Humanitarian Standards Pocket Guide

This Pocket Guide, prepared by the World Vision Asia Tsunami Response Office in Singapore, is a shortened, easy reference booklet for field workers. It must not be used as a stand-alone document, and reference should be made to the full version of The Sphere Project 2004 Edition.

World Vision Asia Tsunami Response Team
Singapore
June 2006

Distributed by:
World Vision International
6, chemin de la Tourelle
1209 Geneva / Switzerland
Email: geneva@wvi.org

The Sphere Project

Humanitarian Standards Pocket Guide

June 2006

INTRODUCTION

The main focus of this ***Standards Pocket Guide*** is on the Sphere Project, to which approximately 400 organisations from 80 countries contributed. It is intended as a shortened, easy reference document for staff while working in the field. As a quick reference guide, *it must not be used as a 'stand alone' document*. Page numbers referred to in this Standards Pocket Guide correspond to the relevant pages in The Sphere Project, 2004 Edition. Reference must always be made to the original, full version of each document referred to in the Pocket Guide to ensure good practice.

Adherence to international standards of best practice in humanitarian responses and development programs guide genuine participation and inclusion, partnership with government and local organisations, integration of all program components, reduction of vulnerabilities, effective coordination, transparency and accountability, impartiality and neutrality and help to ensure quality of programs.

June 2006
World Vision Asia Tsunami Response Team, Singapore

World Vision

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6, chemin de la Tourelle
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Guidelines to:

Humanitarian Charter and Minimum Standards in Disaster Response

What is Sphere

Sphere is based on two core beliefs: first, that all possible steps should be taken to alleviate human suffering arising out of calamity and conflict, and second, that those affected by disaster have a right to life with dignity and therefore a right to assistance. Sphere is three things: a handbook, a broad process of collaboration and an expression of commitment to quality and accountability.

The **Sphere** initiative was launched in 1997 by a group of humanitarian Non-Government Organisations (NGO) and the Red Cross and Red Crescent movement, who framed a Humanitarian Charter and identified Minimum Standards to be attained in disaster assistance, in each of five key sectors (water supply and sanitation, nutrition, food aid, shelter and health services).

The cornerstone of the handbook is the Humanitarian Charter, which is based on the principles and provisions of international humanitarian law, international human rights law, refugee law and the *Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organisations in Disaster Relief*. To date, 400 organisations in 80 countries, all around the world, have contributed to the development of the Minimum standards and key indicators in the Sphere Handbook.

When to use Sphere

It is designed for use in disaster response, and may be useful in disaster preparedness and humanitarian advocacy. It is useful in a range of relief situations, including natural disasters and armed conflict, but is not designed for response to technological disasters such as those involving transport, industrial, chemical, biological or nuclear calamity. However, while not addressing these types of disasters specifically, it is relevant to situations where population movements or other consequences triggered by such an event create a need for humanitarian assistance.

Timeframe

It depends largely on the context. It may take days, weeks or even months before agencies are able to achieve the Minimum Standards

and indicators specified in a particular sector. A timeframe for implementation needs to be agreed in any given situation. Where relevant, guidance notes suggest realistic timescales for the implementation of the standards and indicators.

How to use Sphere

It offers a set of Minimum Standards and key indicators. The standards are general statements that define the minimum level to be attained in a given context; the indicators act as "signals" that determine whether or not a standard has been attained; while the guidance notes provide additional information on specific points that should be considered when applying the standards in different situations.

Each chapter also contains a brief introduction and appendices containing select lists of references detailing further sources of technical information, assessment checklists and, where relevant, formulas, tables and examples of report forms. All the chapters are interconnected and standards described in one sector frequently need to be addressed in conjunction with standards described in other sectors.

Recognising vulnerabilities and capacities of disaster-affected populations

To maximise the coping strategies of those affected by disasters, it is important to acknowledge the differing vulnerabilities, needs and capacities of affected groups. Specific factors, such as gender, age, disability and HIV/AIDS status affect vulnerability and shape people's ability to cope and survive in a disaster context. In particular, women, children, older people and people living with HIV/AIDS (PLWH/A) may suffer specific disadvantages in coping with a disaster and may face physical, cultural and social barriers in accessing the services and support to which they are entitled. Frequently, ethnic origin, religious or political affiliation, or displacement may put certain people at risk who otherwise would not be considered vulnerable.

Disaster-affected populations must not be seen as helpless victims and this includes members of vulnerable groups. They possess, and acquire, skills and capacities and have structures to cope with and respond to a disaster situation that need to be recognised and supported.

Cross-cutting issues

Children Special measures must be taken to ensure the protection from harm of all children and their equitable access to basic services. As they often form the larger part of an affected population, it is crucial that their views and experiences are not only elicited during emergency assessments and planning but that they also influence humanitarian service delivery and its monitoring and evaluation.

According to the Convention on the Rights of the Child, a child is considered to be an individual below the age of 18. Depending on cultural and social contexts, however, a child may be defined differently amongst some population groups. It is essential that a thorough analysis of how a client community defines children be undertaken.

Older People are men and women aged over 60, according to the United Nations (UN), but may vary from one context to another. They may make up a large proportion of the most vulnerable in disaster-affected populations, but they also have key contributions to make in survival and rehabilitation. If supported, they can play important roles as carers, resource managers and income generators, while using their knowledge and experience of community coping strategies to help preserve the community's cultural and social identities and encourage conflict resolution.

Disabled people can be defined as those who have physical, sensory or emotional impairments or learning difficulties. To survive, they need standard facilities to be as accessible for their needs as possible and an enabling social support network, which is usually provided by the family.

Gender Women and men, and girls and boys have the same entitlement to humanitarian assistance; to respect for their human dignity; to acknowledgement of their equal human capacities, including the capacity to make choices; to the same opportunities to act on those choices; and to the same level of power to shape the outcome of their actions.

Protection Sphere does not provide detailed descriptions of protection strategies or mechanisms, or of how agencies should implement their responsibility. However, where possible, it refers to protection aspects or rights issues – such as the prevention of sexual abuse and exploitation, or the need to ensure adequate registration

of the population – as agencies must take these into account when they are involved in providing assistance.

HIV/AIDS The coping mechanism and resilience of communities are reduced when there is a high prevalence of HIV/AIDS; the threshold for external stressors may be lowered and community recovery time may be prolonged. PLWH/A often suffer from discrimination, and therefore confidentiality must be strictly adhered to and protection made available when needed.

Environment is understood as the physical, chemical and biological surroundings in which disaster-affected and local communities live and develop their livelihoods. It needs protection if its essential functions are to be maintained. The Minimum Standards address the need to prevent over-exploitation, pollution and degradation of environmental conditions.

Scope and Limitations of the Sphere handbook
Firstly, the Minimum Standards do not cover all possible forms of appropriate humanitarian assistance. Secondly, there will inevitably be situations where it may be difficult, if not impossible, to meet all of the standards.

It is recognised that in many cases not all of the indicators and standards will be met, however, users should strive to meet them as well as they can. The Sphere handbook cannot cover every question or resolve every dilemma, but it can serve as a starting point and a tool for humanitarian agencies to enhance the effectiveness and quality of their assistance, and thus make a significant difference to the lives of people affected by disaster.

Legal Instruments Underpinning the Sphere Handbook
The following instruments inform the Humanitarian Charter and the Minimum Standards in Disaster Response:

* *Universal Declaration of Human Rights 1948.*
* *International Covenant on Civil and Political Rights 1966.*
* *International Covenant on Economic, Social and Cultural Rights 1966.*
* *International Covenant on the Elimination of All Forms of Racial Discrimination 1969.*
* *The four Geneva Conventions of 1949 and their two Additional Protocols of 1977.*

* *Convention relating to the Status of Refugees 1951 and the Protocol relating to the Status of Refugees 1967.*
* *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984.*
* *Convention on the Prevention and Punishment of the Crime of Genocide 1948.*
* *Convention on the Rights of the Child 1989.*
* *Convention on the Elimination of All Forms of Discrimination Against Women 1979.*
* *Convention relating to the Status of Stateless Persons 1960.*
* *Guiding Principles on Internal Displacement 1998.*

CHAPTER 1

Minimum Standards Common to all Sectors

Minimum Standards Common to all Sector

Sphere Minimum Standards

1. Participation:
Disaster affected population actively participates in the assessment, design, implementation, monitoring and evaluation of the assistance programme.
Page 28

Key Indicators

- Women and men of all ages from the disaster affected and wider local populations, including vulnerable groups, receive information about the programme and have the opportunity to comment during all stages of the project cycle. *(see guidance note 1)*
  * Programme should reflect interdependency of individuals, households and communities and protection elements.

- Written programme objectives and plans should reflect needs, concerns and values of disaster-affected people including vulnerable groups, and to contribute to their protection. *(see guidance notes 1-2)*
  * Channels for feedback include public meetings, or via community based organisations.
  * Specific outreach programmes for homebound individuals or disabled.

- Programming is designed to maximise use of local skills and capacities. *(see guidance notes 3-4)*
  * Support/complement existing services or local institutions.
  * Local and government to be consulted in the longer term design of programmes when feasible.

2. Initial assessment:
Assessments provide an understanding of the disaster situation and a clear analysis of threats to life, dignity, health and livelihoods to determine, in consultation with the relevant authorities, whether an external response is required and, if so, the nature of the response.
Page 29

Key Indicators

- Information is gathered using standardised procedures and made available for transparent decision-making. *(see guidance notes 1-6)*
  - * Checklists useful to ensure key areas are examined. *(see Appendix 1: References on page 43)*
  - * Initial assessment should be carried out as soon as possible and report generated within days.
  - * Assessment team should be gender balanced composed of generalists and technical specialists with local knowledge and previous regional or in-country disaster experience.
  - * Team members should be clear on the objectives, assessment methodology and their roles before fieldwork begins.
  - * Information collected should be treated with confidentiality.
  - * Obtain individual's consent before passing on information.
  - * Primary sources of information include direct observation and discussions with key individuals, such as agency staff, local authorities, community leaders (both sexes), elders, children, health staff, teachers, traders and other relevant sources.
  - * Secondary sources include existing literature, reports (published and unpublished), historical material and pre-emergency data.
  - * Assessment report to indicate specific concerns and recommendations by all groups, especially vulnerable groups.

- Consider all technical sectors (water and sanitation, nutrition, food, shelter, health) and the physical, social, economic, political and security environment. *(see guidance note 7)*

- Through consultation, take into account the responses of local and national authorities and other actors and agencies. *(see guidance note 7)*

- Local capacities and coping strategies of affected and surrounding populations are identified. *(see guidance note 8)*
  - * Minimise tensions by consulting the host community to ensure that infrastructure/services for displaced population also lead to sustainable improvement for host population.

- Whenever feasible, data are disaggregated by sex and age. *(see guidance note 9)*
  - * Include age, gender, vulnerability, average family size and number of households as key disaggregated information to design a more appropriate response.
  - * Mortality and morbidity for children under five should be documented from the outset.

- Disaster assessment is underpinned by the rights of those affected by disasters as defined by international law.

- Take into account the responsibility of relevant authorities to protect and assist the population, the national law, standards and guidelines applicable where the affected population is found, as they conform with international law.

- Include an analysis of the operating environment including factors affecting personal safety and security of the affected population and of humanitarian staff. *(see guidance note 10)*
  * Consider underlying contexts such as structural, political, security, economic, demographic and environmental issues.
  * Consider changes in living conditions and community structures for both host and displaced populations.

- Population estimates are cross-checked and validated with as many sources as possible.

- Findings are available to other sectors, national/local authorities and representatives of affected population. Recommendations are made on the need for external assistance and appropriate responses linked with exit or transition strategies. *(see guidance note 11)*
  * Analysis and planning for post disaster recovery should be part of the initial assessment.
  * Ensure external aid supports local population's own survival mechanisms.

3. Response:
A humanitarian response is required in situations where the relevant authorities are unable and/or unwilling to respond to the protection and assistance needs of the population on the territory over which they have control and when assessment and analysis indicate that these needs are unmet.
Page 33

Key Indicators

- Where people's lives are at risk as a result of disaster, programmes prioritise life-saving needs. *(see guidance note 1)*
  * Care taken to ensure superfluous items do not interfere with the delivery of essential items.

- Programmes and projects are designed to support and protect the affected population and to promote their livelihoods, so that they meet or exceed the Sphere Minimum Standards as illustrated by the key indicators. *(see*

guidance note 2)

* Co-ordination among those responding to a disaster is key to addressing critical gaps.

- Effective co-ordination and exchange of information among those affected by or involved in the disaster response. Undertake activities on the basis of needs where their expertise and capacity can have the greatest impact within the overall assistance programme. *(see guidance note 3)*
  * When agencies have excess capacity, make it known to the wider humanitarian community and contribute when and where necessary.

- Organisations, programmes and projects that cannot address identified needs or attain Minimum Standards should make gaps known so that others may assist. *(see guidance notes 4-5)*
  * Wherever possible, recognised terminology, standards and procedures should be used to help others mobile their responses quickly and effectively.
  * Use standard formats and associated guidelines agreed among host government and agencies.

