to the nearest 1,000 meters of a point on the map (Figure 2.4.3.B).



**Figure 2.4.3.B. The 1,000-meter grid square.**

- f. 100-Meter Identification. To locate to the nearest 100 meters, the grid coordinate scale can be used to divide the 1,000-meter grid squares into 10 equal parts (Figure 2.4.3.C.)



**Figure 2.4.3.C The 100-meter and 10-meter grid squares.**

- g. 10-Meter Identification. The grid coordinate scale has divisions every 50 meters on the 1:50,000 scale and every 20 meters on the 1:25,000 scale. These can be used to estimate to the nearest 10 meters and give the location of one point on the earth's surface to the nearest 10 meters.

# Environmental Management



### Environmental Health

#### Establishing a Base Camp Introduction

Environmental Health (EH) practice is encompassed within the broader area of public health and is involved in the assessment, correction, control, and prevention of environmental factors adversely affecting human health.

The primary environmental health preference is to establish a base camp within an existing building with functioning essential services, including water, sanitation & electricity. However, security considerations and approval from local authorities will generally determine the eventual site of the base camp.

The following assumptions have been made in establishing an appropriate AusMAT base camp.

1. The deployment team consists of 30 people.
2. Assistance is to be provided for 3 months with teams deployed on monthly rotations.
3. The local authority has provided an area of open space for the base camp with no infrastructure.
4. Security is required but it is not in a war zone.

#### Specific EH Considerations

##### Location:

An adequate area of at least 1500m<sup>2</sup> (approximately 45-50m<sup>2</sup> per person) is required for the deployment team, which includes the area necessary for roads, footpaths, kitchen, dining, recreation room, water storage and sanitary facilities.

Topography and drainage are also important. The camp should not be located in a flood zone or on flat terrain, but preferably on higher ground with a very gentle slope. Soil type is also important when determining the design of the onsite wastewater treatment system which is generally located downhill and downwind of the main camp.

Access to relief supplies and an appropriate water source and its safe transportation to the base camp are also critical factors in determining the viability of the site.

Camp design will be important to ensure services are nearby, yet buffer zones are in place to separate living from dining and recreational areas, as well as ablution facilities.

Areas of high mosquito activity are large seasonally flooded areas

associated with rivers or drainage lines, flooded coastal swamps, coastal salt marsh, extensive reed swamps and lagoons, ill defined or poorly draining creeks, extensive irrigation areas, and wastewater disposal facilities. Densely shaded areas near these habitats should be avoided during the day, and accommodation areas should be at least 3 km from extensive areas of these habitats.

Extensive areas of mangroves with small dendritic creeks or estuarine areas with muddy banks are potential sources of mangrove biting midges. These midges have seasonal and monthly population peaks with the monthly peaks usually associated with the tidal regime. When camping or choosing a permanent living site, a separation distance of at least 2 km from these areas is recommended.

In residential areas, a local source of mosquitoes may be the cause of the problem. Check nearby potential artificial sources of mosquitoes such as disused tyres, drums, fallen palm fronds, pot plant drip trays, plant striking buckets, animal water storage receptacles, stored building materials, plastic sheeting, blocked roof-gutters, old fishponds, localised ponding of drains, or unsealed septic tanks. Sites with mosquitoes breeding can be rectified by physically removing the source, modifying the source to prevent the ingress and egress of mosquitoes, draining the collected water, or through the use of insecticides.

#### Other factors

Further factors to be considered in designing the layout of the camp, include:

- Security considerations
- Front of camp should face the prevailing wind
- Base Camp will need to have an evacuation plan with assembly points and location of site should take into consideration nature of the disaster (possibility of tidal surge, after shocks, falling buildings etc)
- The location should be free of potentially hazardous materials
- Surrounding land use (pests, mosquitoes, vapours, odours) etc
- Lighting, signage and clear paths of travel
- Separation of work area from camp
- A recreational area for time out and socialising.
- Privacy screening
- Management and supervision of local contractors
- Compliance with any local laws or agreements.

### Water quality:

In the aftermath of a natural disaster, local water supplies should be assumed to be contaminated. Drinking water should be boiled or treated with commercial bleach or iodine before use. Groundwater from a bore or spring will generally have a lower bacterial load than water from an open well, which in turn will have a lower bacteria load than water sourced from a river.

The physical and microbiological quality of the water can be improved through treatment but the chemical quality of the water is much more problematic to treat

Treatment for bacteria is relatively simple through the use of chlorine which is commonly available as household bleach.

Simple testing for bacteria can be carried out using either:

- Membrane filtration
- H2S dip strips
- Colilert tubes and fluorescent light incubator
- Dipslides.

Note: membrane filtration, colilert tubes and dipslides all require power for an incubator

Membrane filtration and to a lesser extent UV Light are also effective treatments for the removal of pathogens however they do not have the residual effect of chlorine.

Testing for turbidity and pH will determine if any pre-treatment of the water is necessary prior to the addition of chlorine which will kill most bacteria, viruses and parasites.

The bacterial load of the water can be determined by simple presence/ absence test for E. coli, which is as an indicator of the level of human and animal waste contamination and potential presence of other harmful pathogens. Drinking water should have no E. coli present.

It is important to ensure that there is a residual amount of chlorine of at least 1mg/L in the system, which will affect taste, although chlorine dissipates readily when decanted. A chlorine residual is required at the outlet tap to protect the water as it is decanted into smaller containers. Initial water should therefore be dosed to 5mg/L and then maintained at 1mg/L. To achieve 5mg/L in 1000 litres of water; add either:

- 125ml or 125g of 4% available chlorine (household bleach);
- 40ml or 40g of 12.5% available liquid swimming pool chlorine;
- 8ml or 8g of 65% granular swimming pool chlorine.

The physical quality of the water can reduce the efficiency of the chlorine treatment and also effect taste. Turbidity is particularly common in surface water such as rivers and makes water difficult to effectively chlorinate. It is best to test the water for turbidity and if the results indicate turbidity above 5 NTU, then Aluminium Sulphate powder or granules (Alum) can be used to treat the water prior to disinfection. Dosing water, at a preferred pH of 6.5-7.5 with Alum in the range of 25-150mg/litre will be sufficient to flocculate the suspended solids into large fluffy lumps which can be manually removed after two hours of contact time. The addition of Alum decreases the pH and the addition of lime will increase and keep the pH within the optimum range.

The chemical quality of water supply is generally less variable with longer term health risk of poor quality supply, rather than short term consequences.

Residual chlorine testing should be undertaken daily, microbiological testing, pH and turbidity should be undertaken several times a week at the water source and storage tanks and chemical quality testing should be undertaken at the camp's commencement.

### Water quantity:

Over a one month deployment, an appropriate quantity of water is required per person for drinking, cooking, oral hygiene, laundry and ablutions. Wherever possible, a combined water supply is preferred, although where water supply is limited, a smaller quantity of high quality drinking water can be used for drinking and cooking and a larger quantity treated to a lesser extent, if at all, for washing of people and clothing.

Sphere Water Supply Standard 1 recommends a minimum of 15 litres per person, per day with 3 litres of this for drinking and cooking. The Australian Army allow around 140L/ person/day (L/P/D) for a base camp.

Given the expectation that the deployment team will generally not be acclimatised and will be working long hours, with a high frequency of washing and laundering, it is recommended that at least 50 L/P/D be provided in the short term (less than a week) and that this quantity be doubled to 100L/P/D over the longer term, with 25% contingency.

The Book 'Engineering in Emergencies' (P201) suggests 5 Litres for an outpatient and 40 to 60 L/P/D for inpatient of Health Centre or Hospital



### Water storage:

There should be sufficient water storage capacity to handle peak loads.

The locations of water storage structures, drainage from outlet points, and drain end points need to be carefully considered in order to avoid drainage problems within the camp.

Containers for treated water should:

- be clean
- have covers
- be constructed and secured to prevent contamination of the supply.
- be above ground and elevated to ensure that any reticulated system has sufficient water pressure to adequately required service, such as ablutions.
- Be preferably located in a cool or sheltered position
- Be animal and mosquito proof.

A bulk water container of the order of 10,000 litres will required to meet the water use requirement of the deployed team for a period of at least two days.

The provision of hot water should also be considered if deployment is anticipated to occur in countries with temperate climates.

### Latrines

Chemical latrines, such as 'portaloos' should be considered if available, while the camp is being set up or for a short deployment. These toilets are self-contained, in that they have a holding tank with chemical additives to aid in decomposition of the waste and for odour control.

Pit latrines, such as the ventilated improved pit latrine (VIP), are recommended for long term deployment. The VIP is recommended as it has features that minimise the impact of flies and odours (see figure 10.8). The bottom of the pit should be at least 1.5 metres above the water table to prevent contamination of groundwater.

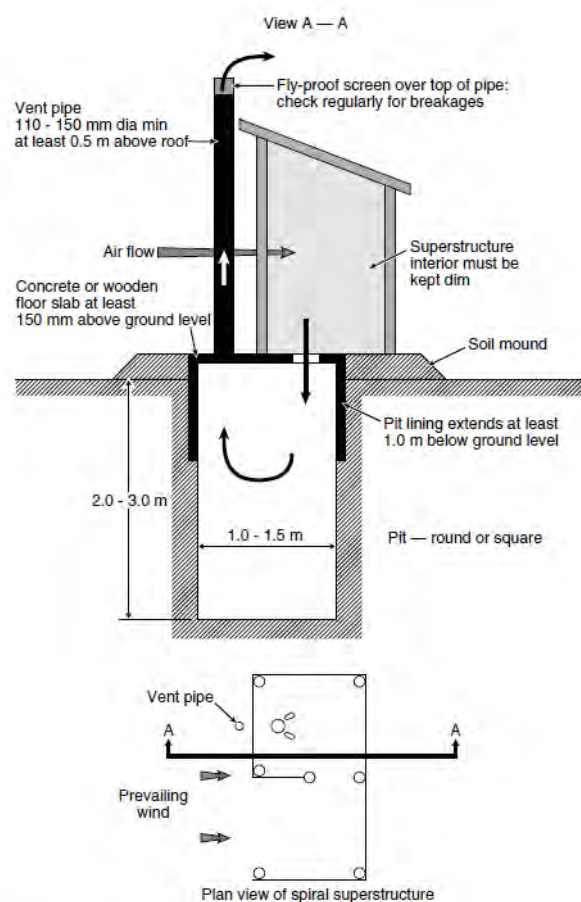


Figure 10.8 A ventilated improved pit (VIP) latrine

John Davis & Robert Lambert. Ch 10, Pgs. 174, 176 & 178, Figs 10.8, 10.9, 10.10 and 10.14. "Engineering in Emergencies. A practical guide for relief workers" Second Edition

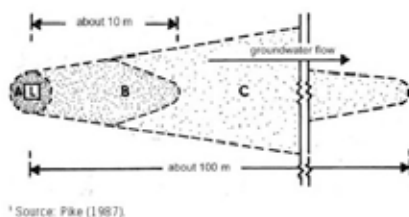
It is also important not to locate ablutions close to any water source such as a well (see figure 8.7) in order to avoid any potential for contamination and. ablutions (latrines and showers) should always be located downstream of the water source.



Figure 8.7 Dispersal of pollution from its source

Key:

- A. Pollution cone, spreading out about 1 metre all round, goes vertically downwards until the ground-water level is reached.
- B. If the groundwater surface is less than about 3 metres deep, the pollution then spreads cone-wise, flowing with the groundwater. The groundwater can be diverted from its natural course if the area is within the circle of influence of pumping from a well. The bacterial content of the pollution spreads sideways and downwards, and becomes absorbed by the soil until, at about 10 metres from the source, it has virtually disappeared.
- C. The cone of chemical pollution continues to spread until about 25 metre from the source, and then gradually reduces to almost nothing at a distance of about 100 metres.
- L. Source of pollution at pit latrine, septic tank, or soakaway.



\* Source: Pike (1987).

Wisner, Benjamin, and John Adams. Chp 8, Pg. 139, Fig 8.7." *Environmental Health in Emergencies and Disasters: a Practical Guide.* Geneva: World Health Organization, 2002. Print

A deployed team of 30 people should have a minimum of 4 latrines (2 male and 2 female) to cater for peak loads, potential frequency of use due to any illness in team members (e.g. diarrhoea) and to reduce the need to dig additional pits during a 3 month deployment.

### Showers and Handwash Basins

Each latrine should be provided with a handwash basin (HWB), soap and paper towels and a reminder poster or sticker for team members to wash their hands. Where water is scarce, antibacterial hand gel dispensers should be provided. An additional HWB should be provided near showers for shaving, brushing teeth and to reduce the demand on the showers. One shower should be provided per 20 people (minimum of 2) and each shower should have facilities for the storage of clothing, towels plus soap holder.

Washing of clothing could be contracted out to locals in some locations, thereby reducing the need for infrastructure and water as well as creating an income for the local community. If clothes washing is to be undertaken onsite, then at least one washing machine, a laundry trough and a sorting bench would provide for an appropriate laundry facility in the short term.

Washing Machines may also be useful in managing laundry generated from temporary field hospital

Drainage is an important consideration for the proposed camp. Channels should be designed to carry stormwater away from the camp and that it does not affect surface or groundwater sources. Washing facilities for people and clothing should be located downhill from the main camp.

Figures 10.9 and 10.10 provide two different types of soakage trenches that can be used dependent on the load. The length of the soakage trench is dependent on amount of wastewater generated and soil type. The base of the soakage trench should be flat with no fall despite preference for a gentle slope away from the camp at ground level.

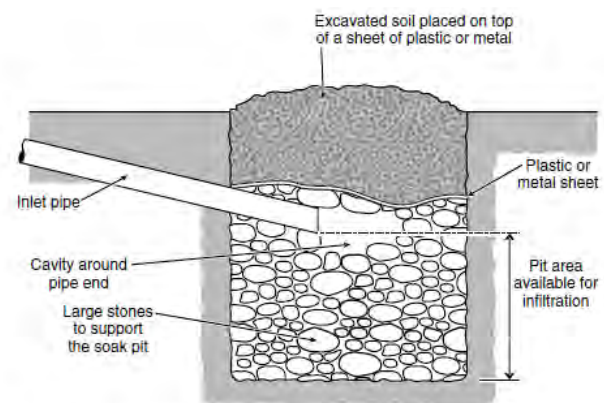


Figure 10.9 A covered soakaway

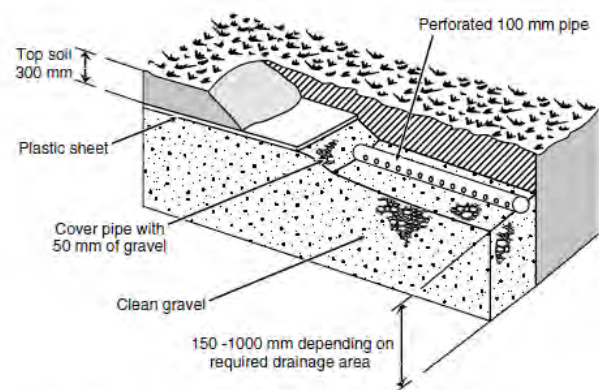


Figure 10.10 An infiltration trench  
Source: Reed, 1994

### Solid Waste

An adequate number of rubbish bins strategically located throughout the camp and regularly maintained will reduce odours and the need for pest control. It is preferable for all domestic waste to be disposed off site as part of the community waste management service. If this is not possible then Figure 10.14 illustrates a method of on site waste disposal.

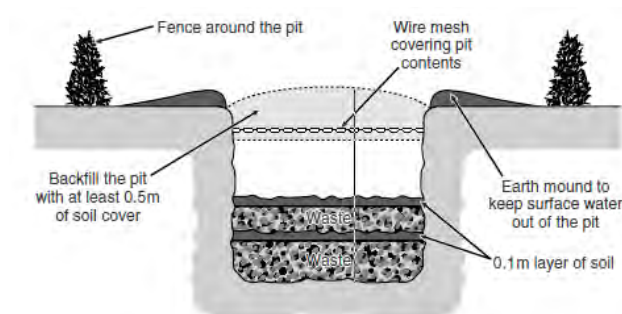


Figure 10.14 Solid waste burial pit

Medical waste needs to be collected in appropriately identifiable bags and disposed of separately from domestic waste.

Separation of the waste stream should be encouraged. In many communities a market exists for cans, glass, plastic and cardboard and separation of the base camp waste stream will reduce the need for disposal to land fill and provide an economic opportunity for the local community. Burning of combustible waste should be encouraged as an alternative to on-site disposal but the prevailing wind direction will need to be considered to avoid its impact on people downwind.

