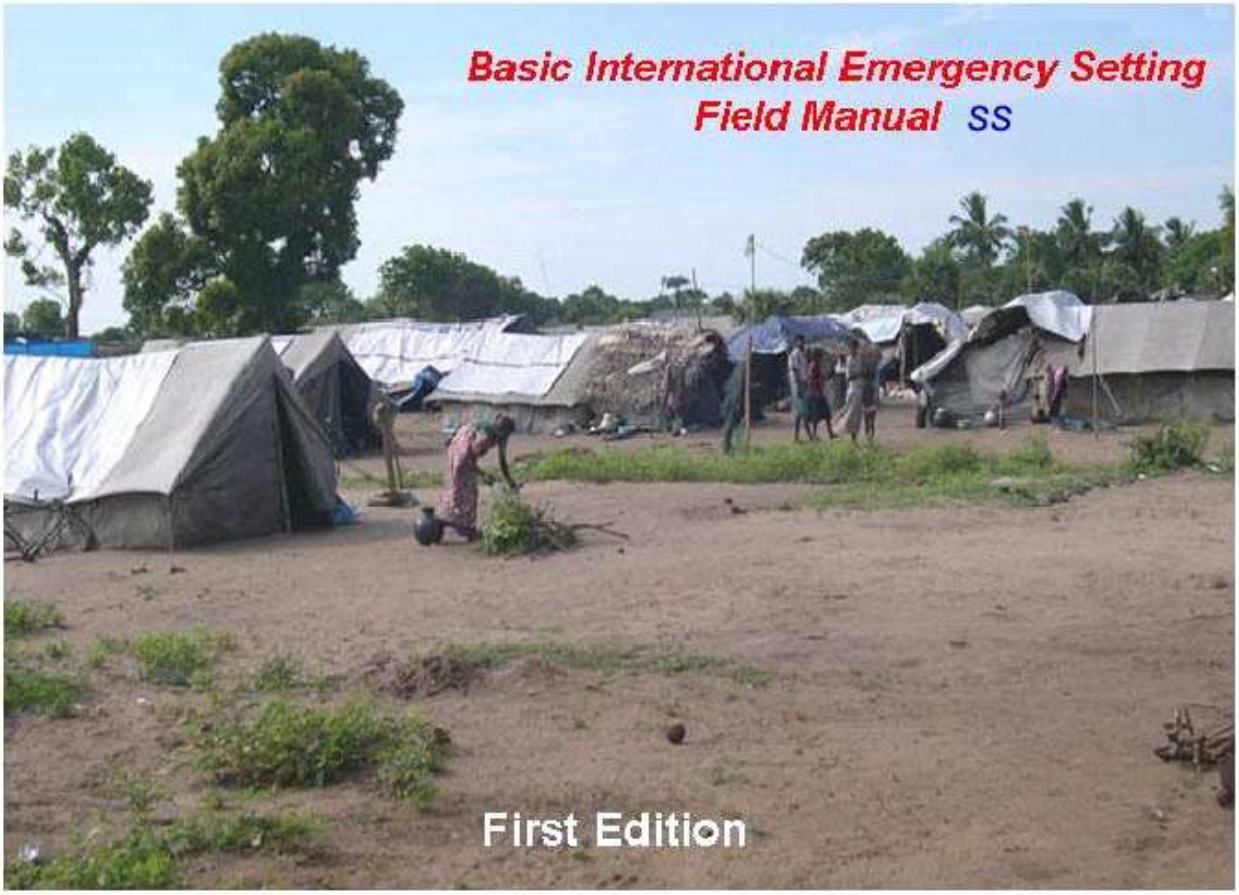
BIES Field Manual
Setting Standards



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Purpose of the manual:

The purpose of this manual is to help staff in dealing effectively and efficiently with humanitarian missions in international emergency setting. It's a baseline guide for field use in international emergencies.

Disclaimer

This manual is the result of distillation of official documents and websites and recent red cross/ red crescent publications. The property of the publications quoted is of the respective authors. Any parts of this manual may be cited, copied and translated into other languages or adapted to meet local needs without permission from the Authors, provided that the source is clearly stated.

Focus points

- Criteria for emergency response.
- The importance of reporting.
- Evaluations.
- Practical tips and checklist.
- Formats for reports.

Structure:

The manual is divided into three parts:

PART I: Deals with official field business: emergency management, reporting, evaluation and public information.

PART II: Summarizes the practical information that is useful when going on mission: such as Environment, Personal security tips and security framework, disease prevention, stress management.

PART III: Proposes means for standardized data collection and provides formats for field paperwork.

APPENDIX A: Useful websites and contacts.

Acknowledgements

This manual has been the fruit of the distillation and synthesis of existing official documents adapted for use. From an idea of Dr. Mario Braga and Dr. Laura Pacifici, this manual has been compiled by Dr. Flavia Riccardo. Contributions to the drafting and review of the text have been provided by Dr. Laura Pacifici, Dr. Elena Scaroni and Dr. Michelangelo Rossi. Special thanks to Dr. Giorgio Ferrario and Dr. Lorenzo Caraffi for the support and teachings during the BTC course 2005.

Contents page:

Abbreviations and Acronyms:

FAO: Food and Agricultural Organization.

ICRC: International Committee of the Red Cross.

IFRC: International Federation of the Red Cross.

IHL: International Humanitarian Law

ItRC: Italian Red Cross

NS: National Societies.

OCHA: Office for Coordination of Humanitarian Affairs.

ONS: Operating National Society.

PNS: Participating National Societies.

UN: United Nations.

UNDP: UN Development program.

UNHCR: UN High Commissioner for Refugees.

UNICEF: UN Children's Fund.

WFP: World Food Program.

WHO: World Health Organization.

PART I

Response to emergency.

Hazards and Disasters

Hazards are sudden or slow-onset events which can disrupt the lives of people and communities. The hazard may be natural (drought, floods, earthquakes) or it may be based on man-made factors (conflicts, environmental and technological degradation, political and economic deprivation etc.). More and more hazards become a result of man-made effects exacerbating a natural phenomenon (such as deforestation increasing the risk of flooding, drought triggered by adverse agricultural practices etc.).

Not every hazard having an adverse effect on communities becomes a disaster. **Disasters are a *combined result* of hazards and vulnerabilities** (the long-term factors which adversely affect the ability of a community to respond to hazards). Disaster only happens when it exceeds the adjustment capacity of the affected communities and individuals and their ability to cope with crisis. Therefore a disaster is fundamentally a socio-economic phenomenon. It is an extreme state of everyday life in which the continuity of community structures and processes temporarily fails.

Disasters will usually have direct and indirect, as well as short- and long-term impact on individuals, communities, systems and services. This distinction is particularly important for planning relief and rehabilitation programme (*source Handbook for Delegates 2002. chap 19).*

The approach to working in an emergency project is through emergency management. Although often perceived as a complicated concept, management means to search for the best way to use resources in order to achieve a goal.

Management of a project involves the following:

· **Planning** — analysing different ways of moving toward identified goals in the order of priorities.

· **Implementation** — transforming inputs through a set of systems and procedures to produce outputs.

· **Monitoring and Evaluation** — continuously and periodically assessing work against the targets.

· **Leadership** — people who are responsible for accomplishing the organisation's goal by making the best use of available resources (staff, money, material, etc.), within given constraints.

· **Coordination** – a harmonious and effective working together of people and organisations toward a common goal.

(Source The Johns Hopkins and Red Cross / Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** chapt.2)

Good management should begin with a clear understanding of management terms. The table below lists common management terms and their definitions.

Fact Sheet: Management Terms and Definitions

Accountability The responsibility of demonstrating to stakeholders, including the beneficiaries, that humanitarian assistance meets with agreed standards.

Activity An action within a project that is done to achieve an objective; activities transform inputs to outputs.

Coordination Harmonious and effective working together of people and organisations toward a common goal.

Coverage The proportion of the target group that has received a service or is protected from a disease or health problem.

Effectiveness The extent to which an organisation is doing the right thing to reach its objectives.

Efficiency The degree to which results (desired outcomes) are achieved without wasting resources. How economically inputs are converted into outputs.

Evaluation A periodic assessment of the relevance, effectiveness and impact of health interventions against the set objectives. Evaluation is a learning and action-oriented tool that requires the establishment of specific objectives, progress indicators and criteria.

Goal General statement about what is to be eventually achieved (i.e. impact) through a program.

Implementation Transforming inputs through a set of systems and procedures to produce specified program outputs.

Indicator A "signal" that shows whether a standard has been reached. It is used to measure and communicate the result of programs as well as the process or methods used. Indicators can be quantitative or qualitative.

Inputs Resources (staff, supplies, money, information) available for carrying out a project in a given time.

Leader Someone who makes people work together, by motivating and inspiring them, to achieve a common goal.

Management Searching for the best use of resources in pursuit of objectives subject to.

Methods Sequence of tasks or activities for achieving objectives.

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

Monitoring An ongoing process of checking the progress of activities against the plan to ensure that all processes are going on as intended.

Objective The intended, measurable targets (outcomes) of a program; the specific targets or positions that are to be reached in order to achieve the overall goal.

Planning A continued process of anticipating the resources and services required to achieve objectives determined according to an order of priorities that permits the selection of the optimal solution or solutions from among several alternatives; these choices take account of the context of internal and external constraints, whether already known or foreseeable in the future. The core of planning consists of analysing alternative means of moving toward identified goals in the light of priorities and existing constraints.

Process The steps or tasks for carrying out activities (diagnosing, counselling, referral, etc.).

Program An organised set of projects or services seeking to attain specific (usually similar or related) objectives.

Project A planned scheme aimed at achieving specific objectives within a given time/budget.

Results Outcomes of processes and necessary inputs for the target population as:

· Outputs — Direct results (products or services) a program delivers to a target population to produce the expected impacts.

· Effects — Changes in knowledge, attitudes, behaviour/practice, coverage resulting from the output.

· Impacts – Changes in health status (morbidity, mortality, disability, fertility) resulting from the output.

Staffing Planning for the types and number of personnel that will be required.

Strategy The order of pursuing priorities and objectives based on relative effectiveness and consideration of constraints.