- In conflict situations, the assistance programme takes into account the possible impact of the response on the dynamics of the situation. *(see guidance note 6)*
  * Factors to analysis prior to programme planning include the actors, mechanisms, issues and context of the conflict.

4. Targeting:
Humanitarian assistance or services are provided equitably and impartially based on the vulnerability and needs of individuals or groups affected by disaster.
Page 35

Key Indicators

- Targeting criteria must be based on a thorough analysis of vulnerability. *(see guidance note 1)*
  * Meet vulnerable needs efficiently and in a way that minimises dependency.

- Targeting mechanisms agreed among affected population (including representatives of vulnerable groups) and other appropriate actors. Targeting criteria clearly defined and disseminated. *(see guidance notes 2-3)*
  * Options include community-based targeting, administrative targeting, self-targeting and combinations of these methods.

* In conflict situations, it is essential to understand the nature and source of the conflict and how it influences administrative and community targeting decisions

- Mechanisms or criteria used should not undermine individual's dignity and security or increase their vulnerability to exploitation. *(see guidance notes 2-3)*
  * Examples are:

  a) Seeking information on individual's assets may be perceived as intrusive and undermine social structures.
  b) Targeting households with malnourished children may undermine people's dignity and encourage dependency.
  c) People who fall out of a clan system may be excluded.
  d) Displaced women, girls and boys may be exposed to sexual coercion.
  e) People suffering from HIV/AIDS may be stigmatised. Confidentiality should be observed at all times.

- Distribution systems monitored, targeting criteria respected and timely correction actions taken when necessary. *(see guidance notes 4-5)*
  * Consult women, children and vulnerable groups on access to and use of facilities and services.

5. Monitoring:
The effectiveness of the programme in responding to problems is identified and changes in the broader context are continually monitored, with a view to improving the programme, or to phasing out as required.
Page 37

Key Indicators

- Information collected for monitoring is timely and useful, recorded and analysed in an accurate, logical, consistent, regular and transparent manner and it informs the ongoing programme. *(see guidance notes 1-2)*
  * Regular monitoring allows for managers to determine priorities, emerging problems, follow trends, determine the effect of the response and guide revisions to their programmes.
  * Information documented and disseminated to other sectors, agencies and affected populations.
  * Language must be appropriate and the information accessible for intended audiences.

- Systems are in place to regularly collect information in each sector and identify if indicators for each standard are met.

- Women, men, children are regularly consulted and involved in monitoring activities. *(see guidance note 3)*
  * People involved in monitoring should collect information in a culturally acceptable manner esp. with regard to gender and language skills.

- Information flow systems in place between programmes, sectors, affected population, local authorities, donors and other actors as needed. *(see guidance note 4)*
  * Regular meetings and use of notice boards can facilitate exchange of information.

6. Evaluation:
A systematic and impartial examination of humanitarian action, intended to draw lessons to improve practice and policy and to enhance accountability.
Page 39

Key Indicators

- Programme evaluated with reference to stated objectives, agreed minimum standards to measure overall appropriateness, efficiency, coverage, coherence and impact on the affected population. *(see guidance note 1)*

- Take into account views and opinions of affected populations and host community if different.

- Information collection for evaluation purposes is independent and impartial.

- Results are used to improve future practice. *(see guidance note 2)*
  * Written evaluation reports are shared for transparency, accountability and learning purposes.

7. Aid worker competencies and responsibilities:
Aid workers possess appropriate qualifications, attitudes and experience to plan and effectively implement appropriate programmes.
Page 40

Key Indicators

- Relevant technical qualifications and knowledge of local cultures, customs, and/or previous emergency experience, and workers familiar with human rights and humanitarian principles.

- Knowledgeable about potential tensions and sources of conflict within affected population and host communities. Aware of the implications of delivering humanitarian assistance and pay attention to vulnerable groups. *(see guidance note 1)*
  * Need to be aware of the extent of crimes including rape, other forms of brutality against women, girls and boys during crisis time and of procedures for referral.

- Able to recognise abusive/discriminatory/illegal activities, and refrain from such activities. *(see guidance note 2)*

8. Supervision, management and support of personnel:
Aid workers receive supervision and support to ensure effective implementation of the humanitarian assistance programme.
Page 41

Key Indicators

- Managers are accountable for their decisions and ensure adequate security and compliance with codes/rules of conduct and support for their staff. *(see guidance note 1)*

- Technical and managerial staff are provided with the necessary training, resources and logistical support to fulfil their responsibilities. *(see guidance note 2)*
  * Agencies to ensure gender balance among staff and volunteers.
  * Provide ongoing support and training for staff.

- Staff understand purpose and method of activities and receive feedback on their performance.

- Staff have written job descriptions with clear reporting lines and undergo periodic written performance assessment.

- Staff are oriented on relevant health and safety issues for the region/ environment they work in. *(see guidance note 3)*
  * Receive suitable vaccinations prior to deployment.

* Receive information on security risks, food, water safety, HIV/AIDS and infectious diseases prevention, medical care availability, evacuation policies and worker's compensation upon arrival.

- Staff receive appropriate security training.

- Capacity building systems for staff are set up and subject to routine monitoring. *(see guidance notes 4-5)*
  * Special efforts should be made to promote diversity within the various levels of the organisation.
  * Capacity building is an explicit objective during the rehabilitation phase following a disaster as well as during the disaster/relief phase.

- Capacity of national/local organisations built up to promote long term sustainability.

CHAPTER 2

Minimum Standards in Water Supply, Sanitation and Hygiene Promotion

Minimum Standards in Water Supply, Sanitation and Hygiene Promotion

1. Hygiene Promotion

Sphere Minimum Standards

1. Programme design and implementation:
All facilities and resources provided reflect the vulnerabilities, needs and preferences of the affected population. Users are involved in the management and maintenance of hygiene facilities where appropriate.
Page 60

Key Indicators

- Key hygiene risks of public health importance are identified. *(see guidance note 1, Participation standard page 28)*
  * Identify key hygiene behaviours, practices, knowledge, resources and the likely success of the promotional activity.
  * Special attention to vulnerable groups.

- Include an effective mechanism for representative and participatory input from all users, including in the initial design of facilities. *(see guidance notes 2,3 and 5)*

- All groups have equitable access to resources and facilities to achieve the hygiene practices promoted. *(see guidance note 3)*

- Hygiene messages and activities to address key behaviours and misconceptions for all user groups. Involve all user groups in planning, training, implementation, monitoring and evaluation. *(see guidance notes 1,3 and 4 and Participation standard page 28)*
  * Messages to be culturally sensitive and understood by all, including the illiterate.
  * Define and prioritize hygiene risks and behaviours.
  * A rough guide, in a camp scenario: two hygiene promoters/community mobilizers per 1,000 members of the target population.

- Users to take equal responsibility for the management and maintenance of facilities. *(see guidance notes 5, 6)*
  * Water/sanitation committees (men and women) to manage communal facilities such as water points, public toilets and washing areas, promote hygiene activities and ensure programme sustainability.

2. Water Supply

Sphere Minimum Standards

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.
Page 63

Key Indicators

- 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)*
  * Excessive queuing times are indicators of insufficient water availability.

- The maximum distance from any household to the nearest water point is 500 metres. *(see guidance notes 1,2,5 and 8)*
  * Additional measures may be needed to ensure access is equitable.

- Queuing time at a water source is not more than 15 minutes. *(see guidance note 7)*

- It takes no more than three minutes to fill a 20-litre container. *(see guidance notes 7-8)*

- Water sources and systems maintained to provide appropriate quantities of water consistently or on a regular basis. *(see guidance notes 2 and 8)*

2. Water quality:
Water is palatable, and of sufficient quality to be drunk and used for personal and domestic hygiene without causing significant risk to health.
Page 66

Key Indicators

- A sanitary survey to ensure low risk of faecal contamination. *(see guidance note 1)*
  * Assessment should cover possible sources of contamination at water source, in transport, home, defecation practices, drainage and solid waste management including animal excreta.

- No faecal coliforms per 100ml at the point of delivery. *(see guidance note 4)*

- People drink from protected and treated source in preference to other available water sources. *(see guidance note 3*)
  * Promotion of protected sources needed.
  * Technicians, hygiene promoters and community mobilizers need to understand the rationale for drinking from protected sources.

- Steps taken to minimize post-delivery contamination. *(see guidance note 4)*
  * Improved collection and storage practices.
  * Distribution of clean and appropriate collection and storage containers.
  * Treatment with a residual disinfectant or treatment at the point of use.
  * Routinely sample water at the point of use.

- For piped water supplies, or all water supplies at times of risk or presence of diarrhoea epidemic, water is treated with a disinfectant so that there is a free chlorine residual at the tap of 0.5mg/litre and turbidity is below 5 NTU. *(see guidance notes 5,7 and 8)*
  * Water at hospitals, health centres and feeding centres should be treated and an uninterrupted supply ensured.

- No negative health effect detected due to short-term use of water contaminated by chemicals (including carry-over of treatment chemicals), or radiological sources and assessment shows no significant probability of such an effect. *(see guidance note 6)*

3. Water use facilities and goods:
People have adequate facilities and supplies to collect, store and use sufficient quantities of water for drinking, cooking and personal hygiene, and to ensure that drinking water remains safe until it is consumed.
Page 69

Key Indicators

- At least two clean 10-20 litre water collecting containers per household for water collection, plus enough clean water storage containers to ensure there is always water in the household. *(see guidance note 1)*
  * Smaller or specially designed water carrying containers for children, disabled, older people and PLWH/A

- Appropriately designed water collection and storage containers (ie narrow necks and/or covers) that are safe for storage, drawing and handling. *(see guidance note 1)*

- At least 250g of soap available for personal hygiene per person per month.

- Sufficient separate bathing cubicles for males and females in communal bathing facilities. *(see guidance note 2)*
  * The numbers, location, design, safety, appropriateness and convenience of facilities should involve users, particularly women, adolescent girls and the disabled.

- At least one washing basin per 100 people in communal laundry facilities and private laundering areas for women to wash and dry undergarments and sanitary cloths.

- Encourage participation of vulnerable groups in the siting and construction of bathing facilities and/or the production and distribution of soap, or the use and promotion of suitable alternatives. *(see guidance note 2)*

3. Excreta Disposal

Sphere Minimum Standards

1. Access to and numbers of toilets:
People have adequate numbers of toilets, sufficiently close to their dwellings, to allow them rapid, safe and acceptable access at all times of the day and night.
Page 71

Key Indicators

- Maximum of 20 people to each toilet. *(see guidance notes 1-4)*
  * Where the population has not traditionally used toilets, a concerted education/promotion campaign may be needed to encourage the use of toilets.
  * In urban areas, where the sewerage system is damaged, it may require solutions such as isolating parts of the system that work, installing portable toilets, using septic tanks and containment tanks that can be regularly desludged.
  * In the initial disaster phase, it may be necessary to mark off an area to be used as a defecation field or for trench latrines.

- Use of toilets is arranged by household(s) and/or segregated by sex. *(see guidance notes 3-5)*
  * Disaggregated population data should be used to plan the ratio of women's cubicles to men's (approximately 3:1).
  * Urinals should be provided for men if possible.
  * For families' shared facilities, families should be involved in the design, siting and maintenance.

- Separate toilets for women and men in public places (markets, distribution centres, health centres, etc.). *(see guidance note 3)*

- Shared or public toilets are cleaned and maintained to ensure their intended use. *(see guidance notes 3-5)*

- Toilets are no more than 50 metres from dwellings. *(see guidance note 5)*
  * Provide easy toilet access for PLWH/A.

- Toilets are used in the most hygienic way and children's faeces are disposed of immediately and hygienically *(see guidance note 6)*
  * Provide information about safe disposal of infant faeces and nappy (diaper) laundering practices.

2. Design, construction and use of toilets:
Toilets are sited, designed, constructed and maintained in such a way as to be comfortable, hygienic and safe to use.
Page 73

Key Indicators

- Users (especially women) have been consulted and approve of the siting and design of the toilet. *(see guidance notes 1-3)*

- Toilets are designed, built and located with the following features:
  * Appropriately designed for all sections of the population including children, elderly, pregnant women, and physically and mentally disabled people. *(see guidance note 1)*
  * Located to minimize threats to users, especially girls and women, day and night. *(see guidance note 2)*
  * Easy to keep clean and do not present a health hazard.
  * Provide a degree of privacy in line with the norms of the users.
  * Allow for the disposal of women's sanitary protection and privacy for women's washing and drying of sanitary protection cloths. *(see guidance note 4)*

* Minimize fly and mosquito breeding. *(see guidance note 7)*

- Adequate water supply for toilet flushing. *(see guidance notes 1 and 3)*

- Pit latrines and soakaways (for most soils) are at least 30 metres from any groundwater source and the bottom of any latrine is at least 1.5 metres above the water table. Drainage or spillage from defecation systems must not run towards any surface water source or shallow groundwater source. *(see guidance note 5)*

- People to wash their hands after defecation and before eating and food preparation. *(see guidance note 6)*
  * Soap or alternatives supplied for hand washing.