### Food Preparation

Depending on the security risk, the employment of an experienced local camp cook to prepare all meals is recommended; alternatively a camp cook could be included in the deployment team. From a public health perspective, it is preferable to have one person cook rather than each team member cooking their own food, as it is less resource intensive, much easier to maintain good food handler practices, and encourages the storage of food and cooking utensils in one location.

Special consideration should be given to the construction and fit out of the kitchen. Items that need to be considered include:

- Pest and dust control (Tarp on a dirt/grass floor and minimum of shade cloth walls and ceiling, control strategies for cockroaches, rodents and ants)
- Suitable food preparation area (easily cleaned and non absorbent material)
- Food temperature control (Above 60° for hot food or below 5°C for cold food)
- Sanitiser, thermometer and access to how water
- Separate sink or receptacle for the washing of vegetables and equipment
- Hand wash basin
- Adequate dry goods storage area that protects food from pests such as cockroaches, ants, and rodents.
- Knowledge and experience of the cook, particularly in relation to temperature control and safe food handling practices

### Pest Control

#### Rodent control:

Small modern plastic rodent traps that are easy to use and minimise the risk of getting fingers jammed in the mechanism are readily available in Australia and are preferable to poison baits that once consumed by mice and rats may disperse to areas outside the response team's compound before dying. The corpses of these animals may contain enough bait to poison dogs or other animals that might consume them.

#### Fly control:

While there are a number of baits that can be used to attract and kill flies, the most important component of fly control is to limit fly access to wet waste. Wet waste should be double bagged. Bins should always be lidded. "Binkill" pest strips, which contain a slow release dichlorvos insecticide that kills both adult flies and maggots, should also be used and attached in a lidded bin.

### Biting insect self protection and control

- Personal repellent containing 20% or more of either DEET or Picaridin are recommended for all personnel.
- Both picaridin and DEET based products should be included since some people may have skin sensitivity to one of these products. Creams and gels are more effective than sprays and alcohol based lotions.
- Mosquito nets: Insecticide impregnated mosquito nets or insecticide impregnated mozzie domes should be included in the kit. These will not be available locally. Mosquito nets can be insecticide treated with permethrin (Perigen Defence ) to significantly increase their effectiveness. Insecticide impregnated clothing: Australian Defence Force personnel on deployment in areas where insect borne disease is prevalent impregnate outer clothing layers with permethrin insecticide. Commercially available insecticide impregnated clothing (Bisley brand) is currently available through work wear outlets around Australia.
- Mosquito lanterns: Candle operated or gas operated repellent (d-allethrin) dispensing devices that run for 4 hours (Mortein, Raid, Hovex and Thermocell) can be used in outdoor situations such as recreation and mess areas to repel mosquitoes, midges and sandflies.
- Mosquito zappers: Plug-in repellent (d-allethrin) dispensing devices that run for 10 hours can be used inside buildings or tents to repel and kill mosquitoes, midges and sandflies but require access to power.
- Barrier spray applications of residual synthetic pyrethroid insecticides such as bifenthrin, lambda-cyhalothrin and alpha-cypermethrin of around houses or buildings and can provide excellent mosquito protection for up to 6 weeks. These residual insecticides are available as water-

based formulations and can be applied (according to label recommendations) with the aid of a garden pressure sprayer or by back pack mechanical misters onto outside walls, fences, solid surfaces and low thick vegetation and shrub areas around houses in a band 1.5 to 2 m high.

- Residual synthetic pyrethroid insecticides such as bifenthrin, lambda-cyhalothrin and alpha-cypermethrin can also be applied to the inside and outside surfaces of tents and buildings to kill resting or harbouring biting insects before they bite humans.
- Insecticide fogging (thermal or ultra low volume) for the control of biting insects will only provide very short term control (up to 30 minutes) of insects that are flying at the time of application. Airborne insecticide fog is quickly dispersed and no residual control is provided. Barrier spray treatments and residual surface treatments using synthetic pyrethroid insecticides are preferable to time intensive, twice-daily insecticide fogging operations.

### Conclusion

An AusMAT team will need to be supported while they give support to others; a team member who falls sick becomes part of the problem rather than part of the solution. To maintain morale, health and productivity, the AusMAT team will need the best designed and operated base camp possible.

The above comments are a general overview of some of the more important public health issues that need to be considered. There are a variety of solutions with the most appropriate one being dependent on physical conditions encountered at the proposed base camp and the level of security required to perform the team's assignment.



# Equipment for Deployment



# Team Uniforms / Equipment

## CHECKLIST OF ESSENTIAL ITEMS FOR DEPLOYMENT- TEAM MEMBER

Waterproof Barrel Bag Large Red	
Camel Back Mule	
Sleeping Bag Compact Dictated by area climate	
Sleeping Bag Liner	Polo Shirt Green x 2
Mattress Thermarest	Shirts L/S Blue x 3
Pillow Self Inflating	Pants Beige x 3
Towel Tek	Pants Cargo Blue x 1
Thermarest Stuff Sack additions)	(+/- cool climate uniform
Water Proof LED Torch (AA)	
10 ltr Water Container Collapsible	Wide Brimmed Hat x 1
Plate Metal	
Mug Stainless Steel	
Canteen Cup Military	<b>PPE Pack</b>
Poncho / Raincoat	Safety Glasses Clear x 1
Toilet Paper x 1	Safety Glasses Tinted x 1
	Dust Masks P2 x 2
LED Headlight (AAA) Petzal E93PS	Ear Plugs x 4
Water Purification Tablets Pk x 1	Riggers Gloves Pr x 2 (Medium)
Knife Fork Spoon Set	Glow Sticks x 2
Peg less Clothes Line	Sun Block x 2
Plastic Bag Lge x 1	Insect Repellent x 2 Bushmans
Plastic Bag Sml x 2	Heat Powder
Money/Document Belt	Lip Balm
Note Book Small	AA Batteries x 2
Pen x 2 flammable	Waterless Hand Cleaner non
Permanent Marker x 1	Liquid Detergent
Eye Mask	Electrolyte Satchels x 6
Emergency Ration Pack	
Mosquito Net Hanging WHO Std chemical impregnated	
Mosquito Dome XLarge to accommodate stretcher bed	
Plastic Tarp 6x4	
Medicine Pack, Qty- Anti-Malarial –as per requirements	

### Personal Emergency Care Kit

2x 10cm Bandages	6 x Band-aids
1x giving set and tourniquet	2x Cannula 18G & 20G
2 pkt Gauze Dressings	2 x Opsite Dressings
1x 10 ml Syringe	2 x 10ml NaCl
2x Fixomull Dressings	4x Alcohol swabs
Mosquito Head Net	
Malaria prophylaxis and regular meds as required	

## PERSONAL ITEMS

- Sufficient amount of cash for a number of days deployed. Card facilities may or may not be available and credit cards may not work.
- Personal hygiene products: sunscreen, shampoo, shaving kit, deodorant, toothbrush, toothpaste, floss, foot powder, Kleenex, lip balm, wet wipes (this may be your bath), feminine hygiene products, talc powder. Mirror.
- Extra eyeglasses, prescription and over the counter medications for the duration of the mission plus 7 days afterwards (in original prescription bottles), allergy medication, eye drops, aspirin, etc.
- Pair of boots - appropriate foot wear, as nails, debris, mud, and water will be present. Inexpensive flip flops for shower shoes, plenty of dry socks and undergarments.
- Sunglasses
- Snacks and light food
- Two changes of personal clothing appropriate for weather conditions (heat and humidity) or location of work. It may be necessary to hand wash some of your clothing.
- Watch
- Copy of professional license, drivers license, professional identification



### Team Member Bag

- Must be large enough to carry all items of personal gear listed in previous table.
- Should have wheels for easy move, and carry options. Must be strong enough for difficult long haul with a tear and water resistant exterior. A uniform colour assists in identification.
- Bags will be replaced by large backpacks in austere destinations requiring access by foot.

### Team Uniforms - Tropical / heat deployment



#### Uniform Shirts,

- Light weight for tropical environments
- Long or short sleeve option – numerous pockets. Open weave vents at the back
- Easy wash, stain resistant and quick dry.
- Australia written on reverse with role specification below and AusMAT above the front pocket



#### Uniform Pants

- Light weight – neutral colour
- Pockets in legs
- Zip off option at the knee
- Easy wash, stain resistant and quick dry



#### Casual Uniform Shirts,

- Polo style, light weave. Australia on reverse



#### Medium Weight pants for travel or cooler climates

- With / without reflective markings dependent on role. Padded knees. Cotton fabric, Navy blue to accommodate alternate shirt colours.



#### Camel Bak

- Team Travel Bag, small backpack for essential items for Grab bag or team travel bag can accommodate change of clothes, ration pack, water and personal papers.



#### **Polar Fleece**

- Light weight polar fleece for cooler evenings – in uniform colour.

#### **Outer Shell**

Weather proof outer shells with appropriate markings will be available for cooler climate deployments.

#### **Uniforms**

In general, 4 sets of uniform will be provided per person. This will be dependant on destination and climatic conditions:

##### **Hot climates:**

- 3 tropical uniforms
- 1 Cool climate uniform

##### **Cold climates:**

- 3 cool climate uniforms
- 1 tropical uniform

#### **Personal Team Equipment**

Personal team equipment is a combination of essential items and comfort items all of which when packed as a guide should not exceed what you can carry and ideally should fit into one bag. In addition a small backpack to carry identification documents, money, snacks and water is necessary and can double as your grab pack.

When packing you should bear in mind that you will be required to move your own luggage, if you can't not lift or move it, you should reconsider what items are essential or just nice to have.

It is pertinent to find out before you leave what the

accommodation arrangements are, the clothes washing facilities, and the availability of meals and drinking water. Define the communication options and how you will get access to money if needed.

Essential items include equipment that will assist in keeping you safe and healthy whilst deployed. Comfort items are pieces of kit that will make your life more pleasant when away from home.

If deploying with the Australian Defence Force for extended periods, there may be opportunity to receive "care" packages from home. Arranging these prior to your departure packed with 'luxury' items to be received when 'in country' is a real morale booster. Addresses are normally provided early in a deployment once supply routes have been confirmed.

- Consider carefully the clothing that you pack for deployment. Think quick drying, and minimal wrinkles. Packing additional clothing should be kept to a minimum, allowing for a change of clothes after a shift that can be worn repeatedly. Your uniform should suffice for official functions and travel home receptions.
- Ensure that you can easily hand wash your clothing that it is light weight and quick to dry, particularly when conditions are wet or access to washing facilities or water is limited. Deployment to a cold climate creates issues of weight and may create problems with washing and drying kit. A suggestion is to invest in high quality wool undergarments allowing you to layer light clothing over the top which will dry quickly and keep weight to a minimum.
- Sarongs are particularly useful, as they allow you to travel between your tent and showers / toilet facilities in a conservative way, which may be a cultural requirement when deployed internationally. A sarong can also act as a, towel, sun shade, blackout on your mess tent, privacy screen and clothing to wear for washing days.
- The number of undergarments and socks you bring may decrease the need to wash clothes for intervals of at least five days relieving the pressure of accessing washing facilities and allowing you to feel clean when perhaps your outer garments are not. In addition women can consider using underwear liners in case of packing light for shorter deployments.
- Zip lock bags, disposable gloves and a collapsible laundry container are useful items that can help separate dirty or disposable items from the rest of your kit.
- Ensure you also pack essential tools for your work that



# Assessment

The following is an excerpt from International Federation of Red Cross and Red Crescent Societies IFRC Handbook for Delegates (1997): Needs Assessment, Targeting Beneficiaries. pp657



Image Courtesy: Terry Trewin - Katherine Floods

The Purpose of a Disaster Needs Assessment is to firstly inform the National society of the country affected of their own response priorities and plans. The second is to support the National Societies appeal for outside assistance should the disaster be of such a magnitude that the country involved can not meet its humanitarian obligation within the limit of its own resources.

A disaster needs assessment will help emergency response decision makers determine and implement appropriate emergency response measures. To plan effective response efforts, decision makers need to know:

- Whether or not an emergency exists
- The demographics of the affected population and the number of people affected
- The details of the emergency (cause, location, magnitude of disaster, etc.)
- The condition of the affected population (mortality and morbidity rates)
- The local response capacities and available resources, including organisational and logistical capabilities
- The extent and type of life saving needs and priorities
- The likelihood of additional future problems or needs

The starting point for any assessment is identification of the eventual users of the information and their particular information needs. Data, which includes perceptions, numbers and facts only become useful information when they are meaningful, relevant and understandable at particular times and places, for specific purposes.

## Emergency Response priorities

Disaster emergency response should address the immediate and priority needs resulting from disaster. Common priority emergency needs following a disaster include the following list. The disaster assessment will need to determine the existence of these needs as well as their scope.

1. Provide basic life support needs: Drinking water and sanitation, adequate food, appropriate medical assistance, shelter (through housing and clothing) and fuel (for cooking and heating).
2. Protect disaster victims from physical violence and aggression, particularly in disasters involving refugees and internally displaced persons.
3. Address the physiological and social stress caused by the disaster, providing the victims with psychological and social support.

Once the basic life support needs are met, attention can be directed to other less urgent but important needs.

## Emergency response based on emergency assessments

Organisations involved in emergency response should assess the emergency situation and choose their objectives before implementing response activities. Organisations that provide relief without first assessing the disaster impact, the resulting needs, and the local response capacities will most likely offer assistance that is unnecessary and inappropriate and which supplants local efforts. Ideally, an emergency response should consist of the following three stages: assessing the situation, choosing objectives and identifying intervention alternatives, and implementing response based on the objectives and alternatives.

Disaster assessment should be an ongoing and repetitive process. This reflects the fact that circumstances, information availability, and emergency needs change over time. When and how often different assessments are conducted will depend on the type of disaster available resources and specific information needs. Generally, information should be collected more frequently the more a situation changes and when there are critical developments, such as a secondary disaster, new population movements or an epidemic outbreak. The objectives of the assessment and the data-gathering techniques will change as the response evolves. Initial assessments can be quick and unrefined, but should improve as more time and data become available.

It is clear that effective interventions are time-critical and rely greatly on resources already present in the affected area. Most of these can be pre-planned. In the immediate aftermath of a disaster there will be insufficient item for extensive or detailed assessments and the organisation of large-scale external support. For earthquakes, in particular, search and rescue and early emergency medical care must rely substantially on local resources. Accurate and credible information telling decision makers what is not needed can help reduce the overall complexity of the logistical response.

## Assessing the situation

At the outset of any emergency, initial assessments should be timely and inform emergency responders about critical and immediate life-saving needs. In disasters - especially rapid onset disasters or sudden population influxes - there will be a great uncertainty about the actual problems. Therefore, decision makers should use a systematic assessment approach to develop a picture of where people are, what condition they are in, what they are doing, what their needs and resources are, and what services are still available to them. After an initial assessment, more in-depth emergency needs assessments need to be conducted to collect information related to critical sectors and technical areas of concern.

The minimum humanitarian standards in disaster response developed by the Sphere Project can assist organisations in prioritising information collection needs and planning an appropriate level of response. It is important that before the field assessment is conducted, the logistics of conducting the assessment and the standards that will be used are agreed upon by everyone on the assessment team. Assessment tasks should be assigned accordingly. The Sphere Project includes information on the following sectors:

- Water supply and sanitation
- Nutrition
- Food Aid
- Shelter and site planning
- Health Services

In addition to these sectors, assessment teams may want to collect information on personal and household needs; agricultural, economic and infrastructure damage; and the political and security situation.

## Choosing objectives and identifying alternatives

Initially, this stage requires analysis and interpretation of the data with a focus on identifying the risks to various populations. There should be an attempt to define alternatives for reducing immediate risks. It is important to have a detailed understanding of the general risks associated with a particular type of emergency and how these may change. Some general risks frequently present in the emergency phase are:

- Continuing presence of hazard agents - secondary flooding, fire, landslides, extreme cold, chemical pollution, etc.
- Loss of “lifeline services” - clean water, waste disposal, medical treatment
- Inadequate supply of emergency clinical services
- Inadequate supply of essential foods
- Effects of severe climatic conditions exacerbated by lack of shelter, warm clothing or heated fuel

Given adequate information, central decision makers will be able to gauge local response capacity and decide how best to use existing resources for immediate relief. In addition, they will determine their own agency’s response objectives and intervention alternatives. If the affected population is in need of food aid, an agency must decide how best to provide it. Should it purchase the food outside of the affected area and transport it in? Should they attempt to purchase food on the local market? Or, should food be provided as part of a “Food-for-Work” program?