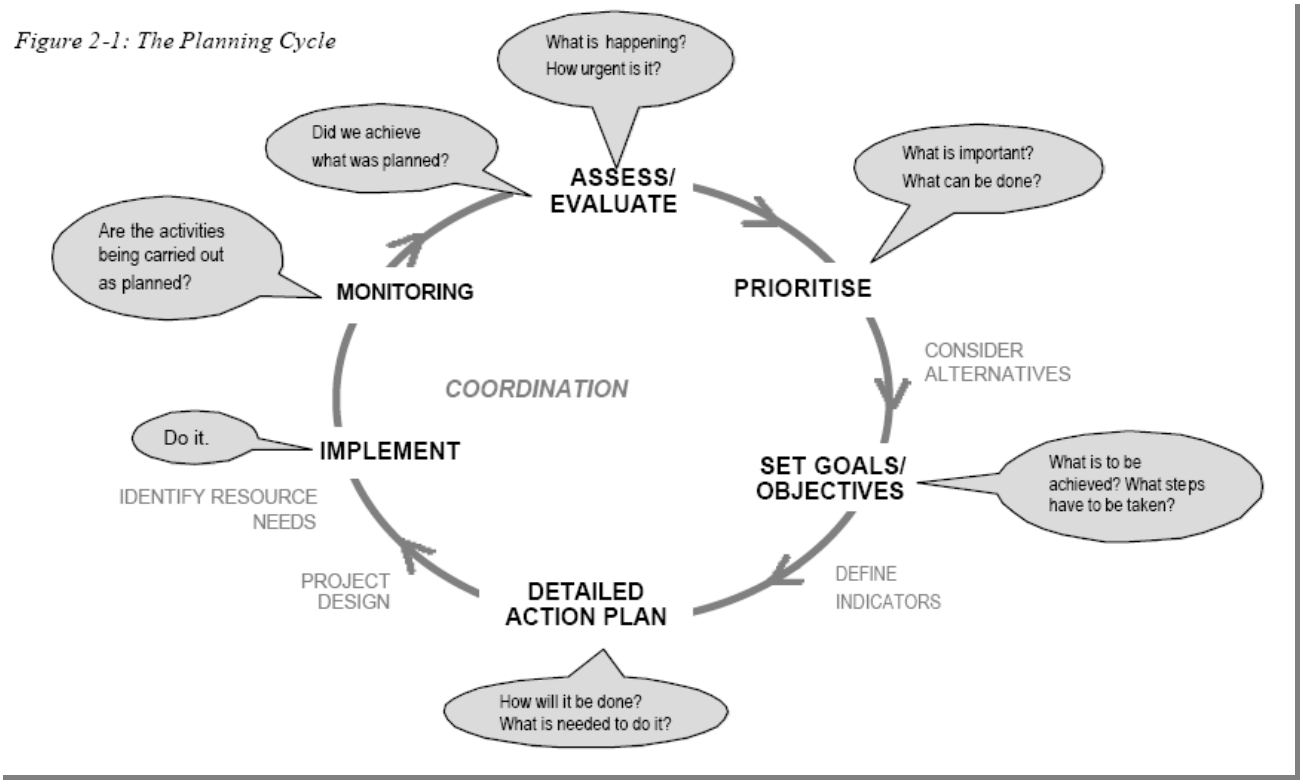
Target Group A family, specific population group, or a community in a defined area of a country.

Training Transferring specific skills and competencies to individuals about to do a particular job.

(Source The Johns Hopkins and Red Cross / Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** chapt. 2)

The process of planning is not static as it may seem, rather it can be seen as a flowing and ever changing situation with consecutive needs assessments, goal setting and project monitoring. It is a team work when all participants can provide special insight and share past experiences. Source The Johns Hopkins and Red Cross / Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES**

Figure 2-1: The Planning Cycle



(The Johns Hopkins and Red Cross/Red Crescent PUBLIC HEALTH GUIDE FOR EMERGENCIES chapt.2)

What do we need to know to assess an emergency?

The United Nations Disaster Relief Organisation (UNDRO) defines a disaster as:

"a serious disruption of the functioning of a society, causing widespread human, material, or environmental losses which exceed the ability of the affected society to cope using its own resources." (source The Johns Hopkins and Red Cross / Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** chapt. 1)

Fact sheet: Disaster Terms and Definitions

Acute Emergency Phase*: Begins immediately after the impact of the disaster and may last for 0-3 months. Characterised by initial chaos and a high crude mortality rate (CMR). Ends when CMR drops below 1/10,000 people/day.*

Asylum: *Giving sanctuary, refuge, shelter or protection from seizure to a refugee from another country.*

Camp*: A place where a group of displaced people temporarily lodge in tents, huts, or other makeshift shelters. A camp setting may vary as follows:*

· *Tented cities relying wholly on external support.*

· *Small, open settlements where the refugee communities have been able to maintain a village atmosphere.*

· *Larger, more crowded settlements where its inhabitants are more dependent on external aid. Level of control exercised by national and international authorities.*

Complex Humanitarian Emergency:

- *A major man-made disaster that may be complicated by natural disaster(s), and loss of life. It often requires the support of a multinational military peace operation.*
- *A humanitarian crisis in a country or region where there is a total or considerable breakdown of authority resulting from internal and/or external conflict, which requires an international response that goes beyond the mandate and capacity of any single agency (UNDHA).*
- *Complex Political Situations in which the capacity to sustain livelihood and life is threatened primarily by political factors, and, in particular, by high levels of violence.*

Disaster: *Regardless of the cause, disasters have the following characteristics:*

- *A great or sudden misfortune*
- *Beyond the normal capacity of the affected community to cope, unaided*
- *The interface between vulnerable human conditions and a natural hazard*

Hazard: *Extreme event (natural, man-made) that may disrupt the lives of people, particularly vulnerable people, exposing them to loss of property or livelihood, injury, or death.*

Integration: *Neighbouring country of asylum allowing refugees to settle permanently with the host population without restrictions.*

Internally Displaced Person (IDP):

- *Persons who have been forced to flee their homes suddenly or unexpectedly in large numbers, as a result of armed conflict, internal strife, systematic violations of human rights, or natural or man-made disasters, and who are within the territory of their own country (UN Secretary General 1992).*
- *Persons or groups of persons who have been forced or obliged to leave their homes or places of habitual residence, in particular as a result of, or in order to avoid the effects of, armed conflict, situations of generalised violence, violations of human rights, or natural human-made disasters, and who have not crossed an internationally recognised state border (Inter-Agency Standing Committee Guiding Principles 1998).*

Post-Emergency Phase: *Begins when the CMR drops below 1/10,000 people/day and may last 1-6 months or longer. Characterised by improvement and expansion of relief activities.*

Refugee:

- *Any person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it (UNHCR 1951).*
- *Every person who, owing to external aggression, occupation, foreign domination, or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is*

compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality (OAU).

Relief: *Assistance given to people in need after a disaster. The initial assistance in an emergency is usually provision of food, clean water, shelter and protection.*

Rehabilitation or Reconstruction Phase: *After the relief phase, reconstruction begins. This should lead to restoration of pre-disaster conditions (repaired facilities, unctioning services, self-reliance).*

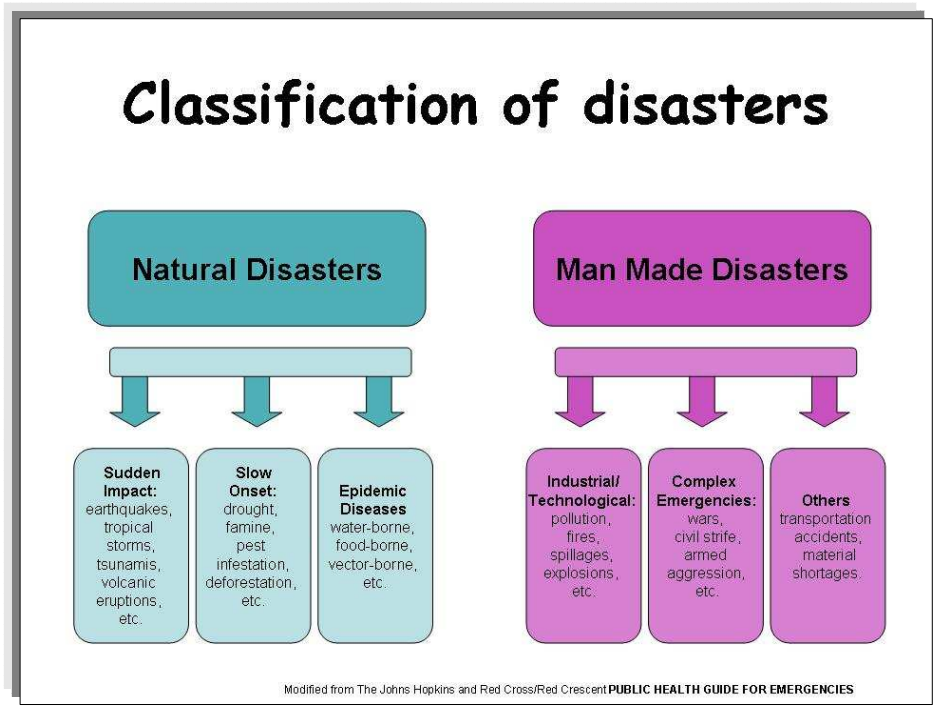
Repatriation: *Returning to the country of birth or citizenship. May be forced or voluntary.*

Resettlement: *Allowing refugees to settle in a third country when repatriation or integration is not possible. Usually offered as a temporary solution.*

Vulnerability: *The defencelessness, insecurity, and exposure to risks, shock, and stress—and having difficulty coping with them. Living on an "edge" such that if something goes wrong, or if part of the situation changes, then the ability to sustain life is endangered. The potential that when something destructive happens, people will not be able to handle the consequences by themselves.*

(The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** chapt 1)

Disasters can be classified in two great categories: natural and man made disasters. Each of these categories is further divided in three sub categories so describing five major disaster types:



1. **Sudden-onset disasters** include floods, earthquakes, tsunamis or tidal waves, tropical storms, volcanic eruptions, and landslides. As their name implies, sudden-onset disasters occur swiftly and often without any warning. Floods are the most frequent type of natural disaster associated with sudden migration of large populations and food shortages. Other types of disasters generally occur more frequently in Asia, Latin America, and the Caribbean rather than in Africa. When these disasters occur, they frequently cause thousands of deaths and casualties. Earthquakes cause the greatest number of deaths and overwhelming infrastructural damage. Communities at risk of these types of disasters should recognise and respond to threats posed by local weather patterns and the shape and contours of the land.

2. **Slow-onset disasters** include droughts, famine, environmental degradation, deforestation (loss of trees and vegetation), pest infestation and desertification (conversion of arable lands to deserts). These disasters are usually the result of adverse weather conditions combined with poor land use. Traditionally, African communities, particularly the poor, have been at increased risk of these types of disasters because of poverty and social inequality, environmental degradation from poor land use and rapid population growth. Slow-onset disasters can be prevented because they happen over a long period of time and human decisions contribute to (or cause) problems. Early warning systems can be easily put in place to lessen or even prevent the disaster.