- Provide appropriate tools and materials for constructing, maintaining and cleaning the toilets. *(see guidance note 7)*

4. Vector Control

Sphere Minimum Standards

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 represent a significant risk to health or well-being.
Page 77

Key Indicators

- All populations at risk from vector-borne disease understand the modes of transmission and possible methods of prevention. *(see guidance notes 1-5)*
  * Vector control interventions should be based on assessment of potential risk and clinical evidence. Risk factors include immunity status of the population, pathogen type and prevalence, vector species, vector numbers and increased exposure to vectors.
  * Indicators for measuring the impact of vector control are vector-borne disease incidence rates and parasite counts.
  * Ensure timely provision of protection measures.

- Access for all to shelters that do not harbour or breed vectors and are protected by appropriate measures.

- Avoid exposure to mosquitoes during peak biting times using non-harmful means. Pay special attention to protect pregnant and feeding mothers,

babies, infants, elderly and the sick. *(see guidance note 3)*

- The people are educated to use treated mosquito nets effectively and correctly. *(see guidance note 3)*

- Control of human body lice is carried out where louse-borne typhus or relapsing fever is a threat. *(see guidance note 4)*

- Bedding and clothing are aired and washed regularly for effective protection against body lice. *(see guidance note 4)*

- Food is protected from vector contamination such as flies, insects and rodents.

2. Physical, environmental and chemical protection measures:
The numbers of disease vectors that pose a risk to people's health and nuisance vectors that pose a risk to people's well-being are kept to an acceptable level.
page 79

Key Indicators

- Displaced populations are settled in locations that minimize their exposure to mosquitoes.
  * for example 1-2km upwind from large breeding sites such as swamps, lakes and others.

- Vector breeding and resting sites are modified where practicable. *(see guidance notes 2-4)*
  * Properly dispose of human and animal excreta and refuse, and drainage of standing water.
  * Programme should be designed with the objectives to reduce vector population density, human vector contact and breeding sites.
  * Environmental mosquito control aims primarily at eliminating breeding sites which include good drainage, functioning VIP latrines, lids for squatting pit latrines, water containers and wells.

- Intensive fly control is carried out in high-density settlements when there is a risk or presence of a diarrhoea epidemic.

- Keep mosquito population density low to avoid the risk of excessive transmission levels and infection. *(see guidance note 4)*

- People with malaria are diagnosed early and receive treatment. *(see guidance note 5)*

3. Chemical control safety:
Chemical vector control measures are carried out in a manner that ensures that staff, the people affected by the disaster and the local environment are adequately protected and avoids creating resistance to the substances used.
page 81

Key Indicators

- Personnel are protected by the provision of training, protective clothing, use of bathing facilities, supervision and a restriction on the number of hours spent handling chemicals.

- The choice, quality, transport and storage of chemicals, application equipment and disposal of substances should follow international norms and be accounted for at all times. *(see guidance note 1)*

- Communities are informed about the potential risks of the substances used and about the application schedule. They are protected during and after the application, according to internationally agreed procedures. *(see guidance note 1)*

5. Solid Waste Management

Sphere Minimum Standards

1. Collection and disposal:
People have an environment that is acceptably uncontaminated by solid waste, including medical waste, and have the means to dispose of their domestic waste conveniently and effectively.
page 83

Key Indicators

- Affected population is involved in the design and implementation of the programme.

- Household waste is put in containers daily for regular collection, burnt or

buried in a specified refuse pit.

- All households have access to a refuse container and/or are no more than 100 metres from a communal refuse pit.

- At least one 100-litre refuse container per 10 families where domestic refuse is not buried on site.

- Remove refuse from the settlement before it becomes a nuisance or a health risk. *(see guidance notes 1,2 and 6)*
  * Waste buried on-site should be covered at least weekly with a thin layer of soil.
  * Encourage recycling if possible and avoid distributing commodities that produce large amounts of waste.
  * Waste management staff should be provided with protective clothing, water and soap.

- Medical wastes are separated 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. *(see guidance notes 3 and 6)*
  * Staff should be properly protected and trained about the risks.

- There should be no contaminated or dangerous medical wastes (needles, glass, dressings, drugs, etc) at any time in living areas or public spaces. *(see guidance note 3)*

- There are clearly marked fenced refuse pits, bins or specified areas at public places such as markets and slaughtering areas with a regular collection system. *(see guidance note 4)*

- Final disposal of solid waste is carried out in a place and a way to avoid health and environmental problems for the local and affected populations. *(see guidance notes 5-6)*

6. Drainage

Sphere Minimum Standards

1. Drainage works:
People have an environment in which the health and other risks posed by water erosion and standing water, including stormwater, floodwater, domestic wastewater and medical facilities wastewater are minimized.
page 86

Key Indicators

- Areas around dwellings and water points are free of standing wastewater and stormwater drains are kept clear. *(see guidance notes 1,2,4 and 5)*

- Shelters, paths, water and sanitation facilities are not flooded or eroded by water. *(see guidance notes 2-4)*

- Water point drainage is well planned, built and maintained, which includes drainage from washing, bathing areas and water collection points. *(see guidance notes 2 and 4)*
  * Involve affected population in the process.

- Drainage waters do not pollute existing surface or groundwater sources or cause erosion. *(see guidance note 5)*

- Sufficient number of appropriate tools are provided for small drainage works and maintenance where necessary. *(see guidance note 4)*.

CHAPTER 3

Minimum Standards in Food Security, Nutrition and Food Aid

Minimum Standards in Food Security, Nutrition and Food Aid

1. Food Security and Nutrition Assessment and Analysis

Sphere Minimum Standards

1. Food Security:
Where people are at risk of food insecurity, programme decisions are based on demonstrated understanding of how they normally access food, the impact of the disaster on current and future food security, and hence the appropriate response.
Page 111

Key Indicators

- Assessments and analyses examine food security in relevant geographic locations and livelihood groupings, distinguishing between seasons, and over time to identify and prioritize needs. *(see guidance note 1)*
  * Focus of the assessment should reflect how the affected population acquired food and income before the disaster and how the disaster has affected this.
  * Assessment to be carried out during programme phase out stage and prior to starting one.
  * Information gathered should complement secondary data from existing information sources.

- Assessment demonstrates understanding of the broader social, economic and political policies, institutions and processes that affect food security. *(see guidance note 2)*

- Assessment to include an investigation and analysis of the coping strategies. *(see guidance note 3)*

- Where possible, the assessment builds upon local capacities, including both formal and informal institutions. *(see guidance note 4)*

- The methodology used is comprehensively described in the assessment report and is seen to adhere to widely accepted principles. *(see guidance note 5)*
  * The approaches need to be coordinated among agencies and government.

* Triangulation of different sources and type of food security information is vital to arrive at a consistent conclusion across different sources.

- Use existing secondary data effectively so that collection of new primary data is focused on additional information needed for decision-making. *(see guidance note 6)*

- Recommended responses are designed to support, protect and promote livelihood strategies besides meeting immediate needs. *(see guidance note 7)*
  * Qualified technical personnel and communities must be involved from planning to assessment.
  * Assessment team should include sectoral experts and other appropriate experts.

- The impact of food insecurity on the population's nutritional status is considered. *(see guidance note 8)*
  * Should not overlook other possible contributing factors such as health and care causal factors.

2. Nutrition:
Where people are at risk of malnutrition, programme decisions are based on demonstrated understanding of the causes, type, degree and extent of malnutrition and the most appropriate response.
Page 115

Key Indicators

- Before conducting an anthropometric survey, information on the underlying causes of malnutrition (food, health and care) is analyzed and reported, highlighting the nature and severity of the problem(s) and those groups with the greatest nutritional and support needs. *(see guidance note 1 and General Nutrition Support standard 2, p. 140)*
  * Causal information can be gathered from primary and secondary sources including existing health and nutrition profiles, research reports, early warning information, health centre records, food security reports and quantitative and qualitative information from community welfare groups.

- Opinions of community and other local stakeholders on the causes are considered. *(see guidance note 1)*

- Anthropometric surveys are conducted only where information and

analysis is needed to inform programme decision-making. *(see guidance note 2)*

* In acute time sensitive crisis, anthropometric survey findings are used to correct malnutrition responses rather than the initial general food distribution plan.

- International anthropometric survey guidelines and national guidelines are adhered to for determining the type, degree and extent of malnutrition. *(see guidance note 3)*
  * Widely accepted practice is to assess malnutrition levels in children aged 6-59 months.
  * If other groups face greater risk, they should be assessed.
  * International guidelines stipulate a representative sample is used that provides trends data rather than a single prevalence figure.
  * National guidelines can promote co-ordination and comparability in reporting.
  * Immunisation coverage rates and retrospective mortality data can be simultaneously gathered.

- Where anthropometric surveys are conducted for children under five years, international weight-for-height reference values are used for reporting malnutrition in Z scores and percentage of the median for planning purposes. *(see guidance note 3)*

- Micronutrient deficiencies are determined. *(see guidance note 4)*

- Responses recommended after nutrition assessment build upon and complement local capacities in a coordinated manner.

2. Minimum Standards in Food Security

Sphere Minimum Standards

1. General food security:
People have access to adequate and appropriate food and non-food items in a manner that ensures their survival, prevents erosion of assets and upholds their dignity.
Page 120

Key Indicators

- Where people's lives are at risk due to lack of food, responses prioritize meeting their immediate food needs. *(see guidance note 1)*
  * In urban areas, priority may be to re-establish normal market arrangements and revitalize economic activities.
  * Co-ordinate with other agencies for a combined and complementary response.
  * General food distribution may not be appropriate when adequate supplies are available in the area (and the need is to address obstacles to access); localized lack of food availability can be addressed by support of market systems; local attitudes or policies are against free food handouts.

- In all disaster contexts, measures are taken to support, protect and promote food security, including preserving productive assets or recovering those lost as a result of the disaster. *(see guidance note 2)*
  * Support measures to include advocacy.
  * Existing strategies that contribute to household food security should be protected and supported.
  * Recovery of assets seeks to prevent further erosion and promote a process of recovery.

- Responses based on sound analysis in consultation with disaster-affected community.

- Responses take account of people's coping strategies, their benefits and any associated risks and costs. *(see guidance note 3)*
  * Risks can be incurred as a result of cutbacks in food intake or diet quality; cutbacks on school fees and health care; prostitution and external relationship to secure food dignity; sale of household assets; failure to repay loans; over use of natural resources; travel to insecure areas; producing and trading in illicit goods; separation of families and mothers from children.

- Transition and exit strategies are developed for all food security responses and are publicized and applied as appropriate. *(see guidance note 4)*
  * These strategies must be considered from the onset especially where the response has long term implications.
  * Before closing programme or transiting to a new phase, there must be clear evidence of situation improvement.

- When a response supports the development of new or alternative livelihood strategies, all groups (including children orphaned as a result of AIDS) have access to support including knowledge, skills and services. *(see guidance note 5)*
  * Structures that provide relevant services should be designed and

planned together with users.

- Responses have the least possible degradative effect on the environment. *(see guidance note 6)*

- Numbers of beneficiaries are monitored to determine the level of acceptance and access by different groups and to ensure overall coverage without discrimination. *(see guidance note 7)*
  * Overcoming constraints such as workload at home, responsibilities for caring for children, chronically ill or disabled and others may limit participation of women, people with disabilities and older people and involves identifying activities that are within the capacity of these groups or setting up appropriate support structures.
  * Targeting mechanism based on self-selection should be established with all groups in the community.

- Effects of responses on the local economy, social networks, livelihoods and the environment are monitored, in addition to ongoing monitoring linked to programme objectives. *(see guidance note 8)*
  * Monitor the wider food security situation in order to assess the continued relevance of the programme, phase out of specific activities, modifications, new projects and to identify any need for advocacy.
  * Local and regional food security information systems, including famine early warning systems are important sources of information.

2. Primary Production:
Primary production mechanisms are protected and supported.
Page 124

Key Indicators

- Interventions to support primary production are based on a demonstrated understanding of the viability of production systems, including access to and availability of necessary inputs and services. *(see guidance note 1)*

- New technologies are introduced only where their implications for local production systems, cultural practices and environment are understood and accepted by food producers. *(see guidance note 2)*
  * As far as possible, food production should follow existing patterns and/or be linked with national development plans.
  * Introduce only new technologies that are appropriate or previously tested in the local area.
  * Capacity within local government departments, NGOs and others to

facilitate this should be assessed and reinforced.

- A range of inputs provided to give producers more flexibility in managing production, processing and distribution and in reducing risks. *(see guidance note 3)*
  * Production should not have negative nutritional implications.

- Productive plant, animal or fisheries inputs are delivered in time, are locally acceptable and conform to appropriate quality norms. *(see guidance notes 4-5)*
  * Timing to coincide with agricultural and husbandry seasons, drought conditions.
  * Priority to be given to local seed. Seeds originating from outside the region must be certified and checked for appropriateness.
  * Government policies regarding hybrid seeds should be complied with before distribution.
  * Genetically modified (GMO) seeds should not be distributed unless approved by the national or other ruling authorities.