A second important element in this stage is forecasting - an attempt to develop a set of predictions based on the relationship between needs, resources and changing conditions over time. In particular, assessors should judge whether resources can actually be made available in time to deal with particular problems before their importance fades. Forecasting is particularly critical early on, when the pattern of need is changing very quickly. For example, decisions on emergency medical care and search and rescue during earthquakes are so time-sensitive that even a few hours delay can lead to an almost total waste of resources. There will also be a need to identify major secondary threats to survivors, such as secondary flooding or landslides, damage to chemical plants or fuel storage fires, etc.

## Implementing response plans

In the early phases of a disaster, assessment activities give decision makers the information they need to set the objectives and policies for emergency assistance. In addition, assessment information helps decision-makers take account of the priorities of the affected population and decide how best to use existing resources for relief and recovery. Response planning and implementation involve allocating and scheduling resources - including people, equipment and supplies - to meet specific relief objectives and later to fulfil recovery and development goals. During this stage, assessments provide information on the progress of recovery, highlighting areas requiring further analysis and intervention.

## Disaster needs assessment reporting

While the precise assessment approach to use depends on the exact type of hazard, the following diagram illustrates the concept of conducting ongoing and repetitive assessments throughout the phases of a disaster. The diagram is followed by a more in depth discussion of the different types of assessment reporting needs.

Ongoing assessment approach for rapid - onset natural disaster						
	PRE-DISASTER	DISASTER	POST DISASTER			
	When possible	First 10 Hours	12 - 36 hours (& then, as needed)	7-15 days	30-60 days	3 Months
Assessment Type	Forecasting & early warning	Disaster (early) notification	More detailed disaster needs assessment	Ongoing monitoring of situation and needs		
Information needs	Collect and disseminate early warning information (especially for flash floods, tsunamis, storms, volcanoes, forest fires, etc)	Alert Headquarters Disaster type, date # casualties reported # properties damaged and type of damage Immediate emergency priority needs (e.g search & rescue, first aid)	Assessment team Disaster magnitude Geographical area affected Detailed assessment of needs and resources and other responders Define intervention for ensuing weeks and months (if necessary)	Continued monitoring and assesement  Ongoing situation, response and needs Changes in status and needs Need for longer-term assistance and rehabilitation (after three months) Plan of action for assistance to continue past 3 months.		

### Forecasting and early warning

For many types of natural disasters, flash floods, storms, forest fires, volcanoes, tsunamis forecasting and early warning information and communication systems need to be in place. Assessment for these systems collect and disseminate information on the potential development of the disaster, and determine the extent to which affected populations are taking measures to protect lives and facilities from expected hazard impact. Capable organisations will also want to prepare for the implementation of a post disaster response and assessment.

### Disaster early notification

In the first few hours of a disaster, decisive action is necessary. In sudden onset disasters, local officials should issue a preliminary “disaster early notification” as soon as possible after the disaster occurrence, preferably within the first 10 hours after a disaster. This early notification alerts headquarters that a disaster has occurred and approximates the magnitude and location of the disaster and immediate priorities, such as search and rescue, and on site first aid.

### Disaster needs assessment

Early notification is followed by a more complete disaster needs assessment usually within the first 12 - 36 hours after the disaster occurs. This assessment will provide additional general information about the disaster: the damage, urgent needs and priorities, and actual response measures being taken. Disaster needs assessment will need to be updated as more information becomes available and as the situation changes.

Usually within 36-72 hours after a disaster occurs, a team of sectoral specialists should conduct a rapid, yet detailed assessment of specific damages, resources, response mechanisms and precise needs within the different sectors: water and sanitation, emergency health, food and nutrition, shelter and household needs, infrastructure and communications, etc. Their job will be to forecast sectoral needs for the next 3-7 days, 7-28 days and 28-90 days. If it appears that the emergency will extend from weeks into months, then these specialists should help define specific interventions for the ensuing months.

### Monitoring

After the first three days, additional assessments should be planned as needed, e.g. 7-15 days, 30-60 days, and 3 months after the disaster occurrence. Newly evolving circumstances, local efforts and capacities and official response measures will all affect the status of the emergency situation and needs. It is important to monitor the situation and the evolving needs over time to gauge whether additional or longer-term assistance is required. The performance of the emergency response program also needs to be monitored for effectiveness, and modifications made accordingly.

## On - site visual inspection

On-site visual inspection is an excellent way to become familiar with a disaster situation. Experienced observers can gather information quickly if they know what they are looking for. Further investigation is often needed, however, as some details may be hidden from view. Combined with interviews, on-site visual inspection is a good method for an initial assessment.

### On-Site Visual Inspection Tasks

- Observe people's physical condition and activities; ask questions
- Visit homes or shelters, water sources, clinics, distribution centres
- Observe children, the elderly and the sick
- Observe the daily lives of women (use women as interviewers)
- Observe the services, vehicles, sanitation systems
- Make sketches, take photographs or use videos. Photos, video footage and even hand sketches are extremely useful in communicating to others the reality of the situation.

In addition, Interviews, Group interviews, Sampling may all be used to gather information.

### Relying on secondary source

National societies will sometimes depend on government agencies, non governmental organisations or community groups for their information. When relying on information provided by another organisation, it is important to carefully consider its accuracy and whether information from one source contradicts from another.

- Decide how accurate and useful the secondary information will be by asking the following questions:
- How was the information collected?
- What methodology was used?
- How reliable is the source of information?
- In what way might the information be biased?
- (Consider the purpose for which it was collected.)
- How recent is the information?
- Is the information based on facts or opinions?
- Always include details of secondary information sources in the assessment report

### **Key message: Always be prepared to have initial ideas contradicted and look out for the unexpected.**

Avoid confirmation bias which is the tendency for people to favour information that confirms their preceptions or hypotheses regardless of whether the information is true.

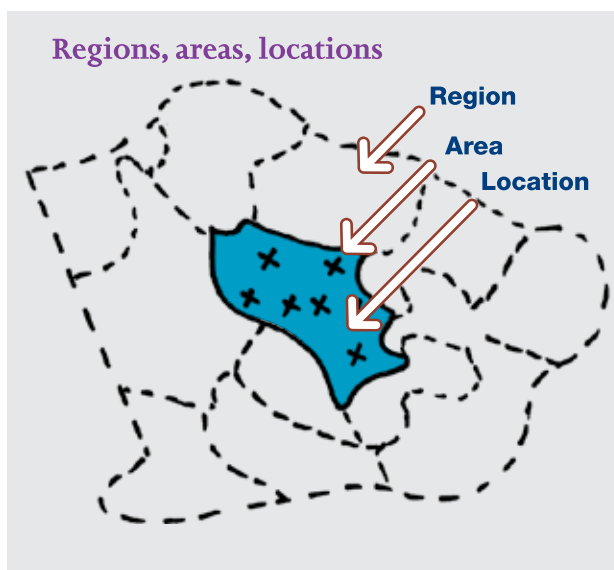
This is especially apparent in emotionally significant issues and for established beliefs. It can contribute to over confidence in personal beliefs and can maintain or strengthen beliefs in the face of contrary evidence, with disastrous results for the organisation of a national response.

## **Secondary information**

### **Detailed review of secondary information**

- One of the team leader's first tasks is to undertake a detailed review of secondary information.
- Look for: Background information about the area to be visited.
- Information directly related to the questions raised in the TOR. s
- Information about the causes and character of recent changes.
- Field assessment reports from the Red Cross Red Crescent or other agencies.
- Media reports.
- Social, economic, political and historical studies by governments, universities and research groups.
- Technical surveys from government ministries, universities, non-governmental organizations (NGOs), United Nations (UN) agencies.
- Red Cross Red Crescent vulnerability and capacity assessments (VCAs).
- Government census data.
- Meteorological data. Maps.
- Eyewitness accounts (people who have recently come from the affected area).
- Verbal communication with experts on the affected area or the relevant technical issues.

There are many other possible sources. In each situation, consider what information will be useful and where this might be found.



### Identification of areas to visit

It is rarely possible to visit the entire region affected by an emergency. Representative areas must, therefore, be selected. Statistical methods for doing this are normally unfeasible because of time and access constraints. Therefore, use the secondary information to identify areas and populations that fit the criteria below.

**Priority 1: Area and/or population directly affected.** An earthquake zone or area of military conflict, for example, or a population forcibly displaced from their homes.

**Priority 2: Area and/or population indirectly affected.** For example, areas economically affected by conflict in a neighbouring region.

**Priority 3: Area and/or population unaffected or minimally affected.** The emergency has no significant impact on lives and livelihoods (very useful for comparison with affected areas).

In a rapid assessment, it is normally only possible to visit locations and populations in the “priority 1” category described. In detailed and continual assessments, a selection of all three categories may be visited. Sometimes, during a rapid assessment, it is impossible to gain access to priority 1 areas. If this is the case, try to talk to people who have come from these areas.

Explain the reasons for your choice of areas in the assessment report. The list of areas to visit may change after the first field visits.

If, after having started fieldwork, it becomes clear that you have overlooked certain important areas, these can be added. However, if you have a set timeframe, this means that other areas will have to be removed from the list.

If the areas chosen are large, containing many villages or municipalities (“locations”), it may be necessary to undertake a second level of selection. There are two options:

- Random sampling. Do this when locations are similar. List all the locations and randomly pick the number that you intend to visit.
- Priority 2: Area and/or population indirectly affected.
- For example, areas economically affected by conflict in a neighbouring region.

Priority 3: Area and/or population unaffected or minimally affected. The emergency has no significant impact on lives and livelihoods (very useful for comparison with affected areas).

**Key message: Explain the reasons for your choice of areas in the assessment report. The list of areas to visit may change after the first field visits.**

**Purposive sampling.** If the locations differ significantly, choose a variety of locations reflecting their characteristics (ethnicity, economics, town/village, etc.).

It is generally better to visit more locations, and interview less people in each, than vice versa.

Checklists should not be treated as questionnaires. They are used as a memory aid. During interviews, refer occasionally to your checklist of questions to ensure that you cover everything. Remain open to new information that emerges from the interviews. The more experienced you become, the less you will need your checklist!

### Caution

In many emergency situations, “humanitarian hubs” develop around key towns. Organizations congregate in these locations and coverage of needs is good in the immediate vicinity. However, gaps in coverage often exist between the hubs. When deciding upon the areas and locations to visit, try to include some of these “gap” areas.

### Initial checklist

The assessment team compiles a checklist of information requirements and sources before going to the field. This is an important part of the assessment process, as it provides a focus for team discussion. Checklists are related to the specific assessment. Standard checklists are not appropriate because:

- Every emergency is different. The process of designing the check lists is crucial.
- Checklists are revised every day during the field assessment.
- Revisions are based on new information received and the team’s ongoing analysis of this information.

**Key message: Checklists are revised every day during the field assessment. Revisions are based on new information received and the team’s ongoing analysis of this information.**

Initial checklists should include the following information:

- Questions to be asked.
- Methods of collecting information.
- Informants (groups and individuals).
- Locations to be visited.
- Responsibilities of team members (which member covers which set of questions).

### Fieldwork: organization and management

#### Fieldwork principles

These principles should be followed during fieldwork:

- Consultation with affected people is always essential. Encourage the people affected by the emergency to explain the situation in their own words and in their own time. Even in rapid-onset emergencies it is always possible to include local opinion.
- Consider the particular needs of different groups and individuals (men, women, elderly, children, etc...).
- Consider the reliability of information. Information may be “fact” (definitely true), “opinion” (depends upon the perspective of the person giving the information) or “rumour” (based on unverified information).
- Consider bias. Every body is biased. Take into account the perspectives of informants and those carrying out the assessment.
- Look for marginalized groups and ensure that their interests are considered. Who is powerful and whose voice is not heard? Marginalization may be based on gender, ethnicity, social status and/or many other characteristics.
- Look for changes and trends that affect society. Try to understand what is causing these changes.
- Look out for the unexpected. Be prepared to have your assumptions challenged. Be alert and try to find out what issues are most important to the people with whom you are talking.
- Consider the impact of issues on society as a whole. For example, HIV/AIDS is not only a health issue. In many parts of the world, it has a devastating social and economic impact.

## Fieldwork: how to collect information

Information is collected through observation and semi-structured interviews. This section provides guidance on these processes.

### Observation

Observation is often under-rated as an information source. An enormous amount of information can be gathered very quickly through observation. Crucially, it gives a “feel” for the situation – sounds and smells and visual impressions. This, after all, is the point of going to the field.

It is a good idea to start the assessment with a walk around the location. During the assessment take the opportunity to observe as much as you can. If you are discussing water, ask to see the water source. If people describe a foodstuff that you do not know, ask to see (and taste!) it. You can learn a lot by spending time in communal meeting places (cafes, tea shops, etc.). Look around and talk to people.

Observation is useful for cross-checking. For example, you are told that all the livestock have been lost in the recent drought. Soon afterwards you see a large herd of goats. This does not necessarily contradict the previous information many explanations are possible but it does provide the basis for the next line of questions: “Who do these animals belong to?”, “How did they survive the drought?” and so on.

Walking through the area with local people facilitates discussion. The atmosphere is informal and questions are prompted by things that you see. This is more natural than referring to a prepared checklist. Very importantly, walking and observing are excellent ways to come upon unexpected information (issues that were not predicted).

### Health Information sources

Ministry of Health, local clinics, community health workers, humanitarian organizations (local and international), communities (women).

### Issues of interest

- Is this a real health emergency? What is its nature? How is it likely to evolve?
- Is the main problem related to health, health systems and/or access to health systems?
- What is the existing capacity to respond? Who is responsible for what?
- Are there gaps in the response? Is there a need for health intervention?
- Is there a need for specialized units (emergency response unit (ERU), surgical, etc.)?
- What further information is needed?

	Subject	Indicative Information
H1	Age breakdown (if proportions differ significantly, investigate the reasons)	Average for developing countries: 0-4 years: 12.4 per cent 5-9 years: 11.7 per cent 10-14 years: 10.5 per cent 15-19 years: 9.5 per cent 20-59 years: 48.6 per cent Pregnant: 2.4 per cent
H2	Crude mortality rate	Problem If exceeds: 1 per 10,000 per day Critical if exceeds: 2 per 10,000 per day
H3	Under 5 mortality rate	Problem If exceeds: 2 per 10,000 per day Critical if exceeds: 4 per 10,000 per day
H4	Acute respiratory infection (ARI) in children under 5	Problem If exceeds: 10 per cent per month in cold weather
H5	Diarrhoeal diseases in children under 5	Problem If exceeds: 50 per cent if affected per month
H6	Malaria in non-immune population (adults who have not grown up in malaria-affected areas and children under 5 years of age)	Problem If exceeds: 50 per cent affected per month
H7	Measles coverage	Problem If less than: 90 per cent immunisation coverage for children aged 6 months to 12 years
H8	Expanded programme on immunisation (EPI) coverage	Problem If less than: 85% coverage
H9	HIV prevalence	Data on prevalence at current time
H10	Tuberculosis (TB)	Does a national policy exist? Does a DOTS (directly observed treatment, short-course) program exist?

	Subject	Indicative Information
N1	Nutrition information	<-2 Z scores weight for height [WfH] [overall malnutrition]: normal/increasing/decreasing <-3 Z scores WfH [severe malnutrition]: normal/increasing/decreasing Iodine deficiency: prevalence of 5 – 19.9 per cent in children aged 6-12 years = mild public health problem. Vitamin A deficiency: prevalence of more than 1 per cent in children under 6 years of age = public health problem.
N2	Risk of malnutrition due to poor public health	Acute reparatory infection in children under 5: Problem if exceeds: 10 per cent per month in cold weather Diarrhoea diseases in children under 5: Problem if exceeds: 50 per cent affected per month Measles coverage: Problem if less than: 90 per cent immunisation coverage for children aged 6 months to 12 years HIV prevalence: data on prevalence at current time

**NUTRITION** Ministry of Health, nutrition surveys, demographic health surveys, local clinics, humanitarian organizations, communities (particularly women). Water and sanitation Information sources

	Subject	Indicative Information
N3	Risk of malnutrition due to inadequate care	Change in work patterns Change in composition of house-holds: large numbers of separated children or orphans Normal infants feeding, practices [bottle feeding, breast feeding, manufactured complementary foods]
N4	Risk of malnutrition due to reduced food access	See livelihoods, agricultural, market indicators
N5	Nutrition intervention or community-based support already in place prior to the disaster	Mandate, policies and experience of Movement components Local population's capacity

**SANITISATION** Ministry of Health, Ministry of Water, local water authority, local clinics, humanitarian organizations (local and international), communities, observation.