3. **Industrial/technological disasters** result from a society's industrial and technological activities that lead to pollution, spillage, explosions, and fires. They may occur because of poor planning and construction of manmade facilities (buildings, factories, etc.) or from neglect of safety procedures. Sudden-onset disasters such as earthquakes, floods, and terrorist acts may trigger secondary disasters such as fires or pollution. Industrial events have the potential to cause large-scale loss of life and infrastructural damage, especially in developing countries with unregulated industrialisation, and inadequate safety standards and disaster response capacity.

Wherever there is a man-made facility, there is the potential for an industrial or technological disaster to occur. Reducing the occurrence and effects of industrial disasters requires a multi-sectoral approach.

4. **Complex emergencies** are usually man-made, with multiple contributing factors. They often follow wars between states, internal conflict, and, increasingly, terrorist acts. Massive population displacements may occur due to lack of food, insecurity, and increasing death rates. Poverty and risk of conflict go hand in hand.

Civilians that are not part of the conflicts end up bearing the majority of casualties because they are often targets of both sides of the conflict.

5. **Epidemic diseases** are those diseases that normally do not occur in stable communities but have the potential to spread under certain conditions. This can cause frequent and severe outbreaks. These diseases may be spread by contaminated water or food, person-to-person contact, or through animals or insect vectors. Examples of epidemic diseases that commonly threaten displaced populations include cholera, measles, dysentery, respiratory infections, malaria, and, increasingly, HIV. After a major disaster, the risk of epidemic diseases increases mainly as a result of overcrowding and unhygienic conditions.

(The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** chapt. 1)

Once a disaster strikes and we are called to intervene as a NS or PNS the mission we are called to participate in is the result of a specific project drawn on the basis of the needs of the **"affected population".**

Therefore it is necessary to give an exact definition on what exactly we mean by "Affected population": the people affected by food shortage, by lack of drinking water, by a communicable disease or homeless. This is important because it avoids incomprehension and misunderstandings.

The first thing the an organization is called to do is a Needs assessment.

Soon after a disaster it is hardly ever possible to gather all the necessary information however past experiences and good guesswork can integrate existing information to form an initial plan.

When the plan is underway more information will be gathered and the necessary adjustments will take place.

Emergency Needs Assessment Check-List

This check list can be used as a guide in order to develop complete assessment reports.

General

- What is the type of disaster?
- When it occurred?
- What region(s) / area(s) are affected?

Effects

- What is the nature of damage?
- Are major cities and towns affected? If yes, to what degree?
- Is the infrastructure (housing, roads, electricity, water supply, communications etc.) affected?
- How is the situation developing? Are any secondary effects expected (after-shocks, floods, fires, avalanches, dam-breaks, mudslides etc.)?

People

- How many people are assumed to be affected?
- What percentage of the overall population is affected in the area?
- What is the sex/age composition and average family size of affected population?
- How many people are assumed dead, injured, missing, homeless, hospitalised?
- Were any people evacuated? If yes, how many, where, and what are their needs?
- What was the social/economic situation of the affected population before the disaster?
- Estimated damage to food reserves, crop and livestock of the population?

Action taken

- What actions have been taken by national and local authorities?
- What actions have been taken by the Operating National Society?
- What actions have been taken by local and/or international NGOs?
- What assistance has already been offered, announced or delivered by sister National Societies?
- Has any relief coordination mechanism been established at the national or local level?

Needs

- What are the immediate unmet needs in water, sanitation, shelter, food, non-food items (clothes, blankets, cooking utensils etc.),health (medical supplies, equipment, facilities)?
- What kind of assistance may need to be provided within the coming three months?

Resources

- What material, human and financial resources are available locally?
- What transport and storage facilities (commercial, government, Organizations) are available locally?
- Availability, location and condition of roads, railways, harbours and airports?
- What should be supplied from outside the country?
- What is the capacity of the ONS to carry out the relief operation?

Telecommunications

- How can communication be established within disaster affected area, between disaster area and ONS headquarters, between ONS headquarters and the Federation, between disaster area and Federation?
- What telecommunications equipment is required (telex, fax, telephone, radio etc.)?

(source Handbook for Delegates 2002 chapt. 19)

On the basis of the needs assessment it is necessary to identify priorities or what is known as **Hierarchy of needs:**

- The first is to provide ***basic life support*** needs: drinking water and sanitation, adequate food, appropriate medical assistance, shelter (through housing and clothing) and fuel (for cooking and heating);
- The second is to ***protect*** disaster victims from physical violence and aggression, particularly in disasters involving refugees and internally displaced persons;
- The third is to address the ***psychological and social stress*** caused by the disaster, providing the victims with psychological and social support.

National Societies and the Federation are invariably active at the first level, occasionally at the second and increasingly at the third. (source Handbook for Delegates 2002 chapt. 19)

Outline for a Rapid Assessment Report

Executive Summary – disaster being addressed, program planned and resources needed

Survey – by whom, when it was carried out, objectives and methods used

Background of Disaster – origin, impact and forecast of evolution of disaster

Affected Population – size, age/sex composition, general condition, casualties/ death rates, disease pattern, condition of host population

Current Response – relief measures so far

Needs and Resources – existing services and facilities and unmet health needs (security, access, etc.)

Capacities – of disaster victims, host country, local NGOs, other organisations

Recommendation – aim/strategy for action, target beneficiaries, program implementation

International Aid Needed – equipment, supplies, technical, etc.

Forthcoming Reports – advise on pending surveys, etc.

Appendices – maps/country profiles of affected areas, data analysis of assessment, program design, description of other relief actions, contact names/addresses

(The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES**) chapt 1

Further Reading

- The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** chapter 2.

The Sphere project

The International Federation is one of the leading humanitarian agencies piloting the Sphere project – the Humanitarian Charter and Minimum Standards in Disaster Response.

The purpose of the Humanitarian Charter and the Minimum Standards is to increase the effectiveness of humanitarian assistance, and to make humanitarian agencies more accountable. It is based on two core beliefs; first, that all possible steps should be taken to alleviate human suffering that arises out of conflict and calamity, and second, that those affected by a disaster have a right to life with dignity and therefore a right to assistance.

Sphere is about advocacy on behalf of beneficiaries and about measuring the impact of aid in the five core sectors of disaster response: water and sanitation; nutrition; food aid; shelter and site planning; and health services.

The Sphere manual itself is the result of more than two years of inter-agency collaboration to frame a Humanitarian Charter, and to identify Minimum Standards to advance rights set out in the Charter. These standards cover disaster assistance in water supply and sanitation, nutrition, food aid, shelter and site planning, and health services. Taken as a whole they represent a remarkable consensus across a broad spectrum of agencies (over 200).

Each Minimum Standard has a set of key indicators for measuring performance, which if used skillfully and with respect for cultural diversity, will genuinely make aid organisations more accountable to beneficiaries. More details on the Sphere project are available on its web site http://www.sphereproject.org where you will also find the complete text of the manual in the currently available languages including French, Spanish, English and Russian. (source Handbook for Delegates 2002 chapt 19).

Reporting

" The proverb "no news is good news" does not apply to a Red Cross or Red Crescent operation or programme. No news is certainly bad news in the early phase of an emergency operation and will have a negative impact on the Federation's ability to support the operation. A lack of information can also frustrate the other National Societies' "need to know", and may hamper efforts to create, satisfy, or maintain media interest in the Federation's work.

Reporting deadlines, especially during an emergency, must always be met. ***Even if the collected data is incomplete, the principle "go with what you have" is to be followed."*** *(source Handbook for Delegates 2002 chapt. 6).*

What is true for the Federation is certainly true for a NS or PNS on an emergency mission. Reporting to your Country Coordinator on the field and to HQ in Rome is essential to allow for planning processes, mission monitoring and allows your desk at HQ to help with decision making and problem solving. Certainly **no news is very bad news** and for this reason specific dead lines and reporting formats are necessary.

People on the field may feel independent in urgent decision making, however choices should me made together with HQ in order to avoid loss of common standards and procedures, sub optimal hand over procedures, loss of information and generally misunderstandings.

In the last part of this manual you will find reports formats.

Reports must be sent to the HQ desk every day in the early stages of emergency, every week in post emergency, and during long term projects with no security or political instability issues every month.

TIMELINE	**TYPES OF REPORT**
EMERGENCY STRIKES	ASSESSMENT (EARLY AND LATE)
ACUTE EMERGENCY PHASE	DAILY REPORTS
POST EMERGENCY PHASE	WEEKLY REPORTS
LONG TERM PROJECTS	MONTHLY REPORTS

Evaluation

Evaluation means to systematically establish the **relevance, efficiency, effectiveness**, and **impact** of the project in relation to its goals and objectives. This involves:

- Looking at whether the original problems to be tackled have changed since a project began, and whether the objectives have been achieved or not, in order to improve on-going operations (INTERIM or PROCESS evaluation).
- Measuring the actual results against the set goals and analysing reasons for success or failure in order to draw lessons for future planning, programming and decision-making (FINAL or OUTCOME evaluation).

In other words, evaluation is **"the periodic measurement of performance against intentions."**

Evaluations are only possible if objectives and quantifiable indicators of success were defined at the beginning of a relief project.

It is not enough to carry out regular monitoring of the project. **Interim evaluations** of the Gantt chart, job descriptions, job aids, staff work plans can help identify solutions to problems detected by routine monitoring and to adjust the action plan for the next phase.

Few organisations conduct a **final evaluation** to assess the benefits, the effectiveness and the *impact* of a completed project. Final evaluations are essential for large, complex projects and particularly for long-term development projects where the final benefits may not be known for many years after completing the project.

Note: *Evaluation is a management and learning tool. It does not "put the project on trial," like an inspection (on-thespot checks to investigate a particular problem and determine appropriate solutions) or audit (which is a review of whether activities measure up to set financial or management standards).*

(The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** chapt. 1)

What is the information usually required from an evaluation?