- Introduction of inputs and services does not exacerbate vulnerability or increase risk, e.g. by increasing competition for scarce natural resources or by damaging existing social networks. *(see guidance note 6)*
  * Provision of financial resources (loans or grants) may increase the risk of local insecurity.
  * Free provision of input may disturb traditional mechanisms for social support and redistribution.

- Inputs and services are purchased locally whenever possible, unless this would adversely affect local producers, markets or consumers. *(see guidance note 7)*

- Food producers, processors and distributors receiving project inputs make appropriate use of them. *(see guidance notes 8- 9)*
  * Indicators of the process and the outputs from food production, processing and distribution may be estimated.
  * Quality of input reviewed in terms of their acceptability and producer preferences.
  * Evaluate how project has affected food available to the household.
  * Where project aims to increase production of a specific food type, households' use of these products should be investigated and the result cross-validated with nutritional surveys.

- Responses understand the need for complementary inputs and services and provide these where appropriate.

3. Income and employment:
Where income generation and employment are feasible livelihood strategies, people have access to appropriate income-earning opportunities, which generate fair remuneration and contribute towards food security without jeopardizing the resources on which livelihoods are based.
Page 128

Key Indicators

- Project decisions about timing, work activities, remuneration and the technical feasibility of implementation are based on a demonstrated understanding of the local human resource capacities, a market and economic analysis and an analysis of demand and supply for relevant skills and training needs. *(see guidance notes 1-2)*
  * Where large numbers of displaced people exist, employment opportunities should not be at the expense of the local host population.
  * Understand household management and use of cash to determine the form of microfinance service to support food security.
  * FFW (food for work) preferred over CFW (cash for work) where markets are weak or unregulated or food is scarce.
  * FFW appropriate where women are likely to control use of food rather than of cash.
  * People's purchasing needs and the impact of giving either cash or food or other basic needs (school attendance, health services, social obligations) should be considered.
  * Type and level of remuneration to be decided on a case-by-case basis.

- Responses providing job or income opportunities are technically feasible and all necessary inputs are available on time. Where possible, responses contribute to the food security of others and preserve or restore the environment.

- Remuneration is appropriate, and payments for waged labour are prompt, regular and timely. In situations of acute food insecurity, payments may be made in advance. *(see guidance note 3)*
  * Remuneration takes account of needs of food-insecure households and local labour rates.
  * Where remuneration is in kind, the local food resale value must be considered.
  * Net income gain from individual programme participation should be greater than time spent on other activities.
  * FFW, CFW, credit, business start-up etc to enhance the range of income sources and not replace existing ones.
  * Remuneration should not have a negative impact on local labour

markets.

- Procedures in place to provide a safe, secure working environment. *(see guidance note 4)*

- Projects involving large sums of cash include measures to avoid diversion and/or insecurity. *(see guidance note 5)*
  * Balance the security risks faced by programme staff and recipients by reviewing various options.

- Responses providing labour opportunities protect and support household caring responsibilities and do not negatively affect the environment or interfere with regular livelihood activities. *(see guidance note 6)*
  * Child care or other caring responsibilities should not be undermined.
  * Consider employing care providers or providing care facilities.
  * Should not adversely affect access to other opportunities such as other employment, education or divert household resources from existing productive activities.

- Household management and use of remuneration (cash or food), grants or loans are understood and seen to be contributing towards the food security of all household members. *(see guidance note 7)*
  * Fair remuneration means the income generated contributes significantly to food security.

4. Access to markets:
People's safe access to market goods and services as producers, consumers and traders is protected and promoted.
page 131

Key Indicators

- Food security responses are based on a demonstrated understanding of local markets and economic systems, and where necessary leads to advocacy for system improvement and policy change. *(see guidance notes 1-2)*
  * All affected groups including vulnerable groups should have access to markets.
  * Remuneration in food or inputs such as seeds, tools, shelter material, etc. should be preceded by market analysis. Where inputs are not available on the open market, despite being accessible through farmers' own networks, consideration should be given to their effect.
  * Analysis of governmental policies may be used for a joint agency approach to improve the situation.

- Producers and consumers have economic and physical access to operating markets with a regular supply of basic items including food at affordable prices. *(see guidance note 3)*
  * Factors which influence market access include political and security environment, culture or religion.

- Adverse effects of food security responses, including food purchases and distribution, on local markets and market suppliers are minimized. *(see guidance note 4)*
  * Take into account and monitor the effects of procurement of local and imported food.
  * An understanding of the household sale and purchases is important in determining the impact of food distribution programmes.

- There is increased information and local awareness of market prices and availability, of how markets function and policies that govern this. *(see guidance note 5)*
  * Be aware of market pricing controls and other policies that influence supply and demand.

- Basic food items and other essential commodities are available. *(see guidance note 6)*
  * Selection of food items for monitoring depends on local food habits.
  * Planning nutritionally adequate rations should depend on what food items are essential in a particular context.

- Negative consequences of extreme seasonal or abnormal price fluctuations are minimized. *(see guidance note 7)*
  * Interventions can minimize adverse effects.

3. Minimum Standards in Nutrition

i) General Nutrition Support

Sphere Minimum Standards

1. All groups:
The nutritional needs of the population are met.
Page 137

Key Indicators

- There is access to a range of foods – staple (cereal or tuber), pulses (or animal products) and fat sources – that meet nutritional requirements. *(see guidance note 1)*
  * Average population requirements are 2,100 kcals/person/day; 10-12% of total energy provided by protein; 17% of total energy provided by fat; adequate micronutrient intake through fresh or fortified foods.

- Access to vitamin A-, C- and iron rich or fortified foods or appropriate supplements. *(see guidance notes 2,3,5 and 6)*
  * Distribution mechanisms, choice of food aid commodities and discussion with affected populations could contribute to improved intra-household allocation.
  * Scurvy (vitamin C), pellagra (niacin), beri-beri (thiamine) and riboflavin are common diseases and should be tackled on a population wide as well as on an individual level.
  * Micronutrient deficiencies are difficult to identify in the initial phase of a disaster, except for Xerophthalmia (vitamin A) and goitre (iodine) which can be tackled by population wide interventions.

- Access to iodised salt for the majority (>90%) of households. *(see guidance notes 2,3, and 6)*

- Access to additional sources of niacin (eg pulses, nuts, dried fish) if the staple is maize or sorghum. *(see guidance notes 2-3)*

- Access to additional sources of thiamine (eg pulses, nuts, eggs) if the staple is polished rice. *(see guidance notes 2-3)*

- Access to adequate sources of riboflavin where people are dependent on a limited diet. *(see guidance notes 2-3)*

- Levels of moderate and severe malnutrition are stable at, or declining to, acceptable levels. *(see guidance note 4)*
  * Malnutrition trends might be indicated by health centre records, repeat anthropometric surveys, nutritional surveillance, screening or reports from the community.
  * Local institutions and communities should participate in monitoring activities, findings interpretation, and planning of responses.
  * Determining if malnutrition levels are acceptable requires analysis of population, morbidity and mortality rates, seasonal fluctuations, pre-emergency levels of malnutrition and the underlying causes of malnutrition.

- No cases of scurvy, pellagra, beri-beri or riboflavin deficiency. *(see guidance note 5)*

- Rates of xerophthalmia and iodine deficiency disorders are not of public health significance. *(see guidance note 6)*

2. At-risk groups:
The nutritional and support needs of identified at-risk groups are met.
Page 140

Key Indicators

- Infants under six are exclusively breastfed or, in exceptional cases, have access to an adequate amount of an appropriate breast milk substitute. *(see guidance notes 1-2)*
  * Milk substitutes should be used according to Codex Alimentarius standards and relactation encouraged where possible.
  * If infant formula is distributed, provide caregivers with advice and support on its safe use. Procurement and distribution must adhere to International Code of Marketing of Breastmilk Substitutes and relevant World Health Assembly resolutions.
  * Safe, acceptable, feasible, affordable replacement feeding is recommended for HIV positive women. Specific guidance and support should be provided for the first two years of the child's life.

- Children aged 6-24 months have access to nutritious, energy-dense complementary foods. *(see guidance note 3)*
  * Breastfeed for at least the first two years of life.
  * For children aged six months, it is recommended that 30% of the energy content of their diet comes from fat sources.
  * Households should have the means and skills to prepare suitable complementary food for children under 24 months.
  * Provide vitamin A supplement for children under aged 6-59 months where measles/other immunization is carried out.
  * Iron supplementation can benefit low-birth weight infants and young children.

- Pregnant and breastfeeding women have access to additional nutrients and support. *(see guidance note 4)*

- Specific attention to be paid to protection, promotion and support of the care and nutrition of adolescent girls. *(see guidance note 4)*

- Appropriate nutritional information, education and training given to relevant professionals, care givers and organizations on infant and child feeding practices. *(see guidance notes 1-4 and 8)*

* Support care givers in the care of vulnerable groups, including feeding, hygiene, health, psychosocial support and protection.

- Older people's access to appropriate nutritious foods and nutritional support is protected, promoted and supported. *(see guidance note 5)*
  * Easy access to food sources (including relief food).
  * Food should be easy to prepare and consume and should meet additional protein and micronutrient requirements of older people.

- Families with chronically ill members, including PLWH/A, and members with specific disabilities have access to appropriate nutritious food and adequate nutritional support. *(see guidance notes 6-8)*
  * Ensure PLWH/A are kept well nourished and healthy to delay the onset of AIDS.
  * Ensure disabled people have physical access to food and feeding support.Community-based systems are in place to ensure appropriate care of vulnerable individuals. *(see guidance note 8)*

ii) Correction of Malnutrition

Sphere Minimum Standards

1. Moderate malnutrition:
Moderate malnutrition is addressed.
Page 145

Key Indicators

- From the onset, clearly defined and agreed objectives and criteria for set-up and closure of the programme are established. *(see guidance note 1)*
  * Targeted supplementary feeding programmes implemented only when anthropometrics surveys have been conducted or are planned and if the underlying causes of moderate malnutrition are being addressed simultaneously.
  * Targeted supplementary feeding programmes may be short term before General nutrition support standard 1 is met. The purpose should be clearly communicated and discussed with target population.

- Coverage is >50% in rural areas, >70% in urban areas and >90% in a camp situation. *(see guidance note 2)*
  * Calculated in relation to the target population, defined at the start of the programme.
  * Acceptability of the programme, location of distributions points,

security for staff and those requiring treatment, waiting times, service quality and the extent of home visiting can affect the program.

- More than 90% of the target population is within <1 day's return walk (including treatment time) of the distribution centre for dry ration supplementary feeding programmes and no more than 1 hour's walk for on-site supplementary feeding programmes. *(see guidance note 2)*
  * Affected communities to decide the location of distribution centres based on wide consultation and non-discrimination grounds.

- Proportion of exits from targeted supplementary feeding programmes who have died is <3%, recovered is >75% and defaulted is <15%. *(see guidance note 3)*
  * The total of exited individuals is made up of those who have defaulted, recovered (including those who are referred) and died.

- Admission of individuals is based on assessment against internationally accepted anthropometrics criteria. *(see guidance note 4 and Appendix 5)*
  * Individuals may include PLWH/A or TB or disabled. Where emergency feeding programmes are overwhelming, community home-based support or TB treatment centres may be better alternatives to provide longer-term nutritional support.

- Targeted supplementary feeding programmes are linked to existing health structure and protocols are followed to identify health problems and refer accordingly. *(see guidance note 5)*
  * Delivery of services should take into account the capacity of existing health services.
  * Special consideration given to quality and quantity of supplementary food in areas with high prevalence of particular diseases (e.g. HIV/AIDS).

- Supplementary feeding is based on distribution of dry take-home rations unless there is a clear rationale for on-site feeding. *(see guidance note 6)*
  * On-site feeding only where security is a concern.
  * Ready-to-eat foods may be considered in the short term for populations displaced or on the move with clear information about preparation and the importance of continued breastfeeding for children under 24 months of age.

- Monitoring systems are in place. *(see guidance note 7)*
  * Systems should monitor community participation, programme acceptability, readmission rates, quantity and quality of provided food, programme coverage, admission and discharge rates and external factors.
  * Individual causes of readmission, defaulting and failure to recover should be investigated on an ongoing basis.

2. Severe malnutrition:
Severe malnutrition is addressed.
Page 148

Key Indicators

- From the onset, clearly defined and agreed criteria for set-up and closure of the programme are established. *(see guidance note 1)*
  * Therapeutic care centres should take into account the numbers and geographical spread of affected individuals, security situation, criteria for setting up and closing centres, capacity of existing health structures. Start only if there is a plan for remaining patients to complete their treatment at the end of the programme.

- Coverage is >50% in rural areas, >70% in urban areas and >90% in camp situations. *(see guidance note 2)*
  * Calculated in relation to the target population and estimated as part of an anthropometrics survey.
  * Acceptability of the programme, location of distribution points, security for staff and those requiring treatment, waiting times, service quality and the extent of home visiting can affect the programme.