	Subject	Indicative Information
W1	Diarrhoeal disease	Normal/increasing/decreasing
W2	Acute watery and/or bloody diarrhoea	Normal/increasing/decreasing If increasing, details of age group and area. Encourage authorities to isolate cases

	Subject	Indicative Information
W3	Quantity and quality of water	At least 15 litres per person per day In extreme cases: 5 litres per person per day for drinking and cooking Details if source (is it obviously contaminated?) Is water chlorinated and/or treated?

<b>W4</b>	Water transport and storage	Means of carrying and storing (can water be contaminated?); distance and time to water point (no more than 500m walking distance); household water storage; availability at institutions
<b>W5</b>	Defecation and urination	Are there toilets or open defecation? Are there signs of defecation near dwellings?
<b>W6</b>	Women's use of communal facilities	Safe and/or culturally acceptable? Yes or no; give details
<b>W7</b>	Hand-washing and/or bathing facilities	Do facilities exist? Are they used? Is soap available? Are facilities secure and private for women and girls? 50 people per bathing facility
<b>W8</b>	Disease-carrying vectors (flies, mosquitoes, body lice, rodents)	Are such vectors present? Are there breeding grounds (stagnant water, refuse)?
<b>W9</b>	Level of destruction of water and sewage facilities	Status of facilities, equipment, materials, number of staff

**SHELTER AND HOUSEHOLD ITEMS INFORMATION SOURCES** Meteorological records, aerial surveys, local authorities, communities, observation.

	Subject	Indicative Information
<b>S1</b>	Shelter requirements	Climate factors: need to resist rain, wind, sun, cold
<b>S2</b>	Physical status of existing shelter	Description, percentage not adequate according to S1, reasons for inadequacy (earthquake damage, temporary shelter, etc.)
<b>S3</b>	People lacking shelter	Number of people/households lacking adequate shelter
<b>S4</b>	Essential household items	Proportion of population lacking essential items (defined by affected and/or vulnerable population)
<b>S5</b>	Fuel	Do people have access to fuel for cooking and heating? Where does fuel come from? Is fuel collection damaging the environment?

**SECURITY INFORMATION SOURCES** Local authorities, humanitarian organizations (local and international), community.

	Subject	Indicative Information
<b>SEC1</b>	Existing or potential security threats	For example, conflict, crime, landmines
<b>SEC2</b>	Safety of travel	Give details of security threats and locations
<b>SEC3</b>	Communications	Do telephones and radio systems exist?
<b>SEC4</b>	Supporting network	Red Cross Red Crescent, UN, NGO office locations and contact details in the area
<b>SEC5</b>	Medical facilities	Location and contact details of hospitals for emergency use
<b>SEC6</b>	Contingency plans	Describe support system in case of operational relocation

## Earthquakes

<b>General Characteristics</b>	Shaking of earth caused by waves on or below the earth's surface causing: surface faulting; aftershocks; tsunamis; tremors, vibrations; liquefaction; and landslides.
<b>Typical Adverse effects</b>	<ul style="list-style-type: none"> <li>Physical damage - Damage or loss of structures or infrastructure. Fires, dam failures, landslides, flooding may occur.</li> <li>Casualties - Often high, particularly near epicentre, in highly populated areas or where buildings are not resistant.</li> <li>Public health - Fractures injuries most widespread problem.</li> <li>Water Supply - Severe problems likely due to damage to water systems, pollution of open wells and changes in water table.</li> <li>Secondary threats - due to flooding, contaminated water supply, or breakdown in sanitary condition.</li> </ul>
<b>Typical disaster assistance needs</b>	<p>The immediate impact of an earthquake affects all sectors of a community. Local authorities should initially emphasis search and rescue assistance. Emergency medical assistance must be provided, especially during the first 72 hours. An emergency situation and needs assessment should be conducted during the first 36-72 hours. Finally the survivors will require relief assistance such as food, water and emergency shelter. Attention should be given to re-opening roads, re-establishing communications, contacting remote areas and conducting disaster assessment.</p> <p>At the end of the emergency period, long-term recovery needs to take priority. The post earthquake period presents an opportunity to minimise future risks through enactment or strengthening of land use and building codes as rebuilding takes place. The focus should be on:</p> <p>At the end of the emergency period, long-term recovery needs to take priority. The post earthquake period presents an opportunity to minimise future risks thorough enactment or strengthening of land use and building codes as rebuilding takes place. The focus should be on;</p> <ul style="list-style-type: none"> <li>Repair and reconstruction of water, sewer, electrical services and roads.</li> <li>Technical, material and financial assistance for repair and reconstruction of houses and public buildings (preferably by incorporating earthquake resistant techniques)</li> <li>Programs to rejuvenate the economy</li> <li>Financial assistance for loans to individuals and businesses for economic recovery.</li> </ul>

### Mud and debris flows

<b>General characteristics</b>	Mud and debris flows can arise as a result of heavy storms, abundant rains, beaks of mountain (usually glacial) lakes, or in hot weather as a result of intensive glacier melting. This is a process whereby considerable mud flows are carried out along the bottom of mountain valleys. Very often debris flows cut off rivers. When this occurs, a dam may form resulting in flooding upstream. A break in this dam, however, may cause flooding down the river stream.
<b>Typical adverse effects</b>	Physical damage - Everything in the path of debris flows is usually destroyed, including roads, bridges, electric lines, and constructions. Often irrigation nets are destroyed and agricultural areas are covered with silt.  Casualties - People in the path of a mud flow may perish. In addition people may be lost and injured as a result of secondary effects
<b>Typical disaster assistance needs</b>	In the direct impact area of mudslides, there may be a need for search and rescue of victims. In isolated locations there may be a need to use special equipment. Emergency shelter may be required for those whose homes have been lost or damaged. Secondary effects of mud flows, such as flooding, may require additional assistance measures.

### Landslides

<b>General characteristics</b>	Landslides vary in types of movement (falls, slides, topples, lateral spreads, flows), and may be secondary effect of heavy storms and earthquakes. Landslides are more wide spread than any other geological event.
<b>Typical adverse effects</b>	<ul style="list-style-type: none"> <li>Physical damage -Anything on top or in the path of a landslide will suffer damage. Rubble may block roads, lines of communication or waterways. Indirect effects may include loss of agriculture or forest land productivity, flooding, reduced property values.</li> <li>Casualties - Fatalities have occurred due to slope failures. Catastrophic debris flows and mudflows have killed many thousands.</li> </ul>
<b>Typical disaster assistance needs</b>	Needs for the direct impact area of a landslide include search and rescue equipment and personnel, and possibly use of earth removal equipment. Emergency shelters may be required for those whose homes have been lost or damaged. Experts trained in landslide hazard evaluation should be consulted to determine whether slide conditions pose an additional threat to rescuers or residents. If the landslide is related to an earthquake or flood, assistance to the landslide-affected area will be part of the total disaster effort.

## Volcanic eruptions

<b>General Characteristics</b>	Types of volcanoes are cindercones, shield volcanoes, composite volcanoes and lava domes. Magma flowing out to the surface is lava and all solid particles ejected are tephra. Damage results from the type of material ejected such as ash, pyroclastic flows (blasts of gas containing ash and fragments), mud, debris and lava flows.
<b>Typical Adverse effects</b>	<ul style="list-style-type: none"> <li>• Settlements, infrastructure and agriculture - complete destruction of everything in the path of pyroclastic, mud or lava flows, including vegetation, agricultural land, human settlements, structures, bridges, roads and other infrastructure. Structures may collapse under the weight of wet ash. Transportation by land, sea and air may be affected.</li> <li>• Crops and food supplies - destruction of crops in path of flows, livestock may inhale toxic gases or ash, grazing lands may be contaminated.</li> <li>• Casualties and health - Deaths from pyroclastic flows, mud flows and possible lava flows and toxic gases. Injuries from falling rock and burns, respiratory difficulties from gas and ash. Fracture injuries are the most widespread problem.</li> </ul>
<b>Typical disaster assistance needs</b>	<p>Response to a volcanic eruption must be swift and efficient. Effective warning systems must be in place. Initially, local authorities must ensure that the area is evacuated and medical care is provided to victims. Search and rescue will also be important. Feeding and shelter is normally required and may be assisted by donations or personnel from foreign sources.</p> <p>The secondary response by local authorities involves relocating victims and providing financial assistance for replacement housing, agriculture and small business. Volcano disasters occasionally require temporary shelters, but more often, large volcanoes such as Ruiz, Pinatubo and Mt St Helens, continue to erupt in a manner that threatens large populations for months to years. This may necessitate permanent resettlement of residents or long-term emergency settlements. Emphasis should also be placed on re-establishing infrastructure and communications that have been damaged or disrupted.</p> <p>Cleanup of ash is an important step in the recovery process. Volcanic ash makes excellent foundation material for roads, runways and building sites.</p>

### Tsunamis

<b>General Characteristics</b>	Tsunami waves are barely perceptible in deep water and may measure 160km between wave crests. They may consist of ten or more wave crests and can move up to 800km per hour in deep ocean water, diminishing in speed as they approach the shore. They may strike shore in crashing waves or may inundate the land. Whether or not there is severe flooding will depend on the shape of the shoreline and tides.
<b>Typical adverse effects</b>	<ul style="list-style-type: none"> <li>Physical damage - The force of water can raze everything in its path but the majority of damage to structures and infrastructure results from flooding. Withdrawal of the wave from shore scours out sediment and can collapse ports and buildings and batter boats.</li> <li>Crops and food supplies - Harvests, food stock, livestock, farm implements and fishing boats may be lost. Land may be rendered infertile due to salt water incursion.</li> <li>Casualties and public health - Deaths occur primarily by drowning and injuries from battering by debris.</li> </ul>
<b>Typical disaster assistance needs</b>	<p>Initial local responses include:</p> <ul style="list-style-type: none"> <li>Implement warning and evacuation procedures (before the event)</li> <li>Perform search and rescue in the disaster area</li> <li>Provide medical assistance</li> <li>Conduct disaster assessment and epidemiological surveillance</li> <li>Provide short term food, water and shelter</li> </ul> <p>Secondary responses include</p> <ul style="list-style-type: none"> <li>Repair and reconstruct buildings and homes</li> <li>Provide assistance to agricultural areas.</li> </ul>

## Floods

<b>General Characteristics</b>	<p>There are several types of floods:</p> <p>Flash floods - accelerated runoff, dam failure, breakup of ice jam</p> <p>River Floods - Slow buildup, usually seasonal</p> <p>Coastal Floods - Associated with storm surges, tsunami waves, tropical cyclones.</p>
<b>Typical adverse effects</b>	<ul style="list-style-type: none"> <li>Physical damage - Structures damaged by washing away, becoming inundated, collapsing, and impact of floating debris.</li> <li>Casualties and public health - Death from drowning by few serious injuries. Possible outbreaks of malaria, diarrhoea and viral infections.</li> <li>Water supplies - Possible contamination of wells and groundwater. Clean water may be unavailable.</li> <li>Crops and food supplies - Harvest and food stocks may be lost due to inundation. Animals, farm tools and seeds may be lost.</li> <li>Secondary threats due to landslides from saturated soils and debris flows. Damage greater in valleys than open areas.</li> </ul>
<b>Typical disaster assistance needs</b>	<p>The initial response to flooding by local authorities should include:</p> <ul style="list-style-type: none"> <li>Search and rescue</li> <li>Medical assistance</li> <li>Disaster assistance</li> <li>Short term food and water provision</li> <li>Water purification</li> <li>Epidemiological surveillance</li> <li>Temporary Shelter</li> </ul>

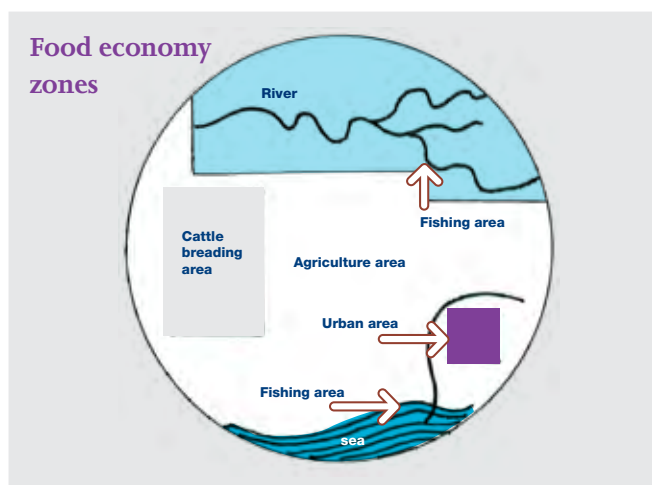
<b>Tropical Cyclones</b>	
<b>General Characteristics</b>	When the cyclone strikes land, high winds, exceptional rainfall and storm surges cause damage with secondary flooding and landslides.
<b>Typical adverse effects</b>	<ul style="list-style-type: none"> <li>Physical damage - Structures lost and damaged by wind force, flooding, storm surge and landslides. Erosion could occur from flooding and storm surge.</li> <li>Casualties and public health - Generally there are relatively few fatalities but there may be numerous casualties requiring hospital treatment. Storm surges usually cause many deaths but few injuries among the survivors. Injuries that do occur may be caused by flying debris or flooding. Contamination of water supplies may lead to viral outbreaks and malaria.</li> <li>Water supply - open wells and ground water may be contaminated by flood waters and storm surges. Normal water sources may be unavailable for several days.</li> <li>Crops and food supplies - High winds and rain can ruin standing crops, tree plantations and food stocks. Plantation crops such as bananas and coconut are extremely vulnerable.</li> <li>Communication and logistics - Severe disruption is possible as wind brings down telephone lines, antennae and satellite disks. Transport may be curtailed.</li> </ul>
<b>Typical disaster assistance needs</b>	<p>The initial response by local authorities, organisations and populations will include.</p> <ul style="list-style-type: none"> <li>Evacuation and emergency shelter</li> <li>Search and rescue</li> <li>Medical Assistance</li> <li>Provision of short term food and water</li> <li>Water purification</li> <li>Epidemiological surveillance</li> <li>Reestablishment of logistical and communications network</li> <li>Disaster assessment</li> <li>Brush and debris clearance</li> <li>Provision of seeds for planting</li> </ul>