Information from Evaluations

1. What were the project's objectives? To what extent have these objectives been achieved?	11. What is the relationship between the project objectives and the problems addressed?
2. In retrospect, how realistic were the objectives when they were set against existing limitations? What alternative objectives were considered and why were they rejected?	12. What factors account for the variations in the level and the distribution of benefits produced?
3. When were the benefits of the project expected to materialise, and when were they actually realised? How did this timing correspond with the timing of the needs which were addressed?	13. What were the intended benefits from the project? Who was expected to benefit from the project; who actually did and who did not benefit?
4. How was the program organised, set up and financed?	14. How were the various levels within the aid system linked?
5. Is the organisation's communication and co-ordination efficient? Is its structure flexible enough to adapt to changing conditions? Are decision-making and authority lines clear?	15. What pressures were exerted on the project and personnel? Where were these pressures generated?
6. What opportunities existed for the beneficiaries to influence the project set up?	16. Which way did information flow? To whom is the organisation accountable?
7. Has the project encouraged the growth of networks to facilitate problem-solving and learning between the communities and organisations?	17. What effect did the project have on local and social processes, on the way different communities and individuals interact and participate in public life?
8. What effect did the project have on the coping mechanisms within the community? Did the project improve or damage this internal system? Was any dependency created?	18. What effect did the project have on the physical environment?
9. Was there an effective control system for tracking the disbursement of financial and capital items and service provision?	19. Is the system geared to avoid and solve conflict – either internal or with other organisations?
10. What policy lessons have been learned from the project?	20. What issues emerged during the setting up and management of the project that might be generalised to other situations?

(The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** chapt. 1)

Fact sheet: Public information and Media terms and definitions.

Media Coverage: Securing and reporting details about a situation or event by the media

Mass Communication: Directing information or a message to a large number of people.

Mass Communication Medium: A means of public communication, which includes television (TV), radio, film, newspapers, magazines, books, and the internet.

Media: Channels for sending information or messages to groups of people, such as:

· *Broadcast* — television, radio, satellite, and terrestrial

· *Print* — newspapers, magazines, etc.

· *Wire services* or *news agencies* — sell stories to broadcast/print outlets

· *Electronic* — Internet-based news services

Public: A group of people sharing a common interest.

Live Link: An interview that is transmitted to listeners or viewers at the same time it is being recorded. (Only the experienced or very confident interviewees should agree to this type of interview.)

Target Audience: The persons or group whose attention a particular information or message is intended to attract.

(The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** chapt. 14)

According to the "Principles and rules for Red Cross Red Crescent Disaster relief" regarding relations with the international news media:

"Since the media can have a major influence on public support for a relief operation and the generation of funds, the National Society of a stricken country should make every effort, consistent with the efficient conduct of the relief operation and any regulations laid down by the authorities, to facilitate journalists' coverage of an emergency situation.

When a disaster situation attracts large-scale international media interest, the Federation may assign a delegate, or delegates, to assist the National Society in coping effectively with

the requirements of the media and responding to the public information needs of Participating National Societies and the Federation's Secretariat in Geneva."

The first and major information source on humanitarian issues and especially disasters are media, so they should be perceived by workers on the field as an asset and tool for information sharing allowing to build up support from the general public and encourage founding.

Therefore all journalists must be treated with respect (they are human beings and are doing their job) and restraint (risk of misunderstandings). The dignity of disaster victims must be at all times protected both in interviews and in photographs (approval from the community leaders after explaining to them what is involved and how the pictures will be used must be ensured. After using a digital camera or a video camera , it's important to ask the operator to show the video or pictures to the people who were filmed.)

While it is essential for relief workers to cooperate with the media, it is even more important to be prepared for the interviews. The following questions may help to define the target audience and the best way to communicate with them:

· **Audience**: Who is the message intended for?

· **Objective**: What is the aim of sending the message?

· **Approach**: What is the most effective way to give the message?

· **Medium**: How and when should the message be conveyed?

· **Impact**: What is the desired result from sending the message?

It is important to follow certain **"protocols"** when one is getting interviewed in order to ensure a positive impact on the target audience and to avoid creating conflict within your relief agency. The following techniques may be helpful for improving your interview skills:

1. Inform your direct supervisor if you have been asked for an interview or have been interviewed.

2. Be prepared! A relief worker who is not prepared can do more harm than good during an interview.

- Find out **who will be doing the interview**, whether it will be broadcast or printed and when it will be made public. Also, find out where, when, and why the interview is taking place.
- **Negotiate with the interviewer about how the interview will be carried out** (e.g., duration, what issues will be discussed, limit to questioning, etc.) before it begins.
- Do your homework — **collect all necessary facts and figures** and prepare a set of notes in point form.

Below is a list of **FAQ** (frequently asked questions) by the media and the public:

1. What happened and what is the damage?

2. When did it happen?

3. Why did it happen?

4. How did it happen?

5. Who was affected?

6. Is there an underlying factor?

7. What has been done about the situation?

8. Who is taking responsibility?

9. What else is required?

3. During the interview, remember you are giving an interview to **deliver your message** to the public, not simply to answer the reporter's questions. Therefore, keep the following points in mind:

- Be brief and to the point. Then there is a greater chance that your own words will be used. **Identify the key points** (not more than three) **that you wish to communicate**. Begin with a statement on the basic facts — the first comment is often the most remembered.

- T**ell the truth without exaggerating and do not be afraid to say, "*I don't know*."** If it is a fact you can get information about, offer to do so but make sure you get it to the reporter in time. A missed deadline is a missed opportunity. If it is a question in an area outside your field (e.g., about national or organisational policy), refer the reporter to the people who are best suited to answer that question.
- **Do not discuss unverified, sensitive or confidential information**. There is no such thing as "off the record." If you have information that you do not want reported, do not disclose it. If a situation is unclear, say so.
- Be polite, helpful, clear, and specific. Courtesy and cooperation help establish your credibility.
- Answer the questions skilfully and remember that you have your own agenda for the interview. Seize the opportunity to discuss the additional points you want the public to know about your organisation.
- Any news deserves comment. Never say, "*No comment*." **If possible, refer any questions that may cause some friction to your supervisor.** Prepare a comment in advance for questions that may potentially cause a dispute.
- Though reporters are trained to ask questions in a probing manner, this does not mean that they are trying to "trick" you. Stay calm and do not be defensive. Listen carefully to questions before answering. Think first before answering a question.
- Clarify a false statement or accusation. Say, "*I believe you are misinformed, and this is why...*" Then explain. Do not repeat offensive words or statements that a reporter used in a question, even to correct or deny. **A reporter's question will never be quoted in the story but your answer will.**
- **Ask the reporter specific questions to help you understand what information he or she is looking for**, how much detail is needed, and how your material is going to be used. Usually, a couple of questions from you can help you give the reporter what is wanted. This is a courtesy they appreciate.

- Stop talking when you have said all that needs to be said. Smile and thank the reporter.

source(The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** chapt. 14)

During field work your will find yourself in contact with people from other organizations and with media workers, not necessarily in official interviews setting.

Remember that **a statement made after the end of an interview or at a social gathering remains a statement.** Avoid making negative remarks on your organization or on your colleagues, whatever incomprehension or delay there may be in your projects.

PART II

Environmental Health

What happens after a natural or man made disaster?

Fact sheet : Environmental Health Terms and Definitions

Chemical Quality Acceptable levels of arsenic, mercury, lead nitrates, fluorides, salts and other hazardous components in water.

Contamination Becoming impure or unusable due to contact or mixture with certain pathogens that are transmitted through faeces or urine. Contamination with human faeces is of major concern, although animal faeces may also cause disease transmission.

Cross-contamination Process by which contaminated liquids (usually sewage) are transferred into potable water pipes. Common causes include a break in the water pipe or changes in pressure inside the pipe.

Disinfection Killing of infectious agents (bacteria, viruses, and protozoa) outside the body by direct exposure to physical or chemical agents.

Faecal Coliforms A category of bacteria that match the characteristics of bacteria found in the stool of warm-blooded mammals. Finding these bacteria in water indicates faecal pollution and the water sample potentially dangerous. Other indicator bacteria are E. coli, faecal streptococci, or total coliforms.

Faecal-Oral Diseases Diseases transmitted by ingesting faecal pathogens through water or food. Includes water-borne diseases.

Filtration Passing water slowly through filters—usually specially constructed sand filters—to remove solid particles, protozoa, and most bacteria.

Flocculation Gentle stirring of water to encourage the formation and settling of heavy colloidal particles called *flocs*.

Free residual chlorine Hypochlorite ion form of chlorine that is lethal to most bacteria and viruses

Microbiological Quality Based on normal levels of indicator bacteria such as coliforms or E. coli. Sometimes includes total viruses.

Pathogen Anything that causes disease, especially micro-organisms.

Personal Hygiene Tasks that are primarily carried out by an individual to promote or preserve his or

her health, such as keeping hands and body clean by bathing, avoiding contaminated articles, clothing, etc.

Physical Quality Acceptable taste, smell, and appearance of water.

Potable Water Water that is of sufficient quality to be drunk and used for domestic and personal hygiene without causing significant health risk from short term use due to waterborne diseases or to chemical or radiological contamination.

Sedimentation The removal of suspended particles in water by gravity.

Settling Storing water undisturbed for 1-2 days to allow heavy matter to settle (sedimentation) and many viruses, protozoa, and bacteria to die off. Aluminium sulphate speeds up the sedimentation process but not the dying off of pathogens.

Spring A location where groundwater flows naturally upwards to the earth's surface.

Water-Borne Diseases Diseases acquired by drinking contaminated water (e.g., diarrhoea, cholera, amoebiasis, leptospirosis, infectious hepatitis).

Water-Washed Diseases Diseases arising due to lack of water (e.g., scabies, skin infections, eye infections, lice (typhus), salmonellosis (food).

Well A deep hole in the ground that is dug or drilled to obtain water.

(The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** chapt. 14)

General Principles of Sanitary Engineering

The field of environmental health is based on the concept that certain *hazards,* (disease-carrying organisms, chemicals, etc.) move through the environment and cause harm to humans. Control measures need to be focused on the following areas:

· preventing the *creation* of the hazard

· preventing the *transport* of the hazard.

· preventing people from being *exposed* to the hazard once they encounter it.

These three types of preventive approaches will apply whether the sanitation technician is trying to prevent diarrhoea or vector-borne diseases, or to control toxic waste. The principal hazard of water and sanitation programs in humanitarian emergencies is usually human **faeces**, which can transmit various types of pathogens.

In vector control, the disease-carrying vector or rodent is the main hazard.

Because *creation* of faeces is unavoidable, a sanitation technician must ensure the following:

· minimise the *transport* and spread of faeces in the environment by setting up a sanitation system for proper disposal.

· minimise the displaced population's *exposure* to faeces.

For diseases that are transmitted by the faecal-oral route, this means minimising oral ingestion through personal hygiene measures, food hygiene and water treatment.