- Proportion of exits from therapeutic care who have died is <10%, recovered is >75% and defaulted is <15%. *(see guidance notes 3-5)*
  * Time needed to achieve the exit indicators is 1-2 months.
  * The total of exited individuals is made up of those who have defaulted, recovered (including those who are referred) and died.
  * Mortality rates should be interpreted in the light of coverage rates and the severity of malnutrition treated. Where mortality rates affected by HIV-positive admissions is unknown, the figures should not be adjusted for these situations.
  * Discharge criteria should be adhered to.

- Discharge criteria include non-anthropometric indices such as good appetite and the absence of diarrhoea, fever, parasitic infestation and other untreated illness. *(see guidance note 4)*

- Mean weight gain is >8g per kg/person/day. *(see guidance note 6)*
  * A lower rate may be more acceptable for out-patient programmes because the risks and demands on the community can be lower.

- Nutritional and medical care is provided according to internationally recognized therapeutic care protocols. *(see guidance note 7)*
  * Clinical staff receive special training to implement treatment protocols.

* HIV positive as well as TB cases have equal access to therapeutic care.
* PLWH/A who do not meet admission criteria should be supported through a range of community home-based care.

- As much attention is attached to breastfeeding and psychosocial support, hygiene and community outreach as to clinical care. *(see guidance note 8)*
  * A breastfeeding corner may be set up to support mothers.
  * Caregivers of severely malnourished children often require social and psychosocial support to bring their children for treatment.

- A minimum of one feeding assistant for 10 in-patients.

- Constraints to caring for malnourished individuals and affected family members should be identified and addressed. *(see guidance note 9)*
  * Support carers through provision of advice, demonstrations and health and nutrition information.
  * Carers should be trained to deal with human rights violations.

3. Micronutrient malnutrition:
Micronutrient deficiencies are addressed.
Page 152

Key Indicators

- All clinical cases of deficiency diseases are treated according to WHO micronutrient supplementation protocols. *(see guidance note 1)*
  * Carefully train staff to ensure assessment is accurate.

- Procedures are established to respond efficiently to micronutrient deficiencies to which populations may be at risk. *(see guidance note 2)*
  * Prevention includes reduction of incidence diseases such as acute respiratory infection, measles, parasitic infection, malaria and diarrhoea that deplete micronutrient stores.

- Health staff are trained to identify and treat micronutrient deficiencies to which the population is most at risk. *(see guidance note 2)*
  * Treatment will involve active case finding, development of case definitions and treatment protocols.

4. Minimum Standards in Food Aid
i) Food Aid Planning

Sphere Minimum Standards

1. Ration planning:
Rations for general food distributions are designed to bridge the gap between the affected population's requirements and their own food resources.
Page 157

Key Indicators

- Rations for general distribution are designed on the basis of the standard initial planning requirements for energy, protein, fat and micronutrients, adjusted as necessary to the local situation. *(see guidance note 1, General nutrition support standards on pages 137-144 and Appendix 7)*
  - * Nutrition requirement should take into account what people can provide for themselves.
  - * Established agreed estimates on the average quantity of food to which people have access.

- Ration distributed reduces or eliminates the need for disaster affected people to adopt damaging coping strategies.

- When relevant, the economic transfer value of the ration is calculated and is appropriate for the local situation. *(see guidance note 2)*

2. Appropriateness and acceptability:
The food items provided are appropriate and acceptable to recipients and can be used efficiently at the household level.
Page 158

Key Indicators

- People are consulted during assessment or programme design on the acceptability, familiarity and appropriateness of food items, and results are factored into the programme decisions on the choice of commodities. *(see guidance note 1)*
  - * Food distributed must be consistent with their religious and cultural traditions, including any food taboos for pregnant or breastfeeding women.

* In assessment reports and requests to donors, choice of particular commodities should be explained.
* Ready to eat food must be provided when there is a lack of cooking facilities.

- When an unfamiliar food is distributed, instructions on its preparation in a locally palatable manner, with minimum nutrient loss, are provided to women and other people who prepare food, preferably in the local language. *(see guidance note 1)*

- People's ability to access cooking fuel, water, and cooking times and requirements for soaking, are considered when selecting commodities for distribution. *(see guidance note 2)*
  * Undertake a fuel assessment to avoid adverse effects to recipients' health when cooking, and without degradation to the environment.
  * When necessary establish a wood harvesting programme supervised for the safety of women and children who are main gatherers of firewood.
  * Provision of milled grain or grain mills will reduce cooking times and the amount of fuel required.

- When a whole grain cereal is distributed, recipients either have the means to mill or process it in a traditional home-based manner or have access to adequate milling/processing facilities reasonably close to their dwellings. *(see guidance note 3)*

- People have access to culturally important items, including condiments. *(see guidance note 4)*
  * Assessment should identify culturally important and essential condiments and determine the people's access to these items.

- No distribution of free or subsidized milk powder or of liquid milk as a single commodity. *(see guidance note 5)*

3. Food quality and safety:
Food distributed is of appropriate quality and is fit for human consumption.
Page 160

Key Indicators

- Food commodities conform to national (recipient country) and other internationally accepted standards. *(see guidance notes 1-2)*
  * Samples systematically checked at the point of delivery by the supplier

to ensure their quality is appropriate.
  * Whenever possible, commodities should be accompanied by phytosanitary/other inspection certificates to confirm their fitness for human consumption.
  * Where there is doubt or dispute, independent quality surveyors should inspect the consignment.

- Imported packaged food has a minimum of six-months shelf life on arrival in the country and is distributed before the expiry date or well within the "best before" period. *(see guidance note 1)*
  * Information on the age and quality of food consignments may be obtained from supplier certificates, quality control inspection reports, package labels, warehouse reports etc.

- There are no verifiable complaints about the quality of food distributed. *(see guidance note 3)*
  * Complaints should be followed up promptly and handled in a transparent and fair manner.

- Food packaging is sturdy, convenient for handling, storage and distribution and is not a hazard for the environment. *(see guidance note 4)*
  * Packaging should allow direct distribution without the need for repacking.

- Food packages labelled in an appropriate language with production date, "best before" date and nutrient content details.

- Storage conditions are adequate and appropriate, stores are properly managed and routine checks on food quality are carried out in all locations. *(see guidance note 5)*
  * Storage areas should be dry, hygienic, adequately protected from climatic conditions, uncontaminated by chemical or other residues, secured against pests such as insects and rodents.

ii) Food Aid Management

Sphere Minimum Standards

1. Food Handling:
Food is stored, prepared and consumed in a safe and appropriate manner at both household and community levels.
Page 163

Key Indicators

- No adverse health effects resulting from inappropriate food handling or preparation at any distribution site. *(see guidance note 1)*
  * Promote food hygiene practices and support measures compatible with local conditions and disease patterns.

- Recipients of food aid are informed about and understand the importance of food hygiene. *(see guidance note 1)*
  * Inform people on how to store food safely and provide care givers with information on the optimal use of household resources for child feeding and safe methods for food preparation.

- No complaints concerning difficulties in storing, preparing, cooking or consuming the food distributed. *(see guidance note 2)*

- Every household has access to appropriate cooking utensils, fuel and hygiene materials. *(see guidance notes 3-4)*
  * Each household should have at least one cooking pot, water storage containers with a capacity of 40 litres, 250g of soap/person/month, adequate fuel for food preparation.

- Individuals who cannot prepare food or cannot feed themselves have access to a carer who prepares appropriate food in a timely manner and administers feeding where necessary. *(see guidance notes 4-5)*
  * Provide access to grinding mills, other processing facilities, household-level food processing, clean water to help save time for other productive activities.
  * Some of those who require assistance include young children, older people, disabled people and PLWH/A.

- Where food is distributed in cooked form, staff have received training in safe storage, handling of commodities and the preparation of food and understand the potential health hazards caused by improper practices.

2. Supply chain management:
Food aid resources (commodities and support funds) are well managed, using transparent and responsive systems.
Page 165

Key Indicators

- Food aid resources reach the intended beneficiaries.

- Assessment is made of the local supply chain management (SCM) capabilities and logistics infrastructure and a co-ordinated, efficient SCM system is established, using local capacity where this is feasible. *(see guidance notes 1-2)*
  * It is important to coordinate the many different activities of the SCM.
  * Appropriate management and monitoring practices should be adopted to ensure all commodities are safeguarded until distribution to recipient households.

- The assessment considers the availability of locally sourced food commodities. *(see guidance note 3)*
  * Where different organizations are involved, purchases of commodities should be co-ordinated.
  * Other in-country sources of food may include loans or reallocations from existing food aid programmes or national grain reserves, and loans from, or swaps, with commercial suppliers.

- The award of contracts for SCM services is transparent, fair and open. *(see guidance note 4)*
  * Food aid packaging should not carry any politically or religiously motivated or divisive messages.

- Staff at all levels of the SCM system are adequately trained and observe procedures relating to food quality and safety. *(see guidance note 5)*
  * Experienced SCM practitioners and food aid managers should set up the SCM system and train staff.
  * Training should include staff of partner organisations.

- Appropriate inventory accounting, reporting and financial systems are in place to ensure accountability at all levels of the SCM system. *(see guidance notes 6-7)*
  * Supply chain managers establish systems to meet donors' specific reporting requirements, including delays and deviations, as well as the day-to-day management needs.
  * Reports shared in a transparent manner.
  * Sufficient stock of documentation and forms should be available at all locations where food aid is received, stored and/or dispatched to maintain an audit trail of transactions.

- Care is taken to minimize losses, including through theft, and all losses are accounted for. *(see guidance notes 8-10)*
  * Ensure security, capacity, access, quality, and that no hazardous goods have previously been stored in the premises.
  * Damaged commodities inspected by qualified inspectors.
  * Ensure disposal of unfit commodities is safe, certified where appropriate, and does not harm the environment or contaminate water sources.
  * In situations of armed conflict control systems to prevent loss and

theft must be established at all levels of the supply chain.
* Check stocks regularly to detect any diversion of food.
* If diversion of food is detected, take measures to ensure the integrity of the supply chain and to analyse and address broader political and security implications.

- Food pipeline monitored and maintained to avoid any interruption to distribution. *(see guidance note 11)*
  * Carry out regular pipeline analysis and share the information with those involved in the supply chain.
  * Regular tracking and forecasting of stock levels will highlight anticipated shortfalls or problems in time for solutions to be found.

- Information on the performance of the supply chain is provided to stakeholders on a regular basis. *(see guidance note 12)*
  * Use local media or traditional news dissemination methods to keep people informed of food supplies and operations. Women groups may be enlisted to help provide information.

3. Distribution:
The method of food distribution is responsive, transparent, equitable and appropriate to local conditions.
Page 168

Key Indicators

- Recipients of food aid are identified and targeted on the basis of need, by means of assessment carried out through consultations with stakeholders, including community groups. *(see guidance notes 1-2)*
  * Aid targeted to meet the needs of the most vulnerable without discrimination on gender, disability, religious or ethnic background etc.
  * Registration list to be completed as soon as possible and updated regularly. Women should have the right to register in their own names if they wish.

- Efficient and equitable distribution methods are designed in consultation with local groups, partner organizations and various recipient groups. *(see guidance notes 1-3)*
  * Monitor distribution methods to ensure that food is reaching intended recipients.
  * Pay special attention to vulnerable groups without adding to any stigma already experienced by these groups.

- Distribution points as close as possible to recipients' homes to ensure easy access and safety. *(see guidance notes 4-5)*
  * Factors to consider are distribution frequency, number of distribution points, travel time to/from centres, practicalities and cost of transporting commodities.
  * Waiting areas and potable water should be provided at distribution points.
  * Assess and minimize security risks to women, children, elderly and people with disabilities.
  * Measures to prevent, monitor and respond to gender-based violence or sexual exploitation associated with distribution may be necessary.

- Recipients are informed well in advance of the quality and quantity of the food ration and distribution plan. *(see guidance notes 6-7)*
  * Changes in the food basket or ration levels must be discussed with recipients through distribution committees or community leaders and a course of action jointly developed.
  * Recipients should be informed of reasons behind the changes, how long the change will persist and when normal rations will resume.
  * Ration quantities should be displayed prominently at distribution sites in the local language and/or pictorially.

- The performance and effectiveness of the food aid programme are properly monitored and evaluated. *(see guidance note 8)*
  * Monitoring and evaluation should be carried out at all levels of the supply chain.
  * At community level, random visits to households can ascertain acceptability, usefulness of the ration, identify people who meet the selection criteria but are not receiving aid, and ascertain if extra food is being received and its sources.
  * Consider the wider implications on the food distribution system (eg. agricultural cycle, agricultural activities, market conditions and availability of agricultural inputs).