# | Field Reports



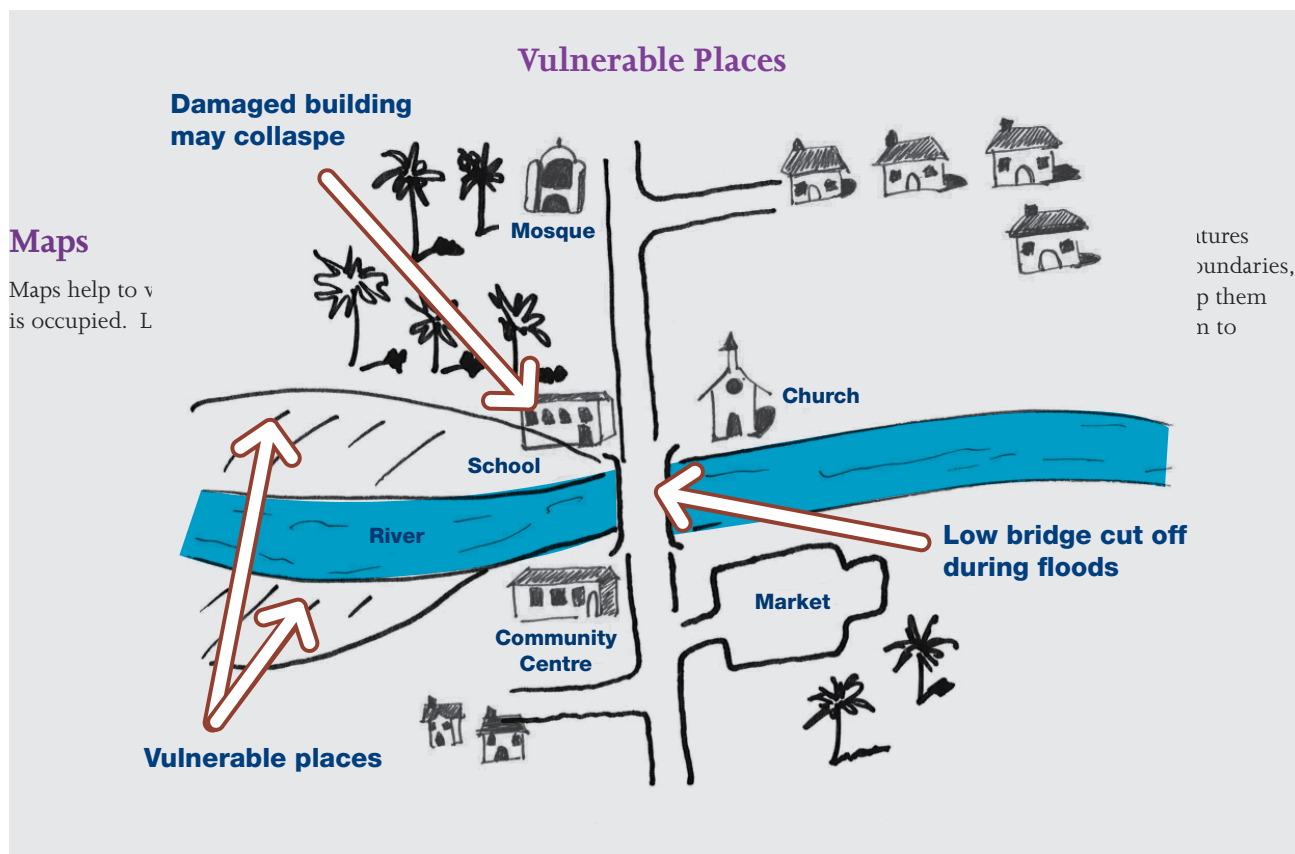
## Maps

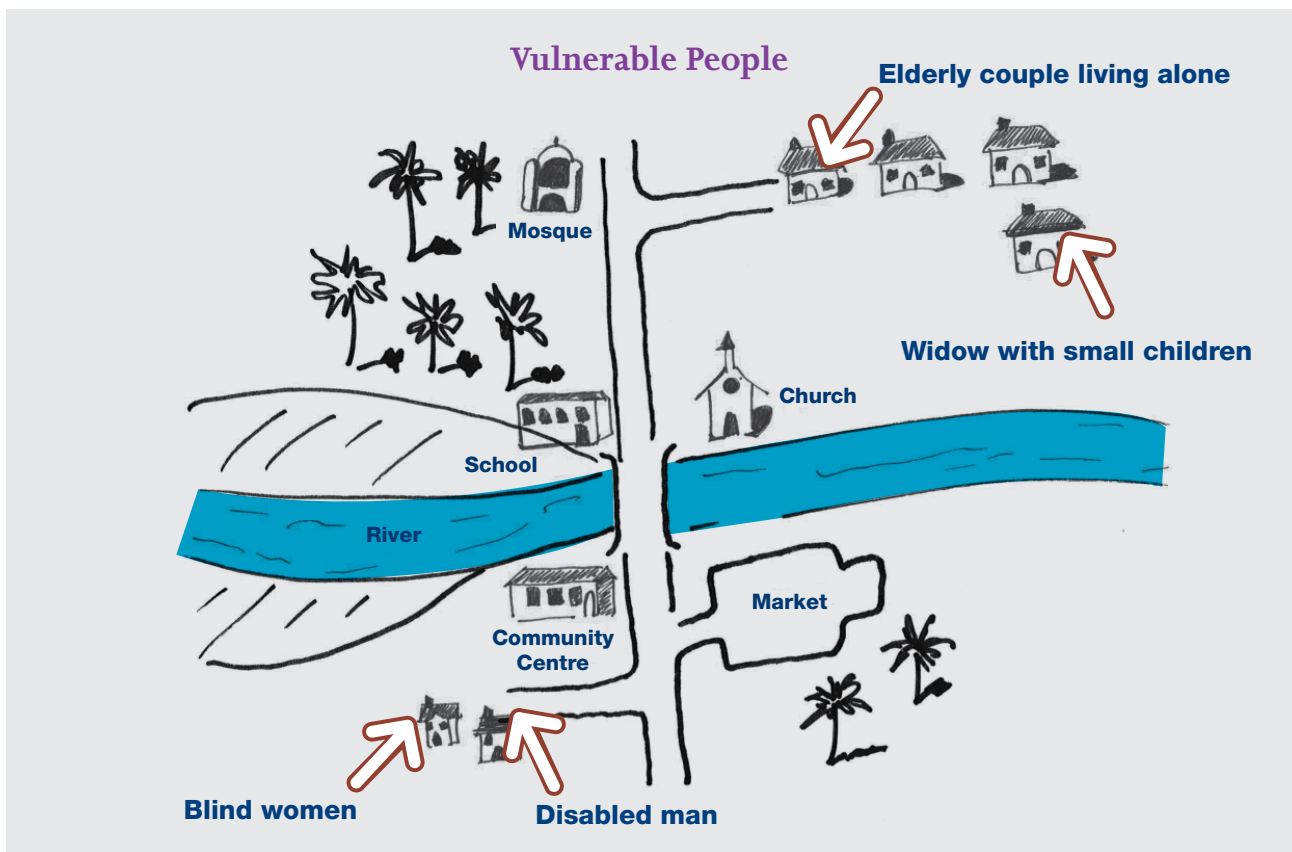
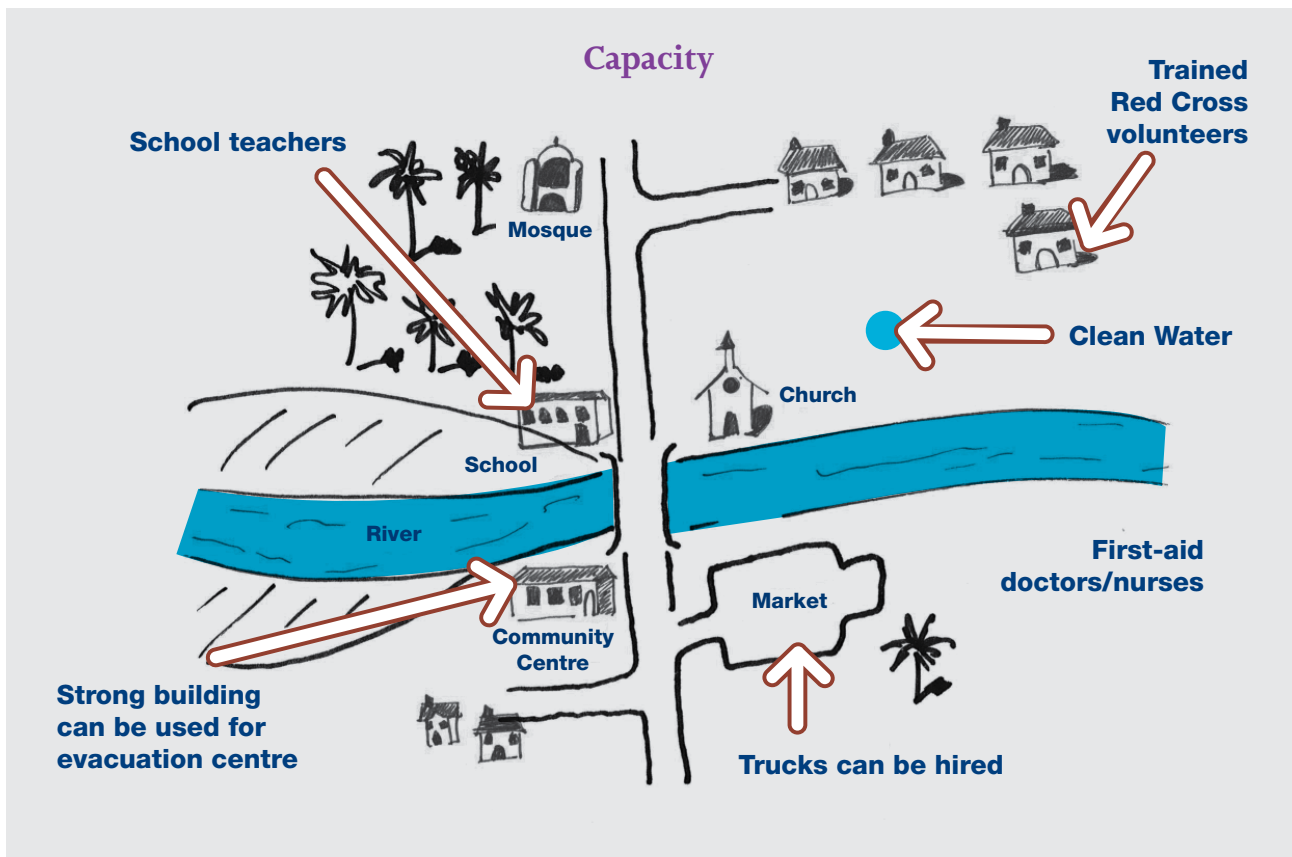
Maps help to visualize a space and how that space is occupied. Like graphs, maps are common tool in humanitarian action. They usually show physical features such as overland routes, dwellings, administrative boundaries, infrastructure, waterways and relief. It is best to keep them as simple as possible for field use and to restrict them to those elements that are necessary. A map can be produced either because a suitable one does not exist or to suit specific purposes.



## Maps

Maps help to visualize a space and how that space is occupied. Like graphs, maps are common tool in humanitarian action. They usually show physical features such as overland routes, dwellings, administrative boundaries, infrastructure, waterways and relief. It is best to keep them as simple as possible for field use and to restrict them to those elements that are necessary. A map can be produced either because a suitable one does not exist or to suit specific purposes.





## Transect walk – transect diagram



<b>Type of ground</b>	Hilly, sloppy, valley	Rocky, hilly, valley
<b>Livelihoods</b>	Irrigation, farming, settlements, health, school, hay storage, water harvesting	Settlements, farming, soil erosion control measures, water harvesting
<b>Risk/hazards</b>	Soil erosion, water contamination, mosquito breeding	Erosion, mosquito breeding, unprotected dam
<b>Conditions that increase vulnerability</b>	Sloppy ground, stagnant nature of water, deforestation, use of artificial fertilizer	Stagnant nature of water, sloppy ground
<b>Beliefs and values</b>	Church, aloe for medicine	Aloe for traditional medicine
<b>Capacities</b>	Rock, catchments, food production, water pump, water harvesting	Dam, catchments, food production
<b>Natural environment</b>	Water, Aloe and eucalyptus trees	Aloe, water

## Transect Walk

A transect walk involves walking through the community to observe the people, the surroundings and the resources. It is used to note the sites and topography of the area and to understand inter-relationships in their natural surroundings.

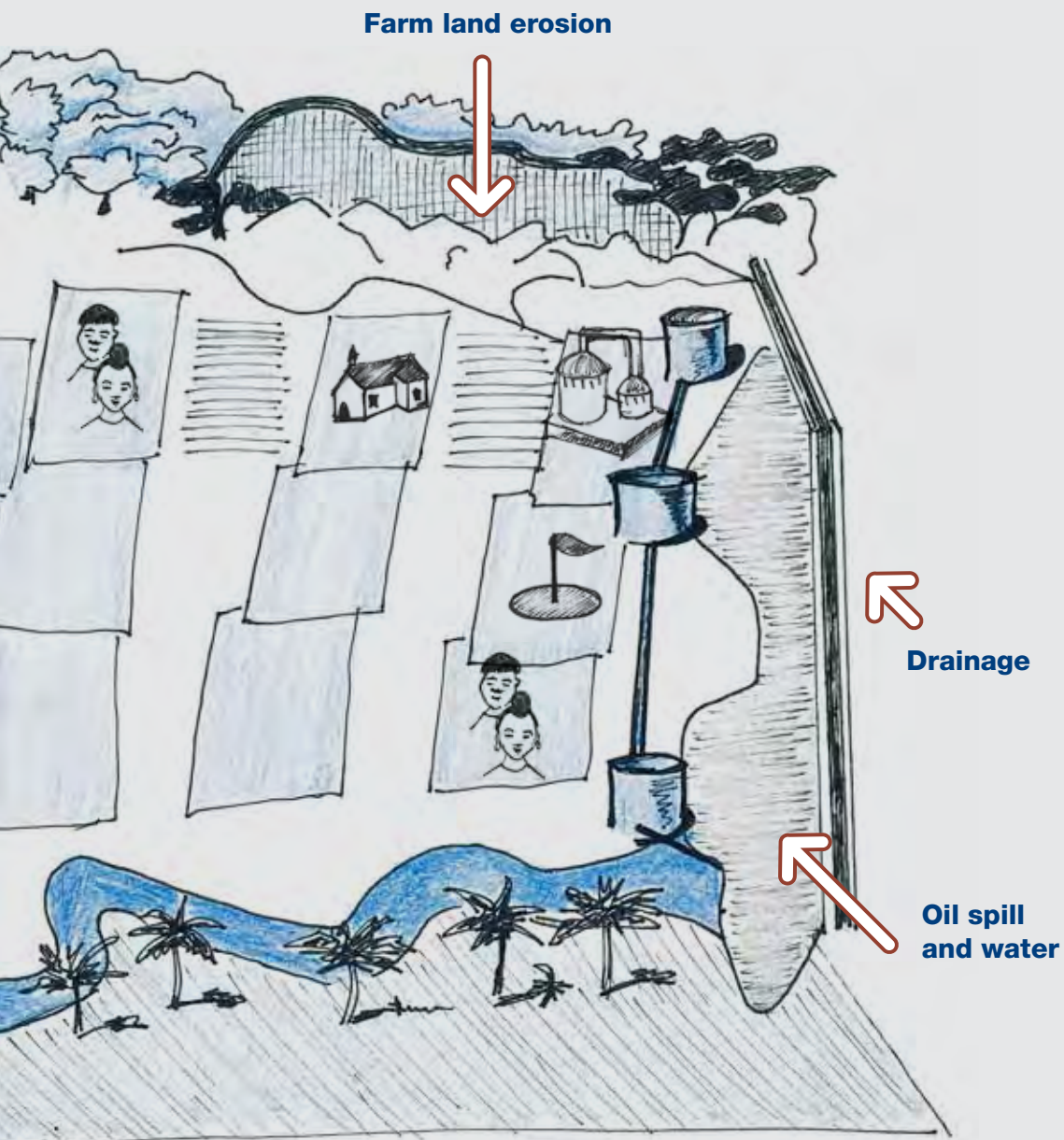
A transect walk is usually done early in the information collection process because it gives an overall view of the community. Thus it enables to observe things that may require further investigation later on during interviews.



Hilly, sloppy, valley	Hilly, sloppy, valley, flat	Hilly, sloppy, rocky, flat
Irrigation, farming, settlements, grazing, water point, water harvesting, soil and water conservation	Farming, grazing, firewood collection	Farming, grazing, soil and water conservation activities
Erosion, poor sanitation at water point, open well	Erosion, soil degradation, contamination of underground water, depletion of underground water	Soil erosion, soil degradation, contamination of underground water, depletion of underground water
Unprotected spring, deforestation, sloppy ground, use of artificial fertilizer, overuse [pressure] on water point	Deforestation, sloppy nature of the ground, overgrazing, use of artificial fertilizer	Deforestation, sloppy nature of the ground, overgrazing, use of the artificial fertilizer
Church, aloe for traditional medicine	Aloe and eucalyptus for traditional Medicine	---
Road access, rocks for construction, soil erosion control measures, food production, potential catchments	Road access, rocks for construction, soil erosion control measures, food production, potential catchments	Rocks for construction, road access, soil and water conservation measures, food production, potential catchments
Grazing area, water well, rocks	Aloe, eucalyptus trees	----