This is an example of environmental control measures for Malaria and Cholera:

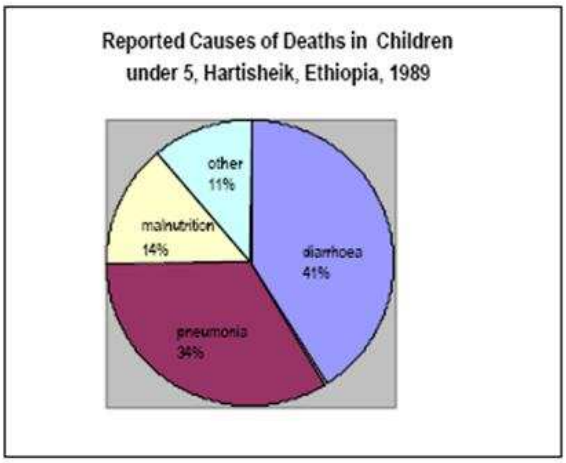
Disease	How to Prevent Creation	How to Prevent Transport	How to Limit Exposure
Cholera	Cook shellfish in areas where cholera has an ecological niche	Chlorinate water Disinfect and sterilise contaminated material	Promote food hygiene and consumption of acidic foods Promote home water treatment
Malaria	Drain stagnant water to stop mosquitoes from breeding	Spray against mosquitoes	Use impregnated bed-nets Apply insect repellents

No environmental control measure functions perfectly 100% of the time, the best way to deal with this shortcoming is by putting **multiple sanitary barriers** between the hazard and a population.

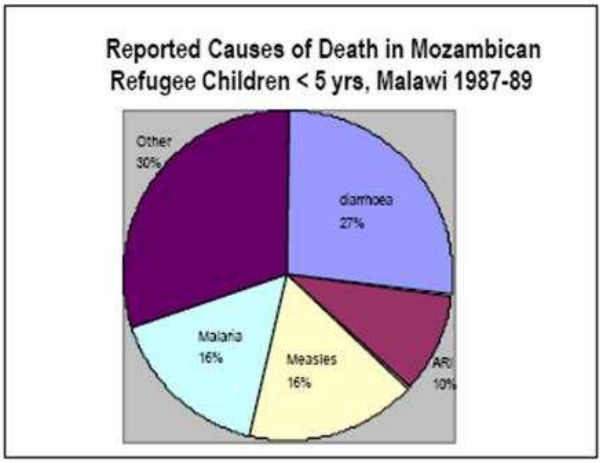
During emergencies the camps of refugees or IDPs are usually set up on the spot with no time to choose healthy locations or predispose drinkable water distribution and waste management. The combination of **overcrowding and unhygienic life stiles** can lead to epidemics.

Large-scale outbreaks of diarrhoea and other environment-related diseases are frequently reported among displaced populations, particularly during the acute emergency phase. These outbreaks may be a sign of insufficient efforts in controlling environmental hazards and the monitoring risk of disease outbreaks. Planners of emergency relief programs have to make environmental health control their top priority.

Control measures should be started immediately and improved gradually (based on urgency and resources) to achieve the Sphere Project's minimum standards of services by the end of the acute emergency phase.



Source: MSF



Source: MSF

Pneumonia	34%
Diarrhoea	41%
Malnutrition	14%

Malaria	16%
Diarrhoea	27%
Measles	16%

Source: The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES chap. 5.**

Potential Needs during on Emergency:

Source: Handbook for Delegates 2002 Adapted from Assisting in Emergencies. Resources Handbook for UNICEF Field Staff, UNICEF 1986

This chart can be used to rapidly evaluate the potential needs during an emergency before having received a complete assessment of the situation.

	Famine Drought	Floods	High Winds	Earthquakes	Refugees	Conflicts
Water and Sanitation						
Distribution, Storage, Treatment				1		
Rehabilitation/development of sources		2	2	1		2
Excreta Disposal		U		U		
Garbage disposal		U		U		
Personal hygiene		U		U		
Vector control				U		
Food and Nutrition						
Short-term general distribution						
Long-term general food distribution		R		U		
Supplementary/therapeutic feeding						
Agricultural production				3		
Nutritional surveillance						
Shelter						
Emergency shelter			C	C		C
Construction		4				
Blankets		C	C	C	C	C
Household fuel						
Household items (cooking utensils etc.)		4				
Health						
Health personnel				5		
Reconstruction, transport and equipment						
Medical supplies				5		
Immunisation						
Diarrhoea control						
Surveillance for communicable diseases						
Social Welfare and Tracing						
Community social services						
Unaccompanied children						
Schools/education						
Tracing						

Key

Needs frequently experienced		Needs primarily in urban areas	**U**	1. Only if ground water flows changed
Needs sometimes experienced		Needs primarily in rural areas	**R**	2. If wells or usual surface sources are contaminated or inaccessible
Needs rarely arise		Depending on climate	**C**	3. If major irrigation works are damaged
				4. Only for flash floods
				5. First few days only for casualty treatment

SANITATION
Basic Concepts

Epidemiological studies in developing countries have shown that use of latrines or other excreta containment facilities provides greater protection against diarrhoeal diseases than any other environmental health measure.

The purpose of a sanitation system is to contain human excreta at the moment of defecation so that it is not free to spread throughout the environment.

Getting as many people to use excreta containment facilities as often as possible is the goal of all sanitation programs. Sanitation workers should clearly communicate to the affected population how it is essential for *everyone* to always defecate in the excreta containment facilities. Whatever the circumstances, an appropriate sanitation program must be developed that considers the following:

- In some cultures, there is need to build separate latrines for men and women and special latrines for children.
- In some settings, latrines may be needed at places of work or public gathering areas (market, health facility, etc.)

Note: *Although animal faeces and urine may also transmit disease, the danger is much lower than from human faeces.*

The minimum standards of the Sphere Project recommend having a minimum coverage **of 20 people per latrine**. (This level of coverage is rarely achieved in transit and reception centres).

Providing some type of sanitation facilities during the first days of a crisis is critical for preventing outbreaks of diarrhoeal diseases. Defecation fields should be established immediately following the arrival of people in an IDP camp. A proper site must be reserved for defecation fields, away from water sources but not too far from the dwellings to discourage people from using them.

Children experience a disproportionate amount of diarrhoea compared to other members of the population, and they shed the most hazardous faeces. Their defecation habits are particularly difficult to control. The solution to this problem involves two steps:

- educate child-care providers about proper handling of children's faeces and the importance of washing their hands after cleaning children and/or handling children's faeces.
- child-friendly latrines need to be available. Child-friendly latrines are not dark (perhaps even have no walls) and have a squat hole that is smaller than in an adult latrine.

Sanitation Options

The following factors should be considered when selecting sanitation systems:

- · *Acceptance* – cultural factors are considered in the design.
- · *Access* – the population has access to latrines.
- · *Use* – the population is educated on proper latrine use.
- · *Maintenance* – proper maintenance of latrines is organised.
- · *Drainage* – the latrines are protected from surface water drainage.

Further reading:

The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** Chap 5

Personal Hygiene:

No area of environmental intervention is more difficult than promoting personal hygiene. Not only do cultural practices vary between people, but some languages often do not easily translate words such as privacy or faeces. Therefore, as in sanitation, local professionals are the people who are best suited to develop and deliver hygiene education. Regardless of the setting, several basic premises seem universal including:

1. People need to be able to clean themselves after defecating. If anal cleansing is done with paper or sticks, these materials must be readily available in or near the latrine. If anal cleansing is done with water or with people's hands, water and soap must be made available at the latrines.

2. Hand washing, particularly after defecating and before preparing food, has been shown to be protective against faecal-oral illnesses. No studies examining the impact of personal hygiene found health benefits associated with education alone. Therefore, any efforts to promote hand-washing should be monitored to ensure that increased hand-washing is actually occurring.
3. Soap provides protection from diarrhoeal illness independent of any educational program that may accompany it. Therefore, providing soap should be a priority in settings where diarrhoeal diseases and dysentery are likely to occur.
4. Educational messages should be short and focused. All messages and pictures included in an educational campaign should promote ways that are known to prevent the specific health threat at hand. They should also focus on behaviours that are not being practised by a significant fraction of the population.

An educational campaign promoting six messages about hygiene was organised in Tajikistan during a typhoid fever outbreak in 1997. An evaluation of the campaign found that people who received and understood the messages were as likely to develop typhoid fever as those who had not. In this case, only one of the six messages, “boil your drinking water,” had any relationship with the way the disease was being transmitted.

The following tables show examples of short and focused messages on hygiene and defecation:

Example of Educational Messages on Hygiene

1. · Wash hands with soap after defecation.
2. · Wash hands with soap after cleaning babies.
3. · Wash hands with soap before preparing food.
4. · Wash hands with soap before eating.

Example of Educational Messages on Defecation

1. · Go to the defecation zone and help children to go to the defecation zone.
2. · Use the shovel to dig a little hole in the ground.
3. · Cover the excreta with soil after defecation.

Water

Sources of Water

Water sources fall into three general categories (refer to the Figure above):

1. **Rainwater***:* In general, rainwater, though pure, is not reliable or a sufficient source to provide for a large displaced population and is rarely considered during complex emergencies.

2. **Surface water***:* Surface water from lakes, ponds, streams, and rivers have the advantage of being accessible (water easily collected) and are predictably reliable and plentiful. They have the disadvantage of generally being microbiologically unsafe, and therefore, requiring treatment.

3. **Groundwater**: Groundwater from wells, springs, etc. tends to be of higher microbiological quality (having undergone natural soil filtration underground). However, it is relatively difficult to extract. More technology and energy is needed (compared with other water sources) to bring water from within the earth up to the surface.

The following factors are important when selecting the type of water sources for displaced population:

1. the reliability of available water sources
2. the water needs in relation to population size
3. the intended length of intervention
4. the locally available skills and resources
5. the capacity of the implementing agency

Water Quantity

In developing countries, evidence shows that providing people with *increased amounts* of water is more effective in protecting against faecal-oral pathogens than providing them with *cleaner* water. The minimum standards of the Sphere Project states that at least **15 to 20 litres per person per day** (l/p/d) is needed to maintain human health. While the availability

of water is influenced by the situation, more water can almost always be obtained with more resources (more wells, trucks, or pipes). Because obtaining water in arid areas is expensive and the relationship between water quantity and health is not well understood, there is a tendency not to invest enough in water infrastructure when other demands seem more serious. This makes monitoring the availability of water during emergency situations an essential component of a public health program.

During the acute emergency phase, water consumption should be estimated weekly. Often, the utility company or relief organisation providing water to a displaced population has these estimates. It is important to realise that water consumption means *what people receive* not what the *water team produces*.