CHAPTER 4

Minimum Standards in Shelter, Settlements and Non-Food Items

Minimum Standards in Shelter, Settlements and Non-Food Items

1. Shelter and Settlement

Sphere Minimum Standards

1. Strategic Plan:
Existing shelter and settlement solutions are prioritised through the return or hosting of disaster-affected households, and the security, health, safety and well-being of the affected population are ensured.
Page 211

Key Indicators

- Affected households return to the site of their original dwellings where possible. *(see guidance note 1)*

- Affected households who cannot return to the site of their original dwellings settle independently within a host community or with host families where possible. *(see guidance note 2)*
  * Shelter assistance may include support to expand or upgrade existing host family shelter and facilities or provision of a separate shelter adjacent to the host family.
  * Appraise and address increased demand on social and infrastructure of the host community.

- Affected households who cannot return to the site of their original dwellings or who cannot settle independently within a host community or with host families are accommodated in mass shelters or in temporary planned or self-settled camps. *(see guidance note 3)*
  * Mass shelter in large buildings or structures can provide temporary protection from the climate when there are insufficient resources.
  * Alternative structures, other than school buildings, should be sought, to enable schooling to continue for host and displaced communities.
  * Ensure collective settlements do not become targets for attack or pose a security risk.

- Actual or potential threats to the security of the affected populations are assessed and the dwellings or settlements are located at a safe distance from any external threats. *(see guidance note 4)*

- Risks from natural hazards including earthquakes, volcanic activity, landslides,

flooding or high winds are minimised, and the area is not prone to diseases or significant vector risks. *(see guidance notes 4-5)*

* Undertake a comprehensive risk and vulnerability assessment.
* Locations at risk should be avoided until the assessed risks have satisfactorily diminished.

- Locations are free of potentially hazardous equipment or material, and existing hazards such as dangerous structures, debris or unstable ground are identified and made safe, or access is restricted and guarded. *(see guidance notes 4,6 and 7)*
  * A suitably qualified person assess the stability of building structures.

- Land and property ownership and/or rights for buildings or locations are established prior to occupation and permitted use is agreed as necessary. *(see guidance note 8)*
  * Land or property rights of vulnerable groups should be identified and supported.

- Water and sanitation services, and social facilities including health care, schools and places of worship are available or can be satisfactorily provided. *(see guidance note 9)*

- The transportation structure provides appropriate accessibility to the settlement for personal services and provision of services. *(see guidance note 10)*
  * Assess access and conditions taking into account seasonal constraints, hazards and security risks.

- Where possible, households can access land, markets or services for livelihood support activities. *(see guidance note 11)*
  * Assess pre-disaster and post-disaster context to guide the settling of affected populations.
  * Vulnerable groups within a displaced or any host communities should be assessed and accommodated accordingly.

2. Physical Planning:
Local physical planning practices are used where possible, enabling safe and secure access to and use of shelters and essential services and facilities, as well as ensuring appropriate privacy and separation between individual household shelters.
Page 215

Key Indicators

- Area or cluster planning by family/neighbourhood/village groups as appropriate supports existing social networks, contributes to security and self-management by affected population. *(see guidance note 1)*
  * Cluster planning to be guided by existing social practices and provision of shared resources.
  * Plot layout maintains the privacy and dignity of households.
  * Safe, integrated living areas provided for vulnerable groups.
  * Principles of cluster planning also apply to dispersed settlements.

- All members of the affected population have safe access to water, sanitary facilities, health care, solid waste disposal, graveyards and social facilities including schools, places of worship, meeting points and recreational areas. *(see guidance notes 2-4)*
  * Social structure and gender roles of the affected population and the requirements of vulnerable groups should be reflected in the planning and provision of services.
  * Respect social customs in dealing with the remains of the dead.
  * Graveyards should be at least 30 metres from groundwater sources used for drinking water, and the bottom of any grave at least 1.5m above groundwater table.

- Temporary planned or self-settled camps are based on a minimum surface area of 45m^2 per person. *(see guidance note 5)*

- Surface topography is used or augmented to facilitate water drainage, and the ground conditions are suitable for excavating toilet pits where this is the primary sanitation system. *(see guidance note 6)*

- There are roads and pathways to provide safe, secure and all-weather access to individual dwellings and facilities. *(see guidance note 7)*

- Mass shelters have openings to enable required access to emergency evacuation and these openings are positioned so that access is well supervised. *(see guidance note 8)*
  * Occupants with walking difficulties should be located adjacent to exits or along access routes.

- Vector risks are minimised. *(see guidance note 9)*

3. Covered Living Space:
People have sufficient covered space to provide dignified accommodation. Essential household activities can be satisfactorily undertaken and livelihood support activities can be pursued as required.
Page 219

Key Indicators

- Initial covered floor area per person is 3.5m^2. *(see guidance notes 1-3)*

- Covered area enables safe separation and privacy between sexes, age groups and separate families within a given household as required. *(see guidance notes 4-5)*
  * Consult vulnerable groups and carers for mobility-impaired individuals.

- Essential household activities can be carried out within the shelter. *(see guidance notes 6 and 8)*

- Key livelihood support activities are accommodated where possible. *(see guidance notes 7-8)*
  * Other functions of shelter include territorial claims or rights, post-disaster psychosocial support and represent a major financial asset.

4. Design:
The design of the shelter is acceptable to the affected population and provides sufficient thermal comfort, fresh air and protection from the climate to ensure their dignity, health, safety and well-being.
Page 221

Key Indicators

- Design of the shelter and the materials used are familiar and culturally and socially acceptable. *(see guidance note 1)*

- Repair of existing damaged shelters or the upgrading of initial shelter solutions constructed by the disaster affected population is prioritised. *(see guidance note 2)*
  * Address security threats and risks from further natural disasters.

- Alternative materials are durable, practical and acceptable to the affected population. *(see guidance note 3)*

- Type of construction, materials used, size and position of openings provide optimal thermal comfort and ventilation. *(see guidance notes 4-7)*

- Access to water sources and sanitation facilities, and the appropriate provision of rainwater harvesting, water storage, drainage and solid waste management complement the construction of shelters. *(see guidance note 8)*
  * Identify pre-disaster practices and opportunities and constraints identified in the post-disaster situation.

- Vector control measures are incorporated into the design and materials are selected to minimise health hazards. *(see guidance note 9)*

5. Construction:
The construction approach is in accordance with safe local building practices and maximizes local livelihood opportunities.
Page 224

Key Indicators

- Locally sourced materials and labour used without adversely affecting the local economy and environment. *(see guidance notes 1-2)*

- Locally derived standards of workmanship and materials are achieved. *(see guidance note 3)*

- Construction and material specifications mitigate against future natural disasters. *(see guidance note 4)*

- Type of construction and materials used enable maintenance and upgrading using locally available tools and resources. *(see guidance note 5)*

- Procurement of materials and labour and the supervision of the construction process are transparent, accountable, in accordance with internationally accepted bidding, purchasing and construction administration practices. *(see guidance note 6)*

6. Environmental Impact:
The adverse impact of the environment is minimized by the settling of the disaster-affected households, the material sourcing and construction techniques used.
Page 227

Key Indicators

- Temporary or permanent settling of the affected population considers the extent of natural resources available. *(see guidance notes 1-2)*

- Natural resources are managed to meet ongoing needs of displaced and host populations. *(see guidance notes 1-2)*

- Production and supply of construction materials and the building process minimises long-term depletion of natural resources. *(see guidance notes 2-3)*
  * Assess pre- and post-disaster demands on natural resources, and alternative, complimentary, sustainable practices identified to minimize depletion.

- Trees/vegetation retained where possible to increase water retention, minimize soil erosion and provide shade. *(see guidance note 4)*

- Locations of mass shelters or temporary planned camps are returned to their original condition, unless otherwise agreed, once they are no longer needed for emergency shelter. *(see guidance note 5)*
  * Enhancement measures should be undertaken during the life of the temporary settlement.

2. Non-Food Items: Clothing, Bedding and Household Items

Sphere Minimum Standards

1. Clothing and bedding:
The people affected by the disaster have sufficient clothing, blankets and bedding to ensure their dignity, safety and well-being.
Page 230

Key Indicators

- Women, girls, men and boys have at least one full set of clothing in correct size, appropriate to the culture, season and climate. Infants and children up to two years old have a blanket of a minimum 100cmx70cm. *(see guidance notes 1-4)*

- People have access to a combination of blankets, bedding or sleeping mats to provide thermal comfort and to enable separate sleeping arrangements as required. *(see guidance notes 2-4)*
  * Insulated sleeping mats to combat heat loss may be more effective than providing additional blankets.
  * Clothing and bedding to be durable.

- Individuals most at risk to have additional clothing and bedding to meet their needs. *(see guidance note 5)*
  * People with incontinence problems, HIV/AIDS and associated diarrhoea, pregnant and lactating women, older people, disabled people and others with impaired mobility, infants and children may require particular attention.

- Culturally appropriate burial cloth is available when needed.

2. Personal hygiene:
Each disaster-affected household has access to sufficient soap and other items to ensure personal hygiene, health, dignity and well-being.
Page 232

Key Indicators

- Each person has access to 250g of bathing soap per month. *(see guidance notes 1-3)*
  * Provide culturally acceptable and familiar products to avoid misuse.
  * Consideration given to replacement of consumables.
  * Additional quantities provided where necessary to people with special needs.

- Each person has access to 200g of laundry soap per month. *(see guidance notes 1-3)*
  * Where culturally appropriate or preferred, washing powder, ash or clean sand can be promoted.
  * Consideration given to replacement of consumables.
  * Additional quantities provided where necessary to people with special needs.

- Women and girls have sanitary material for menstruation. *(see guidance note 4)*
  * Material should be appropriate and discreet and women should be involved in the decision making process.

- Infants and children up to two years old have 12 washable nappies or diapers where these are typically used.

- Additional essential items for personal hygiene, dignity and well-being can be accessed. *(see guidance note 5)*
  * Social and cultural practices may require additional personal hygiene items to be provided, if available.

3. Cooking and eating utensils:
Each disaster-affected household has access to cooking and eating utensils. *Page 233*

Key Indicators

- Each household has access to a large-sized cooking pot with handle and a pan to act as a lid; a medium-sized cooking pot with handle and lid; a basin for food preparation or serving; a kitchen knife and two wooden serving spoons. *(see guidance note 1)*
  * Items provided should be culturally appropriate and enable safe practices to be followed.
  * Women or those overseeing food preparation should be consulted.
  * Items should suit older people, people with disabilities and children.

- Each household has access to two 10-20 litre water collection vessels with a lid or cap (20-litre jerry can with a screw cap or 10-litre bucket with lid), plus additional water or food storage vessels. *(see guidance notes 1-2)*
  * Use only food grade plastic.
  * Women or those overseeing water collection should be consulted.
  * Items should suit older people, people with disabilities and children.

- Each person has access to a dished plate, a metal spoon and a mug or drinking vessel. *(see guidance notes 1-4)*
  * Provide only stainless steel or non-ferrous metal.
  * Infant feeding bottles should not be provided unless under exceptional circumstances.
  * Items should be culturally appropriate and enable safe practices to be followed.
  * Women or those overseeing food preparation should be consulted.

* Items should suit older people, people with disabilities and children.

4. Stoves, fuel and lighting:
Each disaster-affected household has access to communal cooking facilities or a stove and an accessible supply of fuel for cooking needs and to provide thermal comfort. Each household has access to appropriate means of providing sustainable artificial lighting to ensure personal security.
Page 234

Key Indicators

- Where food is cooked on an individual basis, each household has a stove and fuel to meet essential cooking and heating needs. *(see guidance notes 1-2)*
  * Consider existing local practices and promote energy-efficient cooking practices.
  * In mass shelters communal or centralized cooking and heating facilities are preferred to minimize fire and smoke pollution.
  * Stoves designed, fitted and positioned to ensure adequate ventilation and minimise pollution, respiratory problems and fire.

- Environmentally and economically sustainable sources of fuel are identified and prioritized over fuel provided from external sources. *(see guidance note 3)*

- Fuel obtained in a safe and secure manner with no reports of incidents of harm to people in the routine of fuel collection. *(see guidance note 4)*
  * Women are consulted to address location and safety issues on collecting fuel.
  * Demands of collecting fuel by vulnerable groups should be addressed.
  * Special provisions, such as less labour-intensive fuels, fuel-efficient stoves and accessible fuel sources should be considered where possible.

- Safe fuel storage space is available.

- Each household has access to sustainable means of providing artificial lighting, e.g. lanterns or candles.

- Each household has access to matches or a suitable alternative means of lighting fuel or candles, etc.

5. Tools and Equipment:
Each disaster-affected household responsible for the construction or maintenance and safe use of their shelter has access to the necessary tools and equipment.
Page 236

Key Indicators

- Where responsible for constructing part or all of their shelters or carrying out essential maintenance, each household has access to tools and equipment to safely undertake tasks. *(see guidance notes 1-2)*
  * Tools should be easily repaired locally with available technologies.
  * Displaced communities have access to sufficient tools for excavation and to handle deceased's remains.
  * Tools should support appropriate livelihood activities.

- Training or guidance on the use of tools and in shelter construction or maintenance is provided where necessary. *(see guidance note 3)*
  * Female-headed households and vulnerable groups may require assistance from extended families members, neighbours or contracted workers.