## Spatial map





**Community  
leaders**



**Oil refinery**

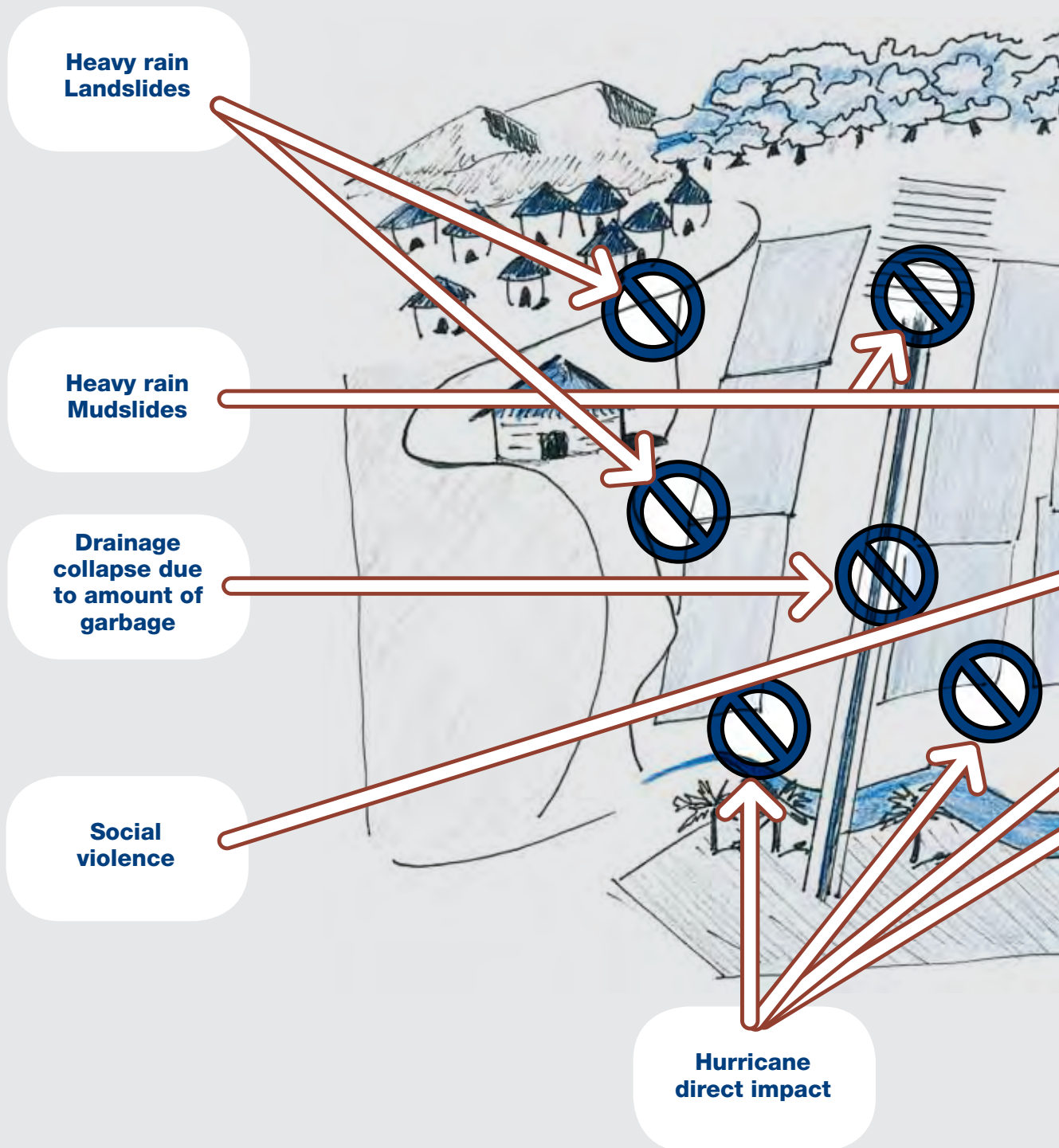


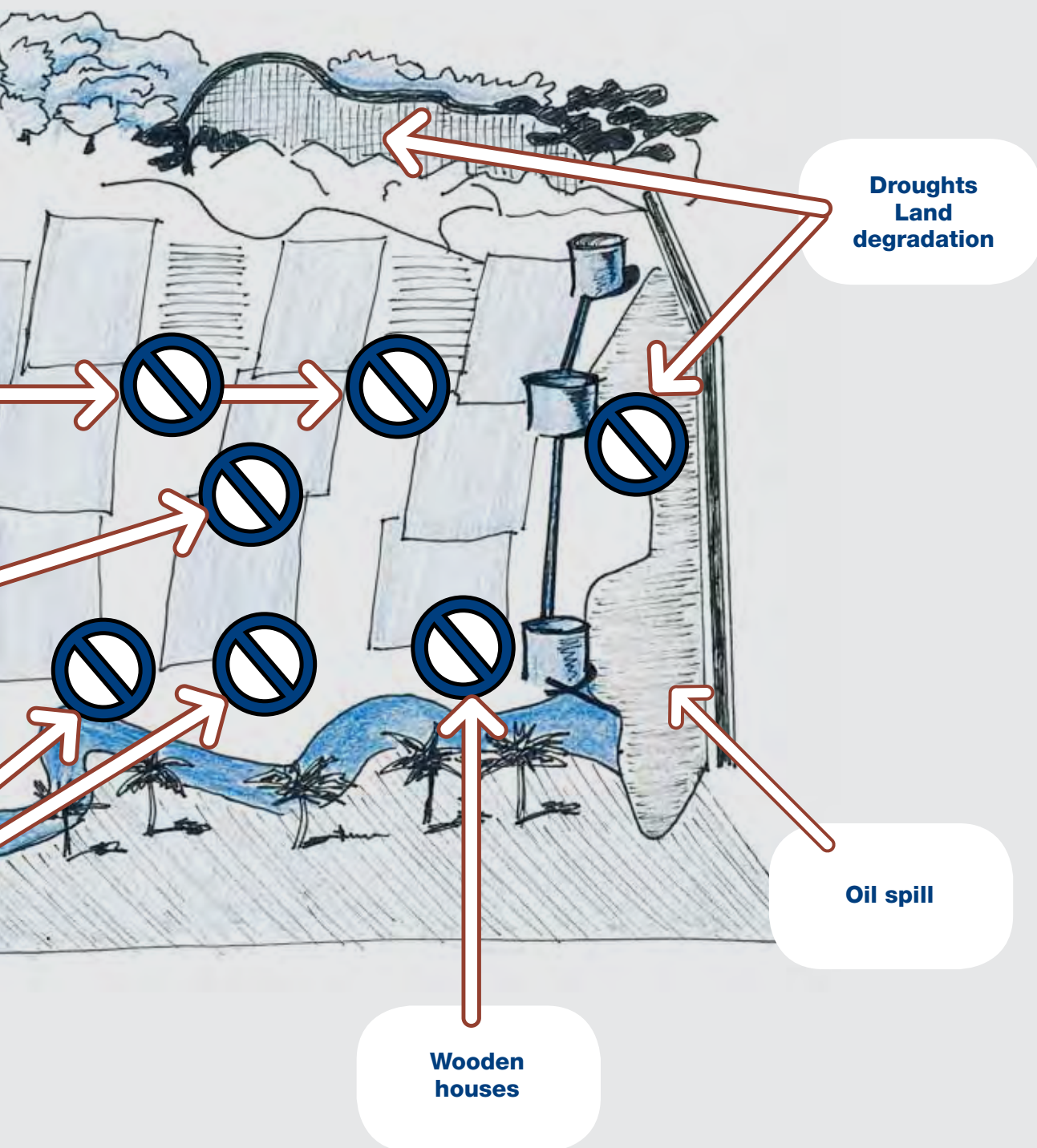
**Oil container**



**Cricket Field**

Hazard/risk map





# | Analysis



Analysis is the process whereby information from all the different sources is synthesized to enable you to answer the questions posed in the vulnerability and capacity framework.

- What are the main problems?
- Who is affected by these problems?
- What is the capacity of the affected population?
- How well can they cope with the problems?
- Is other assistance currently available to the affected population?
- Is there a need for the Red Cross Red Crescent to intervene?
- If so, what type of intervention is required?

**KEY MESSAGE:** You should analyse information continuously, throughout the assessment. Do not leave analysis until the end of the assessment!

The one exception to the key point above concerns analysis of sector information. If the team doesn't include a sector specialist, this information is analysed after the assessment by the relevant specialist. Generalists should, therefore, not try to analyse sector information during fieldwork, unless there is a very obvious inconsistency in the information.

### This section provides advice on:

- Resolving inconsistencies in the information that you collect.
- Summarizing information.
- Synthesizing information from different sources in order to reach conclusions.
- Making proposals for programmes.

## Inconsistent information

In any assessment you will be faced with the problem of inconsistent information. This occurs when informants provide different answers to the same question.

The first step is to think about the information as you collect it. This helps you identify inconsistencies. Ask yourself the following questions:

- Does the new information support or contradict secondary information?
- Does information gathered from one informant support or contradict information from another?
- Is the information collected by different members of the assessment team consistent?
- Does the information "make sense"?

**KEY NOTE:** As a general rule, try to verify important information by comparing input from at least three different sources. These sources should be as diverse as possible. If several different sources provide the same information, it is probably correct.

## Synthesizing information

This section provides a three-step process for synthesizing information from different sources and presenting the conclusions in a format that is useful to programme planners. Each step contains a table, together with notes explaining how to complete it. This process is based on the vulnerability and capacity framework.

### Step 1

Problem ranking: Did all informants agree about the ranking of problems? If not, give details (which problems were considered most severe by each group of informants).

Other comments on information in the table:

Problem	Normal or new?	If normal how often does problem occur	If new when did problem start

### Notes

List all the problems identified during the assessment.

Be specific. Do not say that the problem is “floods”. Do say that the problems caused by the floods are, for example:

Loss of life.

- Injury.
- Destruction of houses.
- Contamination of drinking water.
- Others.

List each of these as a separate problem in the table.

Rank the problems in approximate order of severity (the most severe first).

Note whether each problem is “normal” or “new”. A normal problem is one that happens every year (for example, a “hungry period” before the harvest). A new problem is one that has resulted from the current emergency (for example, contamination of water supplies after floods).

For “normal” problems, note how often the problem occurs (for example, once a year or once every three years).

For “new” problems, note when the problem started (with a date, when possible).

# Civil and Military Interaction

### Tips for civilians deploying with defence force teams

Increasingly, civilian AusMAT teams may be transported by or deployed with Australian Defence Force members. Specific Australian “Joint Task Force” missions such as Pakistan Assist II involved large numbers of defence and civilian team members working and living in difficult field conditions for many weeks and months. Understanding of ADF structure and norms on mission and in “camp life” is valuable for AusMAT members, and will make for a more rewarding and comfortable mission.

#### Civilians on a Defence base, disaster response

If assigned to working with ADF colleagues, you may find yourself passing through an ADF base onshore, or living with the ADF in the field.

Your freedom of movement will be affected by the organisational arrangements.

- Your behaviour on base and in the field will be under scrutiny.
- You should have some knowledge of whose rules you are working under (civilian or ADF).
- What is your line or reporting and chain of command? This will be clearly articulated if under “joint task force” arrangements.

#### General advice

- ADF members, like their civilian counter-parts, will appreciate a friendly demeanour, hard work while on shift, and a sense of fun off shift.
- A sense of “mucking-in” and not “Being Jack”, i.e. refilling the toilet paper holder if it has run out or the hot water urn when running low etc, is expected.

#### Luggage

Think carefully about what you take- you’ll be responsible for moving it at all times, despite the weight.

- Sometimes you may be required to “bag drag” a kilometre or two across a base - so one bag with wheels and one that will sling on your shoulder or stack on the wheeled one is advisable.
- Try to keep luggage to muted colours with some small identification to help you identify it.

- There are severe restrictions on what can be packed in luggage on military aircraft. Ask before you pack at home. The restrictions include but are not limited to: anything flammable or packaged under pressure including aerosol cans. No cigarette lighters or matches except zippo lighters. Do not try to take anything in a pressurised container. No camping gas, no spray deodorant or shaving cream. Take creams and roll-ons.
- On packing the pallets you will be asked what is in your luggage
- A random search will then be conducted before packing up the bags.
- Laptops- it is best if these are in a hard case, or fit into a purpose designed backpack.
- When travelling on military aircraft, you may not be able to have ANY hand luggage- it all needs to be palletted. You may be left with a book, glasses and mints. Care will be provided for backpacks/ laptop cases, but it is palletted inside a circle of larger bags.
- Generally you will be supplied basic food and fluid on the flight (depending on flying time), either before embarking or while airborne.

**Security:** arriving and departing the base. There are strict controls when entering an ADF base.

- You must show photo ID and be formally signed onto the base if you are not a member of the ADF. Departing is easy- but take your photo ID with you, or returning will be a problem.
- Everyone on Base should have ID on display. You should carry and display your ID at all times- even for PT, or to and from the showers. If you see someone without ID, you can ask them to display it. If they can’t, they should be reported to security.

**Sleeping:** is often in a shared area in crisis. You should respect the space and maintain an orderliness to your bed space, sleeping covers/ mosquito net and your belongings. Follow the lead of the ADF members around you.

- Straighten your covers/ or fold as they do.
- Tuck personal belongings under pillows, or into your bags and zip these up. Do not leave clothing and equipment unpacked and disorderly.
- Some people may be working shift work. When you leave the sleeping area, take what you need for the day, and don’t plan to return to the area and disturb others.
- If you want to read at night, use a well adjusted head torch, or a small book light.

- If you have an alarm- have it on a soft sound setting and under your pillow. Try not to wake the whole room. A lost alarm in your bag going off at 2 pm every day will not be appreciated by those on night duty.
- If using sprays eg deodorants, use them outside not in a common area indoors. Preferably take roll-on deodorants rather than aerosols and avoid issues of aircraft transport.

### **Toilets and showers**

Field conditions are often primitive and shared but are usually same sex only- unless working under some European country banners

#### **Toilets**

Men are presented with a 'Piss-o-phone'- basically a funnel on a pipe planted into the soil. Often with no surround. Women- allay your curiosity if you see such a sculpture in the field- men are using it not inspecting its cultural value.

There will likely be a toilet seat mounted over some sort of hole in the ground or portable container. There may be a Hessian screen on 1 side to screen you from the world (in one direction at least). In hot countries this metal seat will be burning hot- beware!

There will be a wash point with at least a 1litre bottle of water with some detergent added and a hole in the lid to limit flow. There may be alcoholic liquid to rub on hands after toileting.

Always carry a sachet of wet wipes and a purse size packet of tissues when travelling away. Forget and regret!.

#### **Showers**

Showers are likely to be communal whilst confronting to some, it is best to 'Just do It'.

Take a plastic bag (and a reusable style shopping bag) for clean clothes and items to hang up out of watery floors.

Try a travel towel instead of a normal towel- it still works, packs more easily and dries more quickly.

Follow the lead of others in the method of washing- but try to avoid giving the full frontal to those walking into the enclosure.

Take thongs for the shower and keep them on for your wash. Do this in any ADF location- and reduce the risk of tinea.

Avoid bar soaps and take some form of liquid shower gel instead.

### **Behaviours- social**

Strict no fraternising policy in ADF, this will also be applicable to AusMAT teams co-located. Breaking of this policy will result in return home.

### **Alcohol rules**

Alcohol rules define and comply- most likely alcohol free on base,

- Even off base, drink responsibly- ADF often 2 cans per man per day maximum
- If there is a 'bar' on base, alcohol will still be restricted. Drinks should be consumed at the bar area, and particularly do not walk around the base with alcohol in hand.

### **Smoking**

Smoking is also usually confined to particular areas. You should not walk around the base smoking.

### **Clothing**

ADF have strict rules on clothing for their members.

- Long sleeves, long pants and boots are the norm even in the hottest climates. This is for protection from the environment.
- A T-shirt is worn under the long sleeved shirt.
- When in individual working spaces, eg a hospital tent, the outer long sleeved shirt may be removed, but must be on when moving around the base.

Air travel- on military aircraft,

- wear long pants and a long sleeved shirt and covered in shoes.
- No sandals or slip on shoes.
- Try to avoid clothing with loops/ pockets that may catch on the aircraft- especially if leaving it in haste.
- The crew will be wearing fire-retardant clothing including gloves for takeoff and landing.

### **Hats**

All ADF members in uniform wear hats when outside. Again this provides protection in hot environments and if you comply with a civilian hat, you'll fit in easily.

- When ADF members go in to eat, the hat is often left on hooks outside the dining room. If a rack is not available, place your hat in your pocket.

- bags- including handbags, satchels or daypacks of any type. These are NEVER taken into a dining area on an Australian base- or you'll be buying the bar.
- On Australian soil, there will be an area in the individual male or female toilet areas to leave hats and bags. In the field, ask and follow advice.

### Clothes washing

- Take a linen (pillow case) or mesh bag for dirty washing.
- You may have no chance to wash anything much except for underwear.
- Be guided by the water availability and ask first if there are any water restrictions.
- Take some washing powder in a double zip lock bag- or if you are concerned re carriage of obscure white powder- take liquid washing soap but still double bag it as there are few tubes that do not leak during air transport. Consider using a "laundry soap" bar as a handy alternative.
- Travel shops also have washing 'leaves' the success of which is untested.
- Hanging your underwear to dry may be acceptable over your bedding if there is no communal line.
- Marking uniform items with your name e.g. under the collar, saves confusion in camp living conditions.

### Dining

- There will always be a wash point on entering a dining facility- even it's a bottle of water with a string around the neck. Use it.
- If ADF members are carrying weapons, they will have to clear their weapons before entering the dining area. This will be a sandbagged site adjacent to the entry. The weapon in then safe. There may be a gun rack for them to leave their weapons when eating. If not, they will carry them and place on the floor by their seat. Don't attempt to move someone's weapon- but ask them to do so if it's blocking you access to something.
- There will be a queue and a limited menu- often hearty if a kitchen has been deployed. Vegetarian options will be limited.
- Lots of bread and cordial- look for dark green eski size containers, for cordial when in the field.
- Water is a bit more challenging- the cordial takes the edge off the potable water. Hot cordial is a variation you may come to enjoy- as an alternative to international roast coffee.