Disagreements may arise between “production” and “consumption” estimates because:

- Water can be lost or wasted during pumping and transport.
- Lack of water containers can prevent people from collecting enough water.

Surveys or household interviews that document the amount of water collected at watering points or people’s actual use of water are preferable to simply dividing the amount of water produced at a well or a plant by the number of people served. Cholera outbreak investigations have repeatedly shown that not owning a bucket puts families at increased risk of illness or death. Thus, not only should the average water consumption be 15 l/p/d or more, but there should not be anyone in the population with very low water consumption (<7 l/p/d). In addition, all families should be provided with suitable water containers for daily collection and storage of water. Special drainage pits should be constructed to manage runoff water at distribution points.

Water Quality

Water quality is usually measured by the presence of specific groups of micro-organisms. This indicates the possible presence of faeces. Because human faeces typically contain tens of millions of bacteria per gram, even the smallest trace of faeces in water is often detectable

by bacterial monitoring. Faecal coliforms are a category of bacteria that match the characteristics of bacteria found in the stool of warm-blooded mammals.

Other indicator bacteria, such as E. coli, faecal streptococci, or total coliforms, are maintained by the same premise — absence implies safe water.

Guidelines for Water Quality (UNHCR)

Faecal Coliforms (per 100 mls of water)	Interpretation	Recommendation
0-10	Reasonable quality	Acceptable
10-100	Polluted	Better protection and simple treatment
100-1000	Very polluted	Treatable, but look for alternative source
Over 1,000	Grossly polluted	Source to be avoided

Note*: Water quality testing may be performed by a competent local laboratory (must be done within 6 hours of sampling), or by using field testing kits.*

While water sources may differ in water quality, it is how water is handled and stored by consumers that will finally determine whether the water is safe for drinking. Studies have shown that dipping hands into household storage buckets causes considerable contamination and that water quality declines over time after the water is initially collected. The best way to keep water safe in the household is to add a chlorine residual to the water.

For further information of collection and transport of water and water treatment consult:

The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** Chap 5 pg 183-185

Assessing Needs

Example of a Survey Questionnaire

HOUSEHOLD WATER SURVEY

Date:_____ Interviewer:_____

Location:_____ Household number:_____

1. *Introduce yourself and explain the purpose of the survey.*

2. *Ask the person who collects water for the household:*
   How much water did you and other family members collect yesterday (for all purposes)? _____

3. How many water vessels do you have? Number _____; Estimate total volume _____

4. a. How many members are there in your family? _____
   b. How many of them consumed water yesterday? _____

5. Does your family have a latrine? _____

6. How many other families share the latrine? _____

7. Do you own livestock? _____
   If yes, what kind of livestock and how many? _____

After the assessment, all the information should be analysed and presented in a way that allows for transparent and consistent decision-making.

Calculations Drawn from Questionnaire

1. *Average Water Consumption =* $\frac{\text{Total amount of water collected}}{\text{Total number of family members present}}$

2. *Give the family credit for ½ or 1/3 of a latrine, depending on their sharing habits with other families.*

   Latrine Coverage = $\frac{\sum \text{Number of latrines}}{\text{Total number of families interviewed}}$

The assessment should help relief planners determine whether external resources are needed, depending on the national standards for water supply, sanitation and vector control

of the host country. The following exhibit outlines the conclusion of an environmental health assessment report:

1. **Main hazard** affecting the disaster situation (human excreta, vectors) should be stated.

2. **Current measures** to control the hazard (note whether they are adequate).

3. **Immediate and future actions** if necessary should be outlined, using a phased approach. Actions may include the following environmental health interventions:

- setting up temporary defecation areas until other solutions are available to improve the general hygiene
- providing sufficient quantities of quality water and restoring damaged water system
- reducing the vector and rodent populations to acceptable levels

4. **External resources required** (technical skills, chemicals, equipment or spare parts, staff to organise culturally and technically appropriate defecation facilities or areas).

5. **Further investigations** if necessary (e.g. by a road or water and sanitation engineer).

Further reading:

The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** Chap 5

SHELTER

Shelter is a critical determinant for survival in the initial stages of a disaster. Beyond survival, shelter is necessary to provide security and personal safety, protection from the climate and enhanced resistance to ill health and disease. It is also important for human dignity and to sustain family and community life as far as possible in difficult circumstances. Involving women in shelter and settlement programmes can help ensure that they and all members of the population affected by the disaster have equitable and safe access to shelter, clothing, construction materials, food production equipment and other essential supplies.

Women should be consulted about a range of issues such as security and privacy, sources and means of collecting fuel for cooking and heating, and how to ensure that there is equitable access to housing and supplies.

Particular attention will be needed to prevent and respond to genderbased violence and sexual exploitation. It is therefore important to encourage women's participation in the design and implementation of shelter and settlement programmes wherever possible.

Planning guidelines require 45m2 per person, this includes household plots and the area necessary for roads, footpaths, educational facilities, sanitation, firebreaks, administration, water storage, distribution areas, markets and storage, plus limited kitchen gardens for individual households. Area planning should also consider evolution and growth of the Population. In the immediate aftermath of a disaster however, particularly in extreme climatic conditions where shelter materials are not readily available, a covered area of less than 3.5m2 per person may be appropriate to save life and to provide adequate short-term shelter to the greatest number of people in need. Graveyards should be at least 30 metres from groundwater sources used for drinking water, with the bottom of any grave at least 1.5m above the groundwater table. Surface water from graveyards must not enter inhabited areas.

Source: Chapter 4:Minimum Standards in Shelter, Settlement and Non-Food Items

HUMAN RESOURCES IN EMERGENCIES

Human resources in relief operations usually comprise of **local staff** (all members recruited from within the host country) and **expatriate staff** (recruited from outside the country) who may work on contract or as **volunteers**.

1. **Local Staff**: Most relief workers are recruited from the beneficiary or host population. Even though local professional and para-professional staff may be available, they may not have enough experience or skills to run a relief operation with special emergency projects for displaced populations, e.g., search and rescue activities, selective feeding programs, prevention of sexual and gender violence, etc. Some professionals from the displaced population may have been considered “enemies” during the conflict and were killed.

The professionals and para-professionals that survive the conflict (doctor, nurse, social worker, psychiatrist, etc.) and are available for recruitment may lack recognition or certification as a professional by the host country.

2. **Expatriate Staff**: Relief organisations have to recruit international professionals where the displaced or host population lacks professionals to set up or deliver essential services (medical, mental health, social services, etc.). However, expatriate staff may be unfamiliar with the culture of the host country and displaced population and keeping them over the long-term may not be cost-effective. Many expatriates have extensive experience and bring new skills from other emergency situations. In reality, they serve as program monitors or neutral parties during relief distribution to displaced people, particularly where there is conflict. The presence of expatriate staff may sometimes be the only guarantee that supplies (food, medical) will actually be provided. Or sometimes, their presence makes high-ranking government officials more co-operative in giving support to the local staff. Thus, when the expatriate staff leave, critical supplies may cease to arrive or it may be more difficult to get any assistance from the authorities.

3. **Volunteers**: Voluntary service is a natural part of life in developing countries. Helping others in situations of distress or emergencies requires no particular motivation because it is

a behaviour that comes with belonging to a family or community. Even though an organisation may recruit and pay many staff members, volunteers are the backbone of a relief operation. Volunteers may include community health workers (CHWs), representatives of the beneficiary population, volunteers from the host or displaced populations, or from local groups or NGOs. These volunteers offer voluntary service for various reasons, for example:

- · to serve others and do useful work in the community
- · to receive training
- · to do challenging work
- · to become involved in Red International Organizations activities.

Determine Staffing Requirements

The affected population should play a central role in delivering services. Outsiders may be limited by language barriers and unfamiliarity with the local culture. The table below defines the minimum standards for staffing in health services:

• Home Visitor:	1 per 500-1000 people (at least 50% should be female)
• Traditional Birth Attendant:	1 per 2,000 population
• Supervisor:	1 per 10 home visitors, 1 senior supervisor
• Qualified health worker:	1 per 10,000 population (based on 1 person per 50 consultations/day)
• Health worker:	1 per 20-30 beds (8 hour shifts)
• Doctor:	1 per 50,000 population
• Locally-trained health worker:	1-2 for pharmacy, 1 for ORT, 1-2 for dressing/injection/sterilisation
• Non-medical staff:	1-2 clerks, 1-3 guards (8 hour shifts), cleaners

It is not enough to base the number of personnel required only on the recommended health worker norms, but also according to the level of competence of the work force. To ensure the most productive use of people, the following should be specified when new staff are recruited:

· Who will do what?

· Who will be responsible?

· Who will report to whom?

Drawing an **organisational chart** and individual **job descriptions** may help answer the above questions. Organisational charts help define reporting lines while job descriptions are

useful for selecting the right staff and preventing future problems of excess staffing or poor performance. For each staff position, very short job descriptions can be drawn (one to two sentences that summarise the main responsibilities will do). The organisational chart and job descriptions may need revision during the course of the relief project because of changes in the emergency situation, in staffing or program funding.

Modified from The Johns Hopkins and Red Cross/Red Crescent **PUBLIC HEALTH GUIDE FOR EMERGENCIES** Chap 3.

Disease prevention and Health Maintenance: Personal tips

The following are general tips for Disease Prevention and Health maintenance:

Immunisation. The operator should be immunised against the diseases prevalent in the country of assignment.

Sensible dress. The operator should consider seasonal variations in the climate of the country of assignment and take along suitable clothing where it may not be available in country. Cotton is strongly recommended for hot climates. Cotton clothes absorb perspiration and can be boiled and ironed at high temperatures. This last point is important, for example, in the prevention (through quick drying of clothes) of ***skin myiasis***, caused by the larva of a fly that lays its eggs on wet linen. A sweater is recommended even for the tropics, as evenings in both the dry and rainy seasons can be cool. In cold climates, warm clothing is naturally required. Warm bedding is equally important, such as a good sleeping bag for the coldest nights or for circumstances where blankets are not available. Good solid footwear is also important no matter what the climate. In hot countries good footwear is a protection against ***jiggers***, parasites which commonly get under the skin of the feet and can give rise to abscesses. Rain gear should be taken regardless of destination. A mosquito net should be available in a tropical climate. (Contact your HQ before leaving to determine what should be brought and what is available on site).

Mission Lifestyle Though the operator may develop health problems while on mission, very few of these problems are likely to be immediately serious. However, if neglected, they may become so. Therefore it is vital that the operator take care of him or herself, lead as healthy a lifestyle as possible and be vigilant against any symptoms of ill-health. A basic principle to be applied in all circumstances is: ***when new to an area, strict health rules are to be followed***. When more is known about living in that area, only then can some rules be safely relaxed.