- Materials to reduce the spread of vector-borne disease, such as impregnated mosquito nets, are provided to protect each member of the household. *(see Vector control standards 1-3, pages 76-82)*

CHAPTER 5

Minimum Standards in Health Services

Minimum Standards in Health Services

1. Health Systems and Infrastructure

Sphere Minimum Standards

1. Prioritising health services:
All people have access to health services that are prioritised to address the main causes of excess mortality and morbidity.
Page 259

Key Indicators

- Major causes of mortality and morbidity are identified, documented and monitored.

- Priority health services include the most appropriate and effective interventions to reduce excess morbidity and mortality. *(see guidance note 1)*
  * Priority health interventions include adequate supplies of safe water, sanitation, food and shelter, infectious disease control, basic clinical care and disease surveillance.
  * Expanded clinical services, including trauma care, are given higher priority following disasters that have large numbers of injuries e.g. earthquakes.

- Community members, including vulnerable groups, have access to priority health interventions. *(see guidance note 2)*
  * Location and staffing of health services ensures optimal access and coverage and addresses the needs of vulnerable groups.
  * Those unable to afford fees have access to services through fee waivers, vouchers etc.

- Local health authorities and community members participate in the design and implementation of priority health interventions.

- Active collaboration with other sectors in the design and implementation of priority health interventions, including water and sanitation, food security, nutrition, shelter and protection.

- Crude mortality rate (CMR) maintained at, or reduced to, less than twice the baseline rate documented for the population prior to the disaster. *(see guidance note 3)*

* If baseline is unknown, aim to maintain CMR below 1.0/10,000/day.

- Under-5 mortality rate (U5MR) is maintained at, or reduced to, less than twice the baseline rate documented for the population prior to the disaster. *(see guidance note 3)*
  * If baseline is unknown, aim to maintain U5MR at 2.0.

2. Supporting national and local health systems:
Health services designed to support existing health systems, structures and providers.
Page 261

Key Indicators

- Ministry of Health representatives lead the health sector response, whenever possible.

- When Ministry of Health lacks capacity, an alternate agency with requisite capacity identified to take the lead in the health sector. *(see guidance notes 1-2)*
  * Lead health authority to ensure responding health agencies support and strengthen capacities of local health systems and ensure the health activities of health agencies are coordinated and complementary.
  * Lead health authority to develop an overall strategy and policy for the response after consultation with relevant agencies and community representatives.

- Local health facilities are supported and strengthened by responding agencies. *(see guidance notes 1-2)*

- Local health workers are supported and integrated into health services taking account of gender and ethnic balance. *(see guidance note 3)*

- Health services incorporate or adapt the existing national standards and guidelines of the disaster-affected or host country. *(see guidance note 4)*
  * Review standards and guidelines with MOH or lead health authority early in the response and update practices that are outdated/ inappropriate.

- No alternate or parallel health facilities and services are established, including foreign field hospitals, unless local capacities are exceeded or population does not have ready access to existing services. Lead health authority to be consulted on this issue. *(see guidance note 5)*

* A field hospital may be deployed when existing hospitals are not functioning properly.
* Field hospital must have a well-defined need, provide appropriate services, be cost effective and should not drain the local resources.

3. Coordination:
People have access to health services that are coordinated across agencies and sectors to achieve maximum impact.
Page 263

Key Indicators

- Coordination mechanisms established at central level (national/regional) and at field level within health sector and between other sectors.

- Specific responsibilities of each health agency are clarified and documented in consultation with the lead health authority to ensure optimal coverage and complementarity of services. *(see guidance note 1)*

- Regular health sector coordination meetings for local and external partners at central and field levels. *(see guidance note 2)*
  * Weekly meetings, initially, to share information, identify and monitor priorities, develop strategies, allocate tasks and standardise protocols and interventions.

4. Primary Health Care:
Health services are based on relevant primary health care principles.
Page 264

Key Indicators

- All have access to health information that allows them to protect and promote their health and well-being. *(see guidance note 1)*
  * Health education and promotion should be initiated in consultation with health authorities and community representatives.
  * Information should include major endemic health problems, major health risks, availability and location of health services, behaviours that protect and promote good health, using appropriate language and media and be culturally sensitive.
  * Messages should be consistent among implementing health agencies.

- Health services provided at appropriate level of the health system: household/community, peripheral health facilities, central health facilities, referral hospital. *(see guidance note 2)*
  * Mobile clinics may be needed to meet the needs of isolated or mobile communities with limited access to care. They should be introduced only after consultation with lead health authority and local health representatives.

- A standardised referral system is established by the lead health authority and utilised by health agencies. Suitable transportation is organised for patients to reach the referral facility.

- Health services and interventions are based on scientifically sound methods and are evidence-based, whenever possible.

- Health services and interventions utilise appropriate technology and are socially and culturally acceptable.

5. Clinical services:
People have access to clinical services that are standardised and follow accepted protocols and guidelines.
Page 266

Key Indicators

- The number, level and location of health facilities are appropriate to meet the population needs. *(see guidance notes 1-2)*

- The number, skills and gender/ethnic balance of staff at each health facility are appropriate to meet the needs of the population. *(see guidance notes 1-2)*
  * Ensure the presence of one female health worker or a representative of a minority ethnic group to encourage women or minority groups to access health services.
  * The following is a guide to staffing levels and may need to be adapted contextually. A "qualified health worker" refers to a formally trained clinical provider such as a physician, nurse, clinical officer or medical assistant.
  a) Community level: One community health worker per 500-1,000 population; one skilled/traditional birth attendant per 2,000 population; one supervisor per 10 home visitors; one senior supervisor.
  b) Peripheral health facility (approx. 10,000 population): total of 2-5 staff, minimum one qualified health worker, based on one clinician/50

consultations/day; non-qualified staff for administering oral rehydration (ORT), dressings, etc, registration, administration etc.

c) Central health facility (approx. 50,000 population); minimum of 5 qualified health workers, minimum one doctor; one qualified health worker/50 consultations/day (out patient care); one qualified health worker/20-30 beds, 24 hour services (in-patient care). One non-qualified health worker for administering ORT; one/two for pharmacy; one/two for dressings, injections, sterilisation. One lab technician. Non-qualified staff for registration, security, etc.

d) Referral hospital: variable. At least one doctor with surgical skills; one nurse for 20-30 beds/shift.

- Adequate clinical staff to handle not more than 50 patients/day. If this threshold is regularly exceeded, additional clinical staff are recruited. *(see Appendix 3)*

- Utilisation rates at health facilities are monitored and corrective measures taken if there is over- or under-utilisation. *(see guidance note 3)*
  * Average utilisation rate among displaced populations is 4.0 new consultations/person/year.
  * Gender, age, ethnic origin and disability should be considered in analysing utilisation rates to ensure that vulnerable groups are not under-represented.

- Standardised case management protocols are established by the lead health authority, and adhered to by health agencies. *(see guidance note 4)*
  * Protocols should be reviewed in consultation with Ministry of Health or lead health authority early in the disaster response to determine their appropriateness.
  * If protocols do not exist, guidelines established by WHO or UNHCR should be followed, e.g. New Emergency Health Kit.

- A standardised essential drug list established by lead health authority and adhered to by health agencies. *(see guidance note 4)*
  * Essential drug lists should be reviewed in consultation with Ministry of Health or lead health authority early in the disaster response to determine their appropriateness.
  * If drug lists do not exist, guidelines established by WHO or UNHCR should be followed, e.g. New Emergency Health Kit.

- Clinical staff are trained and supervised in the use of protocols and the essential drug list. *(see guidance notes 5-6)*
  * As far as possible, training programmes should be standardised and linked to national programmes.
  * As much as possible, health personnel should safeguard a patient's right to privacy, confidentiality and informed consent.

- People have access to a consistent supply of essential drugs through a standardised drug management system that follows accepted guidelines. *(see guidance note 7)*
  * The drug management system should be efficient, cost-effective and rational, based on the four elements of the drug management cycle: selection, procurement, distribution and use.

- Drug donations are accepted only if they follow internationally recognised guidelines. Donations that do not follow these guidelines are not used and are safely disposed.

- Bodies of the deceased are disposed in a dignified and culturally appropriate manner and based on good public health practice. *(see guidance note 8)*
  * Where there is high mortality, bodies should not be disposed of unceremoniously in mass graves. Human remains pose health risks and require specific precautions in only a few special cases.
  * Families should have the opportunity to conduct culturally appropriate funerals and burials.
  * When those being buried are victims of violence, forensic issues should be considered.

6. Health information systems:
The design and development of health services are guided by the ongoing, coordinated collection, analysis and utilisation of relevant public health data. *Page 270*

Key Indicators

- A standardised health information system (HIS) is implemented by all health agencies to routinely collect relevant data on demographics, mortality, morbidity and health services. *(see guidance notes 1-2 and Appendices 2-3)*
  * Build HIS on pre-existing surveillance system whenever possible unless a new or parallel system is required, to be determined in consultation with the lead health authority.
  * Disaster health data should include, but not be limited to, the crude mortality rate, under-5 mortality rate, proportional mortality, cause-specific mortality rate, incidence rates for most common diseases, health facility utilisation rate and number of consultations/clinician/day.
  * Data disaggregated by age and sex as far as possible to guide decision-making.
  * Mortality and morbidity for children under-five should be documented from the outset. More detailed desegregation should be sought such

as (0-11 months, 1-4 years, 5-14 years, 15-49 years, 50-59 years, 60+ years) and gender.

- A designated HIS coordinating agency or (agencies) to organise and supervise the system.

- Health facilities and agencies submit surveillance data to the designated HIS coordinating agency on a regular basis eg daily, weekly, monthly, depending on the context.

- Agencies take adequate precautions for the protection of data to guarantee the rights and safety of individuals and/or populations. *(see guidance note 3)*
  * Data that relates to trauma caused by torture or other human rights violations must be treated with the utmost care. Consideration may be given to passing on information if the individual gives their consent.

- HIS includes an early warning component to ensure timely detection of and response to infectious disease outbreaks. *(see Control of communicable diseases standard 5, page 281)*

- Supplementary data from other relevant sources are consistently used to interpret surveillance data and guide decision-making. *(see guidance note 4)*

2. Control of Communicable Diseases

Sphere Minimum Standards

1. 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.
Page 274

Key Indicators

- General prevention measures are developed and implemented in coordination with other relevant sectors. *(see guidance note 1)*
  * Measures include:
  a) Water and sanitation: sufficient water quantity and quality; sufficient sanitation; hygiene promotion; vector control, etc. *(see water, sanitation and hygiene promotion, page 51)*

b) Food security, nutrition and food aid: access to adequate food and management of nutrition. *(see Food security, Nutrition and Food Aid, page 103)*
c) Shelter: sufficient and adequate shelter. *(see shelter, settlement and non-food items, page 203)*

- Community health education messages provide individuals with information on how to prevent common communicable diseases and how to access relevant services. *(see Health systems and infrastructure standard 4, page 264)*

- Specific prevention measures, such as a mass measles vaccination campaign and Expanded Programme on Immunisation (EPI), are implemented as indicated. *(see guidance note 2 and control of communicable diseases standard 2)*

2. Measles prevention:
All children aged 6 months to 15 years have immunity against measles.
Page 275

Key Indicators

- An estimation of measles vaccination coverage of children aged 9 months to 15 years is made at the outset of the emergency response, to determine the prevalence of susceptibility to measles. *(see guidance note 1)*
  * Mass measles vaccination campaigns be given the highest priority at the earliest possible time.
  * If the vaccination coverage for the population is unknown, campaign should assume that coverage is inadequate.

- If estimated vaccination coverage is <90%, a mass measles vaccination campaign for children aged 6 months to 15 years (including administration of Vitamin A to children aged 6-59 months) is initiated. The vaccination campaign is coordinated with national and local health authorities including the EPI. *(see guidance note 2)*
  * In resource poor settings, priority given to children aged 6-59 months.

- Upon completion of a campaign:
  * At least 95% of children aged 6 months to 15 years have received measles vaccination;
  * At least 95% of children aged 6-59 months received an appropriate dose of vitamin A.

- All infants vaccinated between 6-9 months of age receive another dose of measles vaccine upon reaching 9 months. *(see guidance note 3)*
  * Except those who received their first dose after 8 months of age.
  * These children should receive the repeat dose after a minimum interval of 30 days.

- Routine ongoing vaccination of 9 month old children is established to maintain minimum 95% coverage. This system is linked to the EPI.

- For mobile or displaced populations an ongoing system is established to ensure at least 95% of newcomers aged between 6 months to 15 years receive vaccination against measles.

3. 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.
Page 277

Key Indicators

- Standardised case management protocols for diagnosis and treatment of the most common infectious diseases are consistently used. *(see guidance note 1; Health systems and infrastructure standard 5)*
  * Incorporate in-country integrated management of childhood illness and adapted clinical guidelines into the standardised protocols.