- Take your turn in the queue, and try to appreciate that someone is attempting to provide something edible with very limited resources if in the field.
- When sitting at the table, always place any items still in your possession under your chair, not on the table. If you have to get up for something and risk losing your seat, you can place something on the chair, but never on the table top.
- If you have a phone with you and it rings, excuse yourself from the table and dining room to answer the call.
- If you are working from ration packs and self catering in a field kitchen, there will be tubs of water to wash and rinse your dishes. There will be no-one to do it for you. Observe the procedure or ask to have the system explained. Look after your own kit.
- After eating, if all of your plates and cutlery are disposable- dispose of them as required and leave your area clean.

### Field tents for medical care

- Surgical teams will need to change into scrubs- this is likely to be a communal area and shared between both sexes. Just do it. Keep your kit in a neat pile.
- Working indoors, drop to a T shirt and long pants, or roll up your sleeves.
- If ADF members are wearing a name, stick some tape with your name and title onto your chest.

### Hazards on Base

The ADF have very good policies on hazard minimisation. Most hazards will be marked.

A solid line on the ground or the ships deck, especially if an arc or a circle defines a hazard, and means do not cross.

Radio antennae and dishes are a common hazard- don't walk within 2M in front of the dish.

If you see a hazard, report it. Be responsible.

## Role of the CIMIC (civil military interaction)

CIMIC is the primary mechanism for the coordination between military commanders and civil actors. The three key functions of CIMIC are civil–military liaison, support to the force and support to the civil dimension. The key activities conducted by CIMIC staff in support of the mission are as follows:

- a. liaison with government, IOs and other types of civil actors;
- b. contributing to joint planning and the development of joint operational plans;
- c. continuous assessment of the local civil dimension;
- d. overseeing the conduct of civil-related activities by military forces;
- e. ensuring a timely and smooth transition of civil responsibilities to proper authorities; and
- f. provision of advice to the commander.

Military liaison with civil agencies provides the basis from which support to the force and civil dimension develops. Liaison is a fundamental part of the planning and development process, and will always be conducted in support of the military mission.

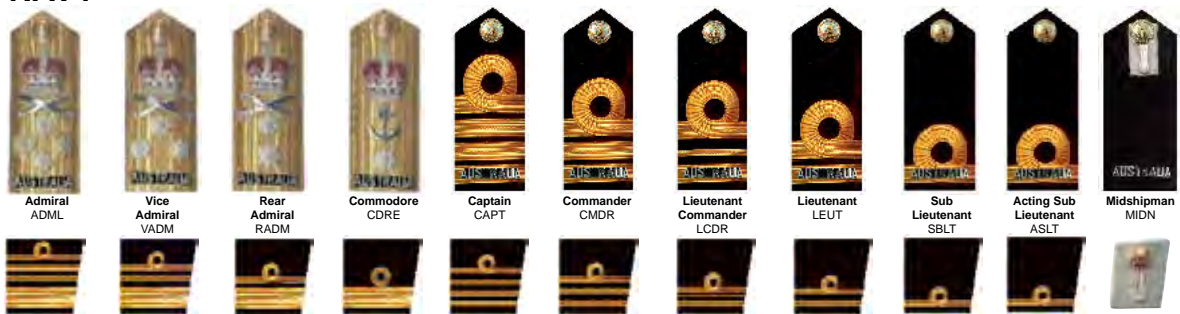
The purpose of CIMIC is to help create and sustain conditions that will support the achievement of operational objectives and to maximise the effectiveness of the military contribution to the overall mission. CIMIC activities assist the commander to interact effectively with all parts of the civil dimension. It provides the interface for cooperation, coordination, mutual support, joint planning and information exchange at all levels between military forces and civil actors. In all cases, CIMIC activity will be consistent with Australian government policy and conducted in accordance with the commander's intent.

Civil actors within the operating environment, including civil agencies of the host nation (HN), IOs, NGOs and other government organisations, may perform a wide range of activities encompassing HA, protection of human rights, legal assistance, medical care, reconstruction, agriculture, education, arts and sciences. Within the AO, the CIMIC contribution facilitates unity of effort between multiple organisations to ensure operational objectives are achieved.

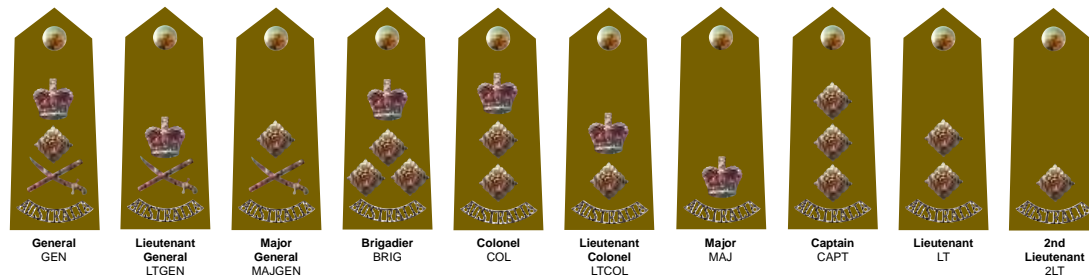


# AUSTRALIAN DEFENCE FORCE BADGES OF RANK AND SPECIAL INSIGNIA

## NAVY



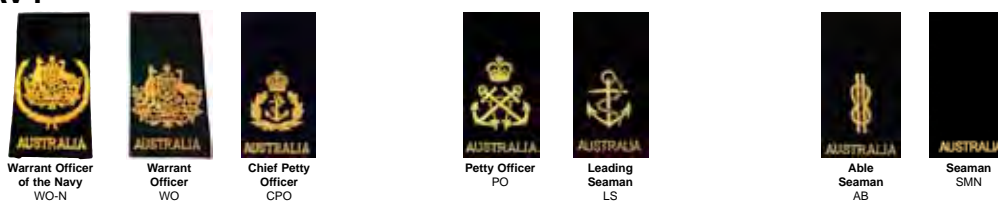
## ARMY



## AIR FORCE



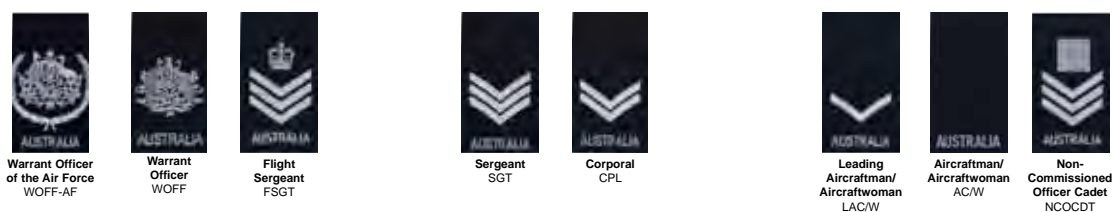
## NAVY



## ARMY



## AIR FORCE

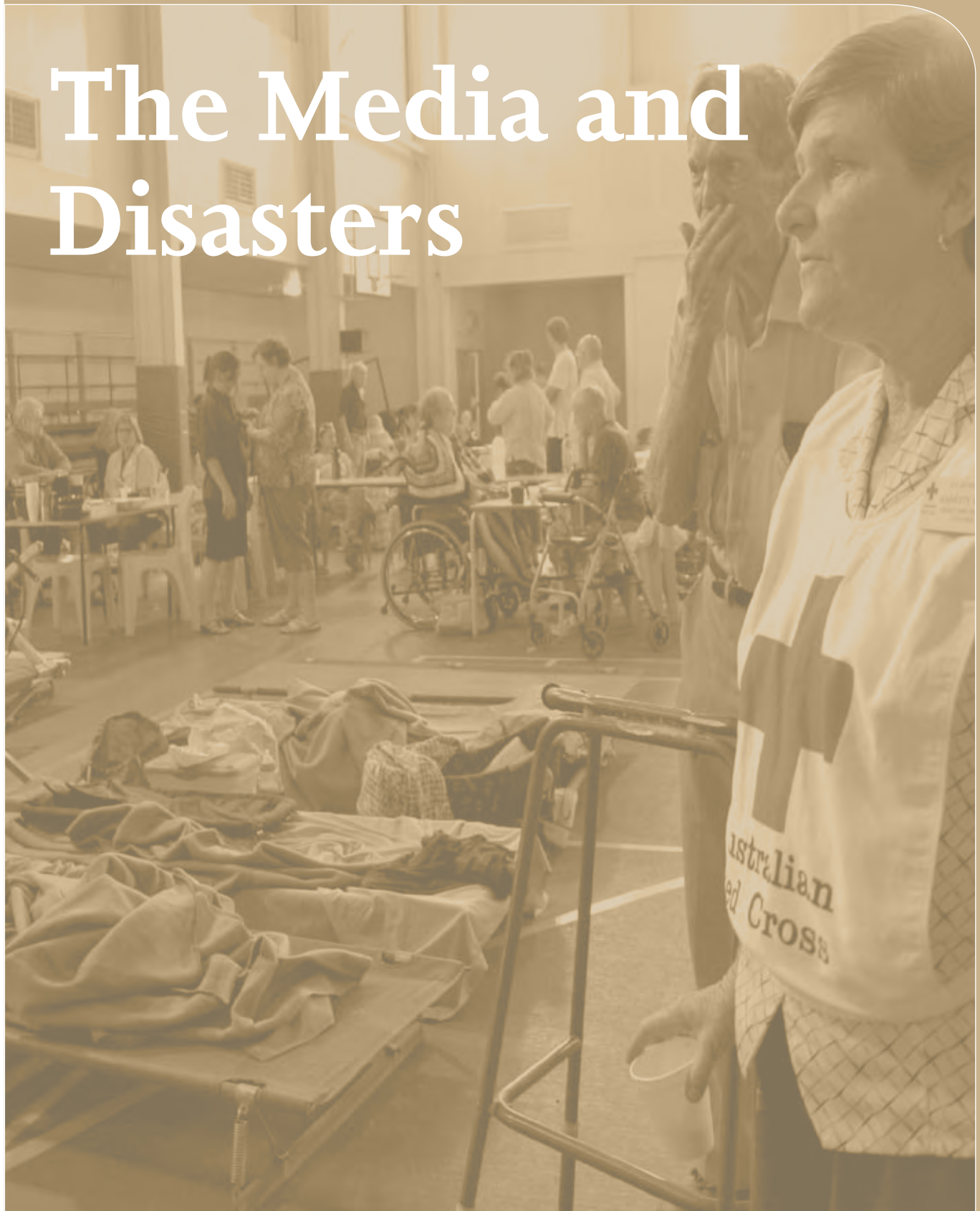


DFB 49/03/08

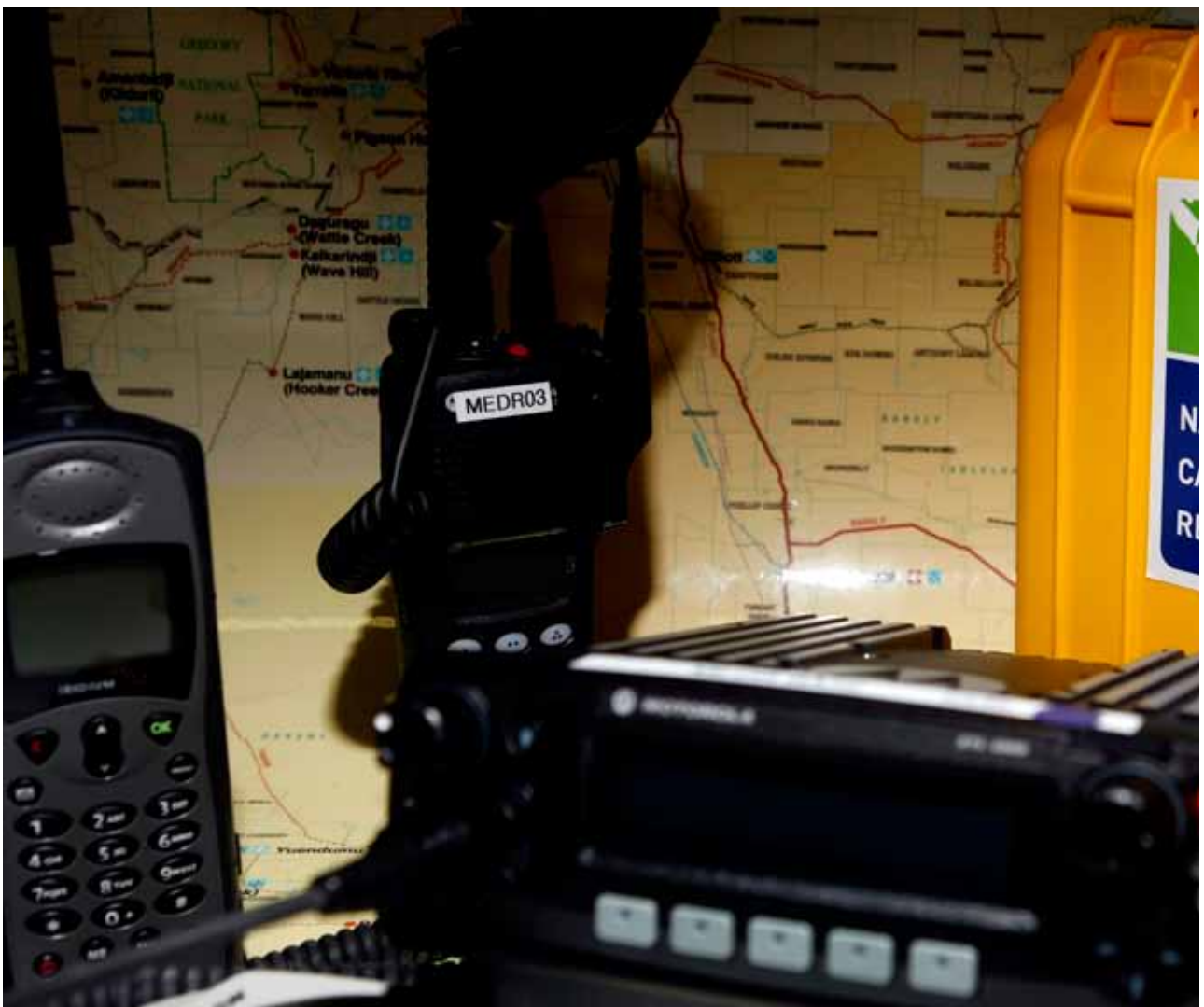




# The Media and Disasters



# The Media and Disasters



## Understanding the role of media

The role of the media is to provide information to the rest of the world. The job entails obtaining news and presenting it in a format that is appealing, easy to digest and timely. There is a competitive component to selling a story and a story will be presented in different ways for different markets. In order to be a successful piece of reporting it needs to be accurate rapid but also appealing. The job of the reporter entails meeting the needs and wishes of the audience, so any style of reporting is a direct function of audience preferences. Logically this means that it is our taste as a society that drives the media reporting style.

It is important to remember that while the job of the AusMAT team is to provide aid; the job of the reporter is to provide coverage of the disaster. Just like us, the reporters are doing their job.

## The impact of media on disaster relief

Disaster relief depends upon resources and those resources in turn depend on the willingness of governments, organisations and individuals to support the disaster relief effort. The media, by informing people of the situation ensures the situation is well understood and well publicised, which in turn significantly impacts upon the support that the relief effort receives. If the relief effort was conducted in secrecy there would be considerably less emotional and practical support available. This impact is not only upon financial aid but also things like the willingness of employers to release aid workers, the attitude of friends and family in support of an aid worker and even our own self evaluation.

## What makes the news?

Unfortunately although both a good news story and a story of a tragedy or a problem are both news we tend to have more of an appetite for stories written about problems, disasters or tragedies than stories about successes and plans working appropriately. The interest in the problems will tend to drive the direction or slant of the story so that a story that exposes errors, corruption or conflict will receive more attention than a story that says that the system is working well. Even if the original reporter created a story about a system working well it is not unusual for that story to receive a degree of influence and change before it is finally published. Once again it is important to remember that the reason that stories are presented in this fashion is that the

audience (which includes us) is more interested in a bad news story than the good news story. The media reporter and editor is merely responding to public choice.

If the story is covered by multiple media outlets it is not unusual to see different outlets casting around for a different angle on that story to make the difference between their coverage and their competitors coverage. The coverage that has the most dramatic angle is likely to sell the most papers or viewing time.

When giving a story to the media we need to be aware that the dramatic or disastrous components will be the ones that receive the most attention.

## Journalistic ethics and publishing rules

As with any group of professionals, journalism contain a variety of individuals whose approach to balancing the ethical and the pragmatic will vary. An ethical journalist will consider the rights and needs of an individual as well as the overall benefit to society when deciding how and if to report an incident. Unfortunately the correct ethical decision might result in a story that was less likely to sell than a competitor with a less ethical approach to the same story. One of the biggest assets when dealing with the media is developing personal relationships over a period of time which enables you to understand the different ethical approaches taken by different individuals. Another advantage of a long-term relationship is that both the journalist and you know that they will want subsequent stories from you and thus will be keen to maintain your trust.