Food and drink. The diet should be watched closely. The daily in-take of energy-giving foods and protein needs to match the operator's level of physical and mental activity. However, food and drink can also carry disease. Before drinking water make sure it has been boiled or filtered or disinfected. Hot coffee and tea are safe as are soft drinks, but ice should be avoided, as it is only as safe as the water it has been prepared from. Where one cannot be sure of the quality and safety of raw food, only food that has been well-cooked and served while hot should be eaten. However this will only be possible for short periods. Fruit and vegetables are a must for essential vitamins. Unless they can be peeled, they should be treated with alimentary disinfectant such as tasteless potassium permanganate (KMnO4). In tropical climate avoid cold buffet, mayonnaise and mayonnaise dressing, custards and creams made with eggs as they can easily be contaminated if left at room temperature.

Alcohol. One can talk about abuse of alcohol when alcohol consumption starts affecting operator's work or working and living conditions. Abuse of alcohol is damaging to a operator's health. Regular abuse of alcohol is usually an indication that an operator is not adapting well and early termination of mission may be necessary. It is a misconception that alcohol consumed with food kills harmful bacteria. In countries where alcohol is forbidden, the operator must strictly comply with the mission's internal regulation.

Rest and recuperation. Mission life is frequently a succession of long periods of work without a real break. In emergency situations this cannot go on for long without the operator taking time out for proper rest and recuperation. Lack of rest can induce health problems related to stress and produce psychosomatic illness. The delegates' work will inevitably suffer. Where regular and normal days off work are not possible, special rest and recuperation ***(R&R)*** periods can be arranged by the Head of mission, based on the level of stress experienced by individual operators.

Sexually transmitted diseases (STDs). Perhaps the proverb "Prevention is better than cure" is truer in the case of these diseases than for any other. The most threatening STD, ***AIDS***, is incurable. Detailed AIDS information can be obtained from HQ.

Hepatitis B is transmitted by blood and semen, and is therefore also considered an STD. Prevention by immunisation does exist, and immunisation is mandatory for all health personnel who might handle blood products. The use of a condom protects equally against Hepatitis B and the HIV virus, as well as other STDs (syphilis, gonorrhoea, clamydiae etc.) It should be remembered that sex ***within*** the PNS staff is ***not*** safer than outside.

Most Frequent Health Problems

Other health hazards will vary from country to country and from mission to mission. Detailed and accurate information on potential hazards should be given to operators upon arrival at their Office.

In hot climates the most frequent problem is ***dehydration***. It can be caused by diarrhoea, or profuse sweating resulting from prolonged sun/heat exposure. Drinking plenty of liquids (but ***not*** alcohol) prevents it and operators should watch out for dehydration

symptoms, which include dry mouth and tongue, headache, nausea and vomiting (which will further aggravate the dehydration). Steps must be taken to rehydrate.

Rehydrating Solution: Can be prepared by mixing Water (one litre) Sugar (two tablespoons) Salt (one teaspoon). If dehydration is caused by diarrhoea it can be accompanied by potassium depletion. Bananas are a good source of potassium and are available in most tropical countries.

Operators need to be particularly attentive to the problem of contaminated water. Where the purity of water is suspect, bottled, boiled or otherwise purified water should be drunk.

Water-borne diseases also include those which contaminate food, as it is always water that provides the main route for the germs. Such diseases are carried in the faeces of those infected. When the infected faeces comes into contact with ground water, the contamination cycle starts. The best prevention is adequate sanitation.

- ***Diarrhoea*** is the water-borne disease symptom most frequently reported: around 30%-50% of all travellers report having diarrhoea at least once. It can be caused by a wide variety of pathogens – from viruses (in up to 90% of cases, therefore antibiotics

are not effective) to bacteria and protozoa. Treatment should always start with careful ***rehydration***. If the diarrhoea is associated with fever (above 38 ° C), or if there is blood in the stools or it continues for more than 48 hours medical advice should be sought.

- ***Poliomyelitis*** and ***Hepatitis A*** and ***E***, are viral diseases and prevention by immunisation exists, except in the case of hepatitis E.
    - Poliomyelitis is primarily Diarrhoeal, but one in one thousand cases has more serious complications.
    - Hepatitis affects the liver and requires long-term rest and a strict diet. Hepatitis E, recently identified, has the potential to become a major disease with a high mortality rate.
- ***Typhoid fever***, ***cholera*** and ***shigellosis*** are bacterial diseases which affect areas with poor hygiene and sanitation. An effective vaccine exists for typhoid fever, and prophylaxis is available for cholera. Treatment is by antibiotics.
- **A*moebiasis*** and ***giardiasis*** are protozoic diseases contracted through eating or intake of contaminated water or food. No vaccine is available. Treatment does exist, but a proper diagnosis needs to be made through stool examination.
- Other parasitic diseases include various types of ***worms*** and adequate treatment can only be prescribed after the eggs have been identified in the urine or the stool.

As well as diseases spread by polluted water or contaminated food there are those carried by vectors such as insects. The most frequently ***vector-transmitted diseases*** posing a risk to delegates are:

- ***Malaria***, a disease carried by mosquitoes, is judged to be the planet's most common infectious disease according to the numbers of people infected. One of the most common forms can cause the serious conditions of cerebral malaria and sometimes renal failure. Malarious mosquitoes are dangerous only at sun-down and at night. So the best form of prevention is to ***avoid mosquito bites*** by using mosquito nets,

mosquito repellents and by wearing long sleeved garments and trousers. Where recommended by medical staff, ***prophylaxis*** should be taken regularly in the prescribed form.

- ***Dengue fever, yellow fever, haemorrhagic fevers, encephalitis*** are among a number of viral diseases known as arthropod-borne viruses. Some are more serious than others: dengue fever can be either of the haemorrhagic or non-haemorrhagic type. Prevention includes immunisation where vaccines are available (yellow fever, Japanese B encephalitis). Treatment is mainly a matter of rest. In case of fever it is preferable to rely on paracetamol to lower temperature rather than aspirin; the latter should be avoided because of possible haemorrhagic complications.

Skin diseases are often considered minor ailments. However, they have a potential for developing unpleasant complications.

- Hot and humid conditions favour ***fungal*** diseases, which require long treatment with anti-fungal cream after careful washing and drying. Operators who already suffer from this kind of problem at home, and particularly female operators with vaginal candidosis, are likely to experience an increase in its occurrence when in hot countries. An adequate supply of the treatment normally in use should be taken on mission.
- Because people sweat a lot in hot climates the smallest wound can become badly infected through humidity and flies. ***Abscesses*** can result which are difficult to cure. All wounds, even insignificant ones, should, therefore, be quickly disinfected and dressed.
- ***Scabies*** is frequently found in crowded living conditions e.g. among refugees and displaced persons. This disease can spread easily. Treatment includes the application of a lotion and the disinfecting of clothes and linen. Prevention is based on careful hygiene, especially the use of soap.

- In Central African and Central American countries whenever a small painful abscess appears, ***ticks***, ***myiasis*** and ***jiggers*** (parasites penetrating under the skin) are to be suspected. They can, however, be easily prevented by wearing proper clothes and footwear and by avoiding swimming in unknown waters.

In cold climates, such as in Eastern Europe and Russia, immunisation against ***tuberculosis*** and ***diphtheria*** is recommended, as outbreaks of these diseases have been registered. The diphtheria germ is still sensitive to antibiotics.

Traffic accidents are probably the single most important cause of injury to aid workers. It is important to always travel with a basic first aid kit in the car. If assisting at the scene of an accident always ensure that you wear a pair of surgical gloves; it is all to easy to forget about the possibility of coming in contact with contaminated blood in the rush to assist injured persons. It is important to ensure that there is a basic repair kit in the vehicle particularly if embarking on a long trip. Food and water should be carried. If working in a cold climate, it is essential to ensure you carry extra blankets and clothing in case you break down and/or become stranded overnight. Most importantly, always wear your seat belt, drive carefully and ensure that your driver does.

On Return

Once the mission is over, the operator will be debriefed. The two major aspects of this process relating to health are the post-mission ***medical examination*** and the ***psychological debriefing***. The ***psychological debriefing*** should not be neglected. It is essential that the operator has at least one interview with someone who understands psychology, in order to see how the operator has coped with mission stress. The operator ought to be aware of the possibility of his or her experiencing ***delayed stress symptoms*** some weeks after return from mission if and when such symptoms occur the operator should refer to local HQ for information. Reference to a psychotherapist is not to be ruled out and should help an operator suffering stress to return to normal. This will also prevent slow and long-term mental deterioration.

The operator also needs to be aware that he/ she will need time to readapt to normal life. The period of readjustment can be very important for couples or families, where one partner or family member has been on mission while the other partner has, or family members have, taken care of affairs at home. This can generate misunderstandings and frustrations, with a common complaint being: “My role has not been fully acknowledged.”

(Modified form Handbook for Delegates 2002 chapt. 8.)

Prevention: Working as a team member

There will always be problems with other team members and sometimes the team leader will not be fulfilling his or her responsibilities. It is essential therefore that all members of the team contribute to building the team spirit and sorting out any issues as they occur.

1. Clarify your own role and responsibilities. When ready to take on more responsibility, initiate a discussion with the team leader. Suggest the area, the objectives and any authority limits. Make sure of receiving the necessary information, coaching and resources.
2. Do not make quick judgements even if you have previous experience. No mission is similar to another: what worked before may not be appropriate in a new country and a different environment.
3. Be willing to learn from the Operating National Society, local people and your colleagues. Do not make statements: take time to listen and ask questions before taking decisions.
4. Welcome, introduce and integrate newcomers to the team. In dealing with them recall your own first days on a mission: what worried you then, what you wanted to find out etc.
5. Support your colleagues, especially the team leader. He or she may need it more than others.
6. Share information, ideas and experiences with other members of the team. It creates confidence and may even become vital in some situations (security for instance).
7. Do not blame or criticise others. Everybody can make a mistake – tomorrow it may be you. Better look for a solution together, and make sure that the lesson is learned and the mistake is not repeated.

8. If having problems with other members of the team or the team leader, raise the issues directly with them and together look for a solution. Most conflicts can be easily resolved if tackled early enough.

During missions on the field the operators are exposed to stressful and unfamiliar situations, are forced to live with people they have never met before and share with them most of a 24h day. For this reason stress management and teal behaviour are essential for the good evolution of a project.