- Public health education messages encourage people to seek early care for fever, cough, diarrhoea, etc, especially children, pregnant women and older people.

- In malaria-endemic regions, a protocol is established to ensure early (<24 hours) diagnosis of fever cases and treatment with highly effective first-line drugs. *(see guidance note 2)*
  * Because of widespread and increasing resistance to some anti-malarial drugs or for non-immune and vulnerable populations exposed to falciparum malaria more efficacious anti-malarial drugs may be required.
  * Determine drug choice in consultation with the lead heath authority following drug efficacy data. Standardised WHO protocols should be used.

- Laboratory services are available and utilised as indicated. *(see guidance*

note 3)

* Identify an established laboratory, either nationally or in another country. Guidelines on correct specimen collection and transportation will be required.

- A tuberculosis control programme is introduced only after consideration of recognised criteria. *(see guidance note 4)*
  * Implemented TB control programme should be integrated with national/host country programme and follow well-established DOTS strategy (Directly-Observed Therapy, Short-course.)

4. Outbreak preparedness:
Measures are taken to prepare for and respond to outbreaks of infectious diseases.
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Key Indicators

- An outbreak investigation and control plan is prepared. *(see guidance note 1)*
  * Following issues should be addressed:
  a) Circumstances under which an outbreak control team is to be convened;
  b) Composition of outbreak control team including representatives from appropriate sectors;
  c) Specific roles and responsibilities of organisations and positions on the team;
  d) Arrangements for consulting and informing authorities at local and national level;
  e) The resources/facilities available to investigate and respond to outbreaks.

- Protocols for the investigation and control of common outbreaks are available and distributed to relevant staff.

- Staff receive training in the principles of outbreak investigation and control, including relevant treatment protocols.

- Reserve stocks of essential drugs, medical supplies, vaccines and basic protection material are available and can be procured rapidly. *(see guidance note 2)*
  * On-site reserves should include material to use in response to likely outbreaks.

* Single use/auto-destruct syringes and safe needle containers should be available.

- Sources of vaccines for relevant outbreaks (e.g. measles, meningococcal meningitis, yellow fever) are identified for rapid procurement and use. Mechanisms for rapid procurement are established. *(see guidance note 2)*

- Sites for isolation and treatment of infectious patients are identified in advance e.g. cholera treatment centres.

- A laboratory is identified, locally, regionally, nationally or in another country, that can provide confirmation of diagnoses. *(see guidance note 3)*
  * A reference laboratory identified for more sophisticated testing.

- Sampling material and transport media for the infectious agents most likely to cause a sudden outbreak are available on-site, to permit transfer of specimens to an appropriate laboratory. In addition, several rapid tests may be stored on-site. *(see guidance note 4)*
  * Sampling materials and transport media should be available on site or readily accessible.
  * New rapid tests available in confirming diagnoses of communicable diseases in the field including malaria and meningitis.

5. Outbreak detection, investigation and response:
Outbreaks of communicable diseases are detected, investigated and controlled in a timely and effective manner.
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Key Indicators

- The health information system (HIS) includes an early warning component. *(see guidance notes 1-2)*
  * Key elements of HIS:

a) Case definitions and thresholds defined and distributed to all reporting health facilities.
b) Community health workers (CHW) trained to detect and report potential outbreaks.
c) Report suspected outbreak to next level of HIS within 24 hours.
d) Communication system for rapid notification to relevant health authorities e.g. radio, telephone.

  * Outbreak confirmation includes:

a) Diseases for which a single case may indicate an outbreak: cholera, measles, yellow fever, Shigella, viral haemorrhagic fevers.
b) Meningococcal meningitis:

- Populations >30,000, 15 cases/100,000 persons/week indicates an outbreak;
- High outbreak risk (i.e. no outbreak for 3+ years and vaccination coverage <80%), threshold is reduced to 10 cases/100,000/week;
- Populations <30,000, 5 cases/week or doubling of cases over three week confirms an outbreak.

c) Malaria: less specific definitions exist. An increase in the number of cases above what is expected for the time of year among a defined population and area may indicate an outbreak.

- Outbreak investigation occurs within 24 hours of notification.

- Outbreak is described according to time, place and person, identification of high risk groups. Adequate precautions to protect safety of individual and data.

- Control measures specific to disease and context implemented as soon as possible. *(see guidance notes 3-4)*
  * Outbreak control includes controlling the source, protecting susceptible groups and interrupting transmission.
  * Vector control for malaria outbreak includes indoor residual spraying, distribution of insecticide-treated bed nets (ITN), guided by entomological assessments and expertise. Rapid re-impregnation of nets with pyrethroids for populations with ITN usage (>80%).

- Case fatality rates (CFR) maintained at acceptable levels. (*see guidance note 5*)
  * If levels exceeded, evaluation and corrective steps taken to ensure CFR maintained at acceptable levels.
    - Cholera : 1% or lower
    - Shigella dysentery: 1% or lower
    - Typhoid: 1% or lower
    - Meningococcal meningitis: varies. CFR as low as possible. *(see guidance note 6)*

6. HIV/AIDS:
People have access to minimum package of services to prevent transmission of HIV/AIDS.
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Key Indicators

- Essential package of services during disaster phase includes:
  - Free male condoms and promotion of use

- Universal precautions to prevent iatrogenic/nosocomial transmission in emergency and health care settings.
- Safe blood supply.
- Relevant information and education for individual to protect themselves against HIV transmissions.
- Prevention and management of the consequences of sexual violence.
- Basic health care for PLWH/A.

- Plans to broaden the range of HIV control services in post disaster phase such as surveillance, prevention, treatment, care and support. *(see guidance note 1)*
  * Involve community especially PLWH/A and their carers in the design, implementation, monitoring and evaluation.
  * Implement protection and education programmes to reduce stigma and discrimination as soon as feasible.

3. Control of Non-Communicable Diseases

Sphere Minimum Standards

1. Injury:
People have access to appropriate services for the management of injuries.
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Key Indicators

- In situations with a large number of injured patients, a standardised system of triage is established to guide health care providers on assessment, prioritisation, basic resuscitation and referral. *(see guidance notes 1-2)*
  * In disaster-prone regions, the emphasis should be on preparing local populations to provide initial care to prevent excess mortality.
  * During armed conflict, the emphasis should be on community-based public health and primary care even if there is a high incidence of violent injury.
  * Triage is a process of categorising patients according to the severity of their injuries or illness, prioritising treatment according to resources and patients' chances of survival.

- Standardised guidelines for first aid and basic resuscitation. *(see guidance note 3)*
  * These include clearing airways, controlling haemorrhage, administrating intravenous fluid, cleaning and dressing wounds, administering antibiotics, tetanus prophylaxis and others.

- Standardised protocols for referral of injured patients for advanced care including surgery, are established. Suitable transportation organised for patients to reach referral facility.

- Definitive trauma and surgical services are established only by agencies with appropriate expertise and resources. *(see guidance note 4)*

- In situations with potentially a large number of injured patients, contingency plans for multiple casualties are developed for relevant health care facilities. These plans are related to district and regional plans.

2. Reproductive health:
People have access to Minimum Initial Service Package (MISP) to respond to their reproductive health needs.
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Key Indicators

- Organisation(s) and individual(s) are identified to facilitate the coordination and implementation of the MISP in consultation with the lead health authority. *(see guidance note 1)*
  * MISP's objectives include: prevent and manage the consequences of gender-based violence; reduce HIV transmission; prevent excess neonatal and maternal mortality and morbidity and plan for comprehensive reproductive health (RH) services.
  * UNFPA RH Kit designed to facilitate MISP implementation that can be used at community/health post, health centre and referral centre.

- Steps taken by health agencies to prevent and manage consequences of gender-based violence (GBV), in coordination with other relevant sectors, especially protection and community services. *(see guidance note 2)*
  * Health services should include medical management for sexual assault survivors, confidential counselling and referral for other care.
  * Sexual exploitation, especially of children and youth by relief staff, military personnel and others in positions of influence must be actively prevented and managed. Codes of conduct and disciplinary measures established for any violations.

- The number of cases of sexual and other forms of GBV reported to health services, protection and security officers is monitored and reported to designated lead GBV agency (or agencies). Rules of confidentiality applied to data collection and review.

- Minimum package of services to prevent transmission of HIV/AIDS is implemented. *(see Control of communicable diseases standard 6)*

- Adequate numbers of clean delivery kits, based on the estimated number of births in a given time period, are available and distributed to visibly pregnant women and skilled/traditional birth attendants to promote clean home deliveries.

- Adequate numbers of midwife delivery kits (UNICEF or equivalent) distributed to health facilities to ensure clean and safe deliveries.

- Standardised referral system established and promoted within the community, including midwives and skilled/traditional birth attendants, to manage obstetric emergencies. Suitable transportation organised for patients to reach referral facility. *(see guidance note 3)*
  * Referral hospital should provide essential obstetric care which includes initial assessment; assessment of foetal well-being; episiotomy; management of haemorrhage; management of infection; management of eclampsia; multiple birth; breech delivery; use of vacuum extractor and special care for women who underwent genital mutilation as well as Caesarean section; laparotomy; repair of cervical and third degree vaginal tears; care for complications of unsafe abortions, and safe blood transfusion.

- Plans initiated to implement a comprehensive range of RH services integrated into primary health care as soon as possible. *(see guidance note 4)*
  * Integrated RH services should include safe motherhood; family planning and counselling; comprehensive GBV services; comprehensive management of STIs and HIV/AIDS; specific RH needs of youth; and monitoring and surveillance.

3. Mental and social aspects of health:
People have access to social and mental health services to reduce mental health morbidity, disability and social problems.
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Key Indicators

During acute disaster phase, the emphasis is on social interventions.

- People have access to ongoing, reliable information on the disaster and associated relief efforts. *(see guidance note 1)*

* Information should be uncomplicated (understandable to local 12-years-old) and empathic (showing understanding of the situation of the disaster survivor).

- Normal cultural and religious events are maintained or re-established (including grieving rituals conducted by spiritual/religious practitioners). People are able to conduct funeral ceremonies. *(see guidance note 2)*
  * Unceremonious disposal of bodies of the deceased should be avoided.

- As soon as resources permit, children and adolescents have access to formal or informal schooling and to normal recreational activities.

- Adults and adolescents are able to participate in concrete, purposeful, common interest activities such as emergency relief activities.

- Isolated persons, such as separated or orphaned children, child combatants, widows and widowers, older people or others without family, have access to activities that facilitate their inclusion in social networks.

- Where necessary, a tracing service established to unite people and families.

- Where people are displaced, shelter is organised to keep family members and communities together.

- Community consulted on decisions on where to locate religious places, schools, water points and sanitation facilities. Design of settlement for displaced people includes recreational and cultural space. *(see Shelter and settlement standards 1-2, pages 211-218)*

Key psychological and psychiatric intervention indicators

- Individuals (general population or aid worker) experiencing acute mental distress after exposure to traumatic stressors have access to psychological first aid at health service facilities and in the community. *(see guidance note 3)*
  * Includes non-intrusive pragmatic care with a focus on listening but not forcing talk; assessing needs and ensuring basic needs are met; encouraging but not forcing company from significant others; protection from further harm.
  * Such aid can be taught quickly to volunteers and professionals.
  * Avoid prescription of benzodiazepines because of dependency risks.

- Care for urgent psychiatric complaints is available through primary health care system. Essential psychiatric medications, consistent with essential drug list, are available at primary care facilities. *(see guidance note 4)*
  * Complaints include dangerousness to self or others, psychoses, severe depression and mania.

- Individuals with pre-existing psychiatric disorders continue to receive relevant treatment, and harmful, sudden discontinuation of medications is avoided. Basic needs of patients in custodial psychiatric hospitals are addressed.

- If disaster becomes protracted, plans are initiated to provide a more comprehensive range of community-based psychological interventions for the post-disaster phase. *(see guidance note 5)*
  * Interventions to include functional, cultural coping mechanisms of individuals and communities.
  * Collaboration with community leaders, indigenous healers and community self-help groups encouraged.
  * Community health workers should be trained and supervised to assist health workers and conduct outreach activities for vulnerable and minority groups.

4. Chronic diseases:
Populations in which chronic diseases are responsible for a large proportion of mortality, people have access to essential therapies to prevent death.
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Key Indicators

- A specific agency (agencies) to co-ordinate programmes for individuals with chronic diseases for which an acute cessation of therapy is likely to result in death. *(see guidance note 1)*
  * Chronic diseases include dialysis-dependent chronic renal failure, insulin dependent diabetes and certain childhood cancers.
  * Not appropriate to introduce new therapeutic programmes for chronic diseases during relief phase if populations did not have access to these therapies prior to the disaster.

- Individuals with chronic diseases are identified and registered.

- Medications for routine, ongoing management of chronic diseases are available through primary health care, provided medication provided are specified on the essential drug list.

Refer to:
The Sphere Project, Humanitarian Charter and Minimum Standards in Disaster Response for the complete text.
For full details visit the website at:
http://www.sphereproject.org/handbook/index.htm

Please feel free to include some of your organization's own codes and standards.