Publishing rules vary from country to country but in general will prevent the publishing of extremely distressing images or images that can identify an individual in a private place who might not want to be identified. Once again the degree to which these vary and are respected is significant. Specific instances can also be subject to extra rules such as a suppression order for legal or national security reasons. Specific suppression orders have the advantage of being created for the specific situation and being more closely monitored therefore are more likely to be followed to the letter.

### There is no such thing as “off the record”

Unguarded comments that express a derogatory or different opinion from the one in the official presentation are very valuable assets to a media reporter. As many political figures have found to their cost every microphone must be considered as live and every comment must be considered as publishable.

The two shot interview is a classic situation where this has to be remembered. In the two shot interview the reporter will ask direct questions face to face which constitutes the interview and then will ask for some more vision which identifies both yourself and the report in the picture talking to each other. At this time they are not recording the key interview therefore providing you are seen talking to each other “stock” vision is created. And unguarded comment when you are relaxing having given the story, is a classic place to forget that the microphone is still live.

### The sound bite

It is usual to record quite a few minutes of interview and then select the best few seconds of that interview to use in the story. A particularly catchy or emotive phrase will appeal and support a dramatic story. The longer an interview goes the more likely you are to utter a phrase which can then be used in its entirety or even partially. This can be used to your advantage if you particularly want a key element to be focused on and a skilful politician will often repeat a sound bite phrase many times during an interview in the hopes that this phrase is one that is then picked up. On the other hand one sound bite phrase which is out of keeping with the rest of the interview can completely turn around the message you are trying to portray.

### Leading questions

In order to make your interview sound more dramatic it is not unusual for a reporter to lead with emotive language in the hope that you will then use the same language in your answer and this can be used as a sound bite. Unless you want to present it as a sound bite it is important not to repeat emotive language used in a leading question. An example would be a reporter leading with a question of “how did this disastrous state of affairs happen in the first place?”. The reporter would love you to lead off your answer with “the disastrous state of affairs .....” because no matter what your

answer is you have still uttered the phrase and hence given credence to the fact that it is a disastrous state of affairs.

### Keep your message simple

A short simple message is more likely to be successfully transmitted from you to the final product with out alteration. As a general rule keep the message to no more than two or possibly three points. Keep the language direct and positive, avoiding negative comments and above all the negative comments about others. Use neutral and non-judgemental words.

Try to use simple direct language without technical or clinical jargon remembering that most newspapers write to a reading age well below that used in normal clinical discussion.

- Two or three points maximum
- Understandable words
- Neutral words
- Positive statements

### Media video cameras

The camera can be quite an intimidating piece of equipment and many people find themselves suddenly tongue tied when faced with a camera. As a rule when interviewed it is probably better not to stare directly into the lens unless you are very confident and you want to achieve dramatic effect. This is a technique that the reporters will use. It is always worthwhile considering the impression that you are going to make and making an effort to straighten your clothes, clean your glasses and take off dark glasses. Talking directly to the reporter and looking them in the eye is the safest and best way to give an interview.

Many of us have a nervous habit moving around, bobbing the head or continually looking to left and right which is very obvious when recorded. Occasional movement and normal behaviour is expected and makes us appear natural but excessive movement and habit ticks can be distracting and influence how your interview is perceived. Being aware of your usual habit ticks is very helpful in controlling them to a reasonable level.

## What to wear

If you are interviewed whilst on a disaster relief mission no one would expect you to be wearing smart business dress and appropriate clothing for the mission creates the correct impression. Shirts do not have to be ironed or spotless and it is expected that you look as if you are working. A neat and tidy presentation within limits however demonstrates that you are in control of the situation and therefore have enough time and energy to consider your appearance and your professional presentation. Being clean-shaven for a male creates an atmosphere of coping and being in control of your personal well-being and therefore adds credibility to your ability to look after others well-being.

Many clothes have obvious logos and messages which can be used to emphasise the organisation you are representing. It is worth considering whether this is the right impression to be giving and whether you are clearly identified as belonging to your organisation. Note that your employer and political sponsors will probably see the interview and are most likely to react to the wrong logo in the wrong place.

Clothes that do not look the part for a dedicated disaster relief team detract from the value of the message. T-shirts with humorous logos and low cut necklines do not create the culturally sensitive professional image that we would prefer to support our interview.

## Political awareness

It is important to understand the political landscape on both large and small-scale before giving an interview that might develop a political agenda. Interviews can be started on a purely local clinical focus and then an unplanned question relating to a wider political issue be introduced. As a rule we should not publically express our opinions on issues of this nature, never the less it is important to know the political environment and where questions might be coming from. Different reporters will have different agendas and be working with different groups.

## Staying on message

A consistent message repeated to all media outlets and given by all those interviewed is a good way of ensuring that the key messages that you want to get out are heard and received. Variation between interviews and variation between those giving the interview will tend to detract from the message and be seized upon to generate interest. Decide on the key

message you want to portray and keep to it. The fewer people giving the interviews with the less chance of variation. An experienced person will give the same consistent message in the same simple words multiple times in one interview and then repeated in subsequent interviews.

## Publicly supporting the local community

Where ever possible attribute success and progress to the local leadership and population. By emphasising the part they have played in the news item you will enhance your relationship with them and support the teamwork aspect of the mission. This is consistent with the core values of AusMAT where we are present to support the local community and leave a viable health care system behind when we leave.

## Avoid the use of “I”

When discussing the activities of your relief team always use the term we or us making it clear that this is a team effort. Where ever possible include reference to local aid providers and the community itself in the interview. Once again this helps to maintain a professional credible impression that is consistent with the AUSMAT philosophy of support and facilitate rather than take over and direct.

## Use of humour

Intentional humour in an interview is always extremely difficult to manage and hence is not used by most experienced people giving interviews. The disaster relief situation is not the place for humour and the style of humour that many emergency workers use to cope with adversity may not be appreciated by the general public.

### The life expectancy of a media story

A large event goes through predictable phases in terms of reporting. These predictable phases are driven by the need to maintain interest in the viewing/reading public. Initially the focus of the story will be on the facts of the disaster and extent of disaster. At this stage the public wants good quality information on the developing situation in real time. The response to the disaster both locally and internationally then becomes the next phase.

Progress reports are then interesting but lack the impact of the initial reporting. At this stage a number of different types of reporting occur continuing the interest in the event. Personal stories, possibly focusing on either a rescue worker or a celebrity patient or member of the community are a different way of breathing life into the story.

If at this stage there is any sign of conflict or disconnect between aid agencies, government or local response these then form a different focus for continuing interest in the story. Ensuring that we do not provide adverse media stories at this stage is an important consideration particularly when the team may be becoming tired and any problems will be revealed.

**Expect a natural progression of story angles to maintain interest.**



Avoiding providing conflict as an interest angle.

### The celebrity survivor

Media focus on a particular individual in a large disaster can work to personalise the disaster and assist in maintaining interest in the story. This can work both for and against the individual. Being the centre of media attention may result in better care and support; however, it may also add extra stress and be disruptive in the long term. From the viewpoint of the relief operation continued public interest in the story ensures continued public support however there is a responsibility to ensure that survivors are not exploited to their detriment. AusMAT members may become a special interest story, particularly for their own state media at home. Members will be carefully coached and managed by the AusAID media liaison representative, and can decline involvement at any time.

### Tear jerkers and emotional hooks

Emotionally charged images and stories have a powerful effect on perceptions and support to relief aid. Rescue workers may well be asked to become involved in portraying these small dramatic incidents in the larger response. Although this somewhat distorted reporting may seem strange and be uncomfortable to the rescue worker it may well deliver a great deal of support to the mission. An honest and careful assessment of the potential to do harm to an individual by involving them in an emotional story needs to be made before becoming involved in such a story, including their ability to fully consent without coercion. Ultimately it may be difficult to prevent this approach being taken by journalists, but in cases we are seen to support and become involved in, must be with these tenants in place.

## Managing the relationship

The relationship between a relief team and media reporters is like any other relationship, requiring trust and respect to work well. Remembering they are individuals who are doing a job and that their activities indirectly allow the relief team to do its job is important to maintaining mutual respect.

A good relationship with the media will allow them to help the relief team at a local level as well as through doing their job. They often find out pieces of information which are of great value to the relief team planning its safe daily operations. They often have access to superior communication technology which can be invaluable to the relief team. If asked for an interview the strategy should be to say yes, agree on the scope of the interview and then stick to that scope. The mission lead, AusAID, EMA and medical team leader will usually be involved in initial media interviews, and requests for AusMAT member interviews must go through this group.

Like any relationship there is a balance of power and the journalist is dependent on maintaining a good working relationship with you therefore the power is not all one sided. If you are open to share appropriate stories in an appropriate fashion with the media and can make a prearranged time then you will both be able to do your job with a minimum interference. Media should not become the primary focus of the mission, and time spent on media should never be to the detriment of performing the medical mission.

## Summary

The media are an essential part of a relief response and if the relationship is understood and managed appropriately can be very useful. Understanding how to work with the media in a disaster response is an essential skill of a relief worker. Team leaders will require a high level of media competence to fulfil their role. They will have media training within their team leadership course, and should also consider supplementary media training, often available through their local department of health.

### Suggested tips in managing the media relationship

- Say yes to interviews on your terms
- Limit the number of “front people”
- Provide what they want
- Ask them to help
- Know where your reporter is coming from (country, party or side of conflict)
- Make follow up arrangements
- Call them if anything happens

# Annex

## Accronyms

AA Action Aid  
ACFID Australian Council for International Development  
AERDO Association of Evangelical Relief and Development  
AID All In Diary  
ALNAP Active Learning Network for Accountability and Performance  
ALPS Accountability Learning Planning System  
BMZ German Development Ministry  
CAP Consolidated Appeals Process  
CARE Cooperative for Assistance and Relief Everywhere  
CCC Crisis Coordination Centre (EMA control room)  
CDA The Collaborative for Development Action Inc.  
CfW Cash-for-work  
CIDA Canadian International Development Agency  
CIMIC Civil-military interaction  
CMI Christian Michelsen Institute  
CRS Catholic Relief Services  
DARA Development Assistance Research Associates  
DFAT Department of Foreign Affairs and Trade  
DOHA Department of Health and Ageing (federal)  
DRC Danish Refugee Council  
DREAMIS Disaster Recovery and Mitigation Information System  
EBRD European Bank for Reconstruction and Development  
ECB Emergency Capacity Building project  
ECHO European Commission Humanitarian Aid Office  
EU European Union  
EMA Emergency Management Australia  
FAO Food and Agriculture Organisation (UN)  
FfW Food-for-work  
FIC Feinstein International Center  
FME Financial Management for Emergencies  
FTS Financial Tracking Service  
GAIN Global Alliance for Improved Nutrition  
GFDRR Global Facility for Disaster Reduction and Recovery  
GHD Good Humanitarian Donorship  
GIACC Global Infrastructure Anti-Corruption Centre  
GIK Gifts in Kind  
HAP Humanitarian Accountability Partnership  
HD Centre for Humanitarian Dialogue  
HPG Humanitarian Policy Group  
HPN Humanitarian Practice Network  
HQ Headquarters  
HR Human resources  
IAF International Accreditation Forum  
IASC Inter-Agency Standing Committee  
IATI International Aid Transparency Initiative  
IBLF The International Business Leaders Forum  
ICAC Independent Commission Against Corruption  
ICRC International Committee of the Red Cross/Red Crescent  
ICVA International Council of Voluntary Agencies  
IDETF Inter departmental emergency task force (Canberra)  
IDP Internally displaced person  
IFRC International Federation of Red Cross and Red Crescent Societies  
IMF International Monetary Fund  
INEE Inter-Agency Network for Education in Emergencies  
INGO International non-governmental organisation  
INSEAD Institut Européen d'Administration des Affaires  
InterAction The American Council for Voluntary International

## Action

IR Islamic Relief  
ISO International Organization for Standardization  
LTA Long-term arrangement  
LTRT Lanka Tsunami Response Team  
LWF Lutheran World Federation  
M&E Monitoring and evaluation  
MANGO Management Accounting for Non-Governmental Organisations  
NCCTRC National Critical Care and Trauma Response Centre  
NFI Non-food item  
NGO Non-governmental organisation  
NIR National Incident Room (DOHA control room)  
NRC Norwegian Refugee Council  
OCHA Office for the Coordination of Humanitarian Affairs (UN Secretariat)  
ODI Overseas Development Institute  
OECD Organisation for Economic Co-Operation and Development  
PATH Program for Appropriate Technology in Health  
PVO Private voluntary organization  
RAPID Research and Policy in Development  
SC Save the Children  
SCHR Steering Committee for Humanitarian Response  
SEA Sexual exploitation and abuse  
SIDA Swedish International Development Agency  
TI Transparency International  
TRACE Transparent Agents and Contracting Entities  
U4 Utstein Anti-Corruption Resource Center  
UN United Nations  
UNDP United Nations Development Programme  
UNHCR United Nations High Commission for Refugees  
UNICEF United Nations Children's Fund  
UNIS United Nations Information Service  
UNJLC United Nations Joint Logistics Centre  
UNOPS United Nations Office for Project Services  
USAID United States Agency for International Development  
VOICE Voluntary Organisations in Cooperation in Emergencies  
WANGO World Association of Non-Governmental Organisations  
WB World Bank  
WFP World Food Programme (UN)  
WHO World Health Organisation (UN)  
WV World Vision Bottom of Form

# References

## NATIONAL CRITICAL CARE & TRAUMA RESPONSE CENTRE

### References:

- Genarla Humanitarian Standards.
- The Sphere Project, Humanitarian Charter and Minimum Standards in Disaster Response.
- Guidelines for assessment in emergencies, International Federation of Red Cross and Red Crescent Societies.
- Guidelines on Humanitarian Negotiations with Armed Groups, United Nations, January 2006.
- The International Federation of Red Cross and Red Crescent Societies - Guide to a safer mission.
- Generic Security Guide for Humanitarian Organisations, European Commission 2004.
- Staff Safety Workshop, The UN Refugee Agency, Pramburi Thailand 2004.
- Security Awareness: An Aide Memoire, 1995 Geneva, UNHCR.
- Module, Preventing and Defusing Anger and Hostility, L Schirch and D Dyck, Conflict transformation program.
- Royal Darwin Hospital, Francis Abbott. Aboriginal Culture.
- The Australian Attorney Generals Department Emergency Management Australia, 2009 Disasters Medicine Manual safer sustainable communities.
- International Federation of the Red Cross and Red Crescent Societies.
- October 2005 International Guidelines for Emergency Assessment.
- International Federation of the Red Cross and Red Crescent Societies, June 2000. Disaster Emergency Needs Assessment.
- US Agency for International Development September 2005. Field Operations Guide Version 4.0.
- World Health Organisation 1999. WHO Emergency Handbook for the Eastern Mediterranean Region.
- World Health Organisation 1999. Essentials for Emergency.
- UNICEF July 2005 Emergency Field Handbook a guide for UNICEF staff
- UNHCR Geneva 1995 Security Awareness an Aide Memoire.
- UNDAC 2006 OCHA Handbook A – Z.
- Pan American Health Organisation 2010 PAHO WHO Regional Disaster Response Team.
- Welling et al (World J Surg 2010) 34:466-470.
- InterAction/OFDA NGO Security Training Preventing and Defusing Anger and Hostility.
- Transparency International. The Global coalition against corruption Preventing Corruption in Humanitarian Operations Section II program and support functions.
- Response Psychological Services Pty Ltd, [www.responsepsychologicalservices.com](http://www.responsepsychologicalservices.com)
- UNHCR Travel Document downloaded 2011.
- Center for Disease Control. [www.cdc.com.au](http://www.cdc.com.au)
- World Health Organisation (2005) Communicable disease control in emergencies: “a field manual” edited by M.A. Connolly.
- Communicable diseases in complex emergencies: impact and challenges, Connolly M.A Gayer M, Ryan M.J Spiegel P, Salam P, Heymann D.L, Lancet 2004; 364 (9449): 1974-1983
- Conflict and emerging infectious disease. Gayer M. , Legros D, Formenty P, Connolly M.A Emerg Infect Dis. 2007 Nov; 13 (11).
- [www.who.int/diseasecontrol/emergencies](http://www.who.int/diseasecontrol/emergencies).
- Humanitarian Negotiation. A Handbook for securing access , assistance and protection for civilians in armed conflict. The Centre for Humanitarian Dialogue. Deborah Mancini-Griffoli and Andre Picot