Common signs of excessive stress:

Stress is an unavoidable reality, and the level of stress in a delegation is often higher than in normal life.

Stress can have both positive and negative sides. Pressure can push operators to perform at their very best or it can be overwhelming and drive delegates to exhaustion or depression. There are many factors causing stress on mission – the disaster itself and the difficult conditions surrounding it (i.e. a high mortality rate); insecurity, uncertainty and lack of safety and support; various frustrations stemming from unmet needs and expectations or conflicting expectations; poor communication or lack of it both inside the delegation and with the National Society; cultural differences and the inevitable change in the

operator's lifestyle and environment. The way the operators themselves interpret the actual events may also increase or decrease the stress level.

Some operators may already be under stress before going on mission because of personal or professional worries. However, such problems are unlikely to be solved by a mission that can itself be highly stressful. Moreover, such individual problems may make life more difficult for other operators.

Fact Sheet : Types of Stress

Basic Stress

A mixture of positive and negative stress related to the situation itself. Operators should learn how to prevent it and cope with it. Basic stress normally decreases after the first weeks of a new assignment.

Cumulative stress

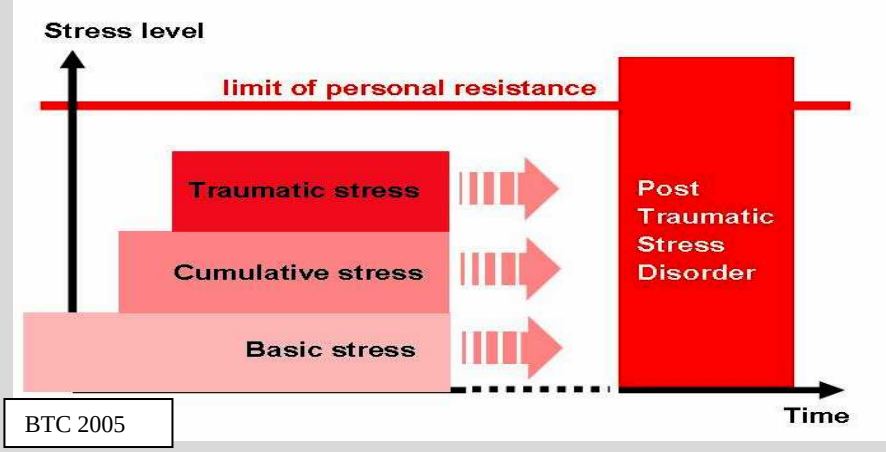
It follows prolonged exposure to work and non-work factors and may develop into professional exhaustion known as "burn out".

Traumatic stress

This is caused by situations outside the range of everyday experience, where the delegate's life is perceived to be under immediate threat, or if he/she witnesses or is subject to violence or natural disaster.

PTSD

Traumatic stress might further develop into Post Traumatic Stress Disorder (PTSD), a pathological condition which will require referral to mental health specialist.



The many and varied symptoms of stress are in fact *coping mechanisms* and normal reactions to abnormal situations. Each individual will have his or her own way of manifesting stress, based on personal and cultural background.

- *Physical signs* of stress are probably the most common ones, experienced by nearly everybody. They include generalised aches and pains, chest pains, headaches, cardio-vascular indications (with or without changes in blood pressure), thirst, dry mouth, nausea, vomiting, diarrhoea, diffuse sweating and chills. Normally they are not life-threatening. If no physical cause can be found for such symptoms, then psychological stress could be the explanation. However, the tendency to blame stress for everything should be resisted.
- *Fear* is a normal safety reaction in threatening situations. However, when an operator expresses unrealistic fears or anger, or guilt or anxiety about something for which he or she is not responsible, or complains of recurrent thoughts or dreams affecting his or her work, then stress may be the likely cause. Fear and/or irrational thoughts can dramatically increase stress levels.
- Another stress symptom is an *abnormal memory*, which forgets significant events/details and at the same time remembers irrelevancies. Difficulty in

concentrating, which may result in poor decision-making, can also be symptomatic of stress with a potentially damaging impact on the mission.

- More important changes in behaviour can occur after lengthy exposure to stress. The operator may progressively *withdraw* from his or her colleagues, friends or family.
- *Hyperactivity* can be confused with enthusiasm and dedication. However, an operator unable to stop, who relentlessly increases the workload without concern for its relevance and also stops questioning the effectiveness of what he or she is doing is more likely to be a victim of stress.
- *Smoking* increases on mission and individuals who smoke tend to consume more cigarettes than they would normally. Stressful situations increase smoking, but smoking will *not* necessarily reduce stress. In fact, it can bring more stress in the long term.
- Stressful situations increase *drinking*, and individuals who drink tend to consume more alcohol than they would normally. However, alcohol does *not* reduce stress; on the contrary – the more a person drinks the less he or she can cope with stress. Alcohol can also bring more stress in the long term.
- Most alarming is *anti-social behaviour*: when the operator may unreasonably break the rules or offend the customs of the host country. If neglected, such behaviour can compromise or place at risk other operators and/or the programme.

Burnout is a state of psychological and physical exhaustion that affects strongly motivated and high achieving people that perceive failure in the achievement of a given task or goal. It is the most serious manifestation of stress as described above usually characterized by exhaustion, withdrawal, anti social behaviour, low self esteem and depression.

Preventing and coping with stress.

How to Avoid Mission Stress

Heads of Mission have a key role to play in creating as far as possible a “low” *stress working* and *living environment* in a mission. They ought to ensure that operators follow a regular work pattern, including a manageable workload.

Lack of clarity in assigning tasks and poor information flow can often increase the stress level. It is important therefore that the operator has a clear idea of what is expected of him or her. Heads of Mission should encourage and facilitate extensive professional and personal *communication* inside the group. Operators have different cultural backgrounds, with different ways of communicating and expressing feelings. Every member of the team should have the opportunity to express him or herself in any way he/she feels comfortable with.

The operator can also avoid a certain amount of stress by making sure he or she lives and works in adequate *working* and *living conditions*. While one should be prepared for a certain lack of comfort, particularly during the initial emergency phase of an operation, operators themselves and, in particular, the Head of Mission should make every effort to establish a reasonably healthy standard of living in terms of food, accommodation and working conditions.

Treating Mission Stress and sustaining others:

The first response to stress is to provide comfort and care: the affected person should be able to rest and, if necessary, be given a rest and recuperation period away from the delegation. The stressed operator should be encouraged to speak about his or her problems, frustrations or unmet expectations in an informal and friendly context. Attentive and friendly *listening* is the first and the simplest thing to do to help a stressed person. Everything should be done to ensure that words match deeds when responding. If these steps are ineffective in relieving the stress, the delegate should then be referred for counselling to a health professional. Medication can be prescribed, but only by a qualified person.

In most cases simple and timely measures can effectively mitigate the consequences of stress. The team will always play a critical role in providing immediate support to an operator in need.

The field team can at any time contact the experts in psychological support at Rome HQ for support: these contacts will remain strictly confidential.

Trauma

An extreme case of stress is trauma. Stress can turn to trauma if the operator's life comes under threat e.g. he or she is involved in a major accident with many victims, held at gun point, or otherwise subjected to violent or aggressive behaviour. Trauma can also result from a long and slow process of building tensions that suddenly breaks down into crisis. It demands management by a health professional. Operators who come to the end of their mission with a feeling of helplessness may develop a psychological state close to trauma and manifest post traumatic stress disorders.

If inadequately managed or ignored, major stress and trauma can lead to serious psychological disorders, social marginalisation and even suicide.

The traumatised operator should be referred to a health professional who preferably speaks the operator's mother tongue. If necessary, arrangements can be made to evacuate the operator his or her National Society. In the meantime, measures should be taken at the office to provide the appropriate material and emotional support. (Source Handbook for Delegates 2002 chapt. 8).

Personal Security Tips:

Health and security of a relief worker are priorities of each relief agency and for this reason a security network must be in place. In international emergencies humanitarian workers find themselves in a foreign country (subject to the laws and regulations of the place) during an emergency (that leads to the disruption of “normal” life in the country). Moreover in complex emergencies workers may find themselves in areas of war and armed conflict and they must be conscious of the setting they are in and behave in a convenient manner.

Security Rules for Non Conflict Conditions

Personal Items

- An identity badge is to be carried at all times.
- Wherever possible, passports should be deposited in the Organization safe. Operators should retain a photocopy of the key pages for identifying themselves when the identity badge is not considered sufficient.
- Personal medical information concerning blood group and current medication, where applicable, is to be deposited at the Organization office.
- As a general rule, operators shall not drive any vehicles, but use the service of locally employed drivers. However, an international driver’s licence, or a licence valid for driving in the host country if present, are to be carried at all times.

Dress and Personal Behaviour

- Dress and personal behaviour of all operators must not offend local traditions, cultural and working customs and habits.

Movement and Travel

- Movement and travel – whether private or work-related – must conform to restrictions that may be in place.

- The Head of Mission should always be informed about any work-related or private movements or travel of operators within the country of assignment. Procedures and schedules for regular contact during travel – by radio, telephone or other means – should be fixed before every trip and strictly followed.

Wherever possible, operators should not travel alone, especially outside towns.

Curfews

- Local curfews, as well as those that may be imposed by the Head of Mission, must be strictly obeyed.

Vehicles

- Local drivers must always be used when travelling outside towns. Operators should as much as possible avoid driving themselves, even inside towns.
- Speed limits in the mission country, as set by the law or by the Head of Mission, must be strictly observed.
- All vehicles used must carry a first aid kit. This is the responsibility of the driver. Operators should have at least basic first aid training.
- All vehicles used must be mechanically sound and road-worthy, drivers will check the vehicles before starting a journey. No arms may be carried in vehicles if your Organization is to appear neutral and involved only in humanitarian business.
- All vehicles must be clearly identified by the Organization logo. Any exception to that rule, including those for security reasons, should be authorised by the Team Leader.

Taking photographs

- No cameras are to be carried or photographs taken in areas where security is unstable.
- It is strictly forbidden to take any photos in airports, at checkpoints or during declared Alerts or Red situations. Similarly taking pictures of local army, police and security personnel or members of any other armed groups is strictly prohibited..

- Even where photographs can be taken, extreme care should always be exercised in doing so, in order not to offend local customs or traditions thereby provoking an incident.

Security Rules for Conflict Conditions

General rule

- In any unusual or dangerous situation:
    - Stay calm and rational.
    - Follow the advice of local people.
    - Try to inform the Head of Mission or other operators as soon as possible.
    - All operators must have with them at all times the Head of Mission's phone number, address and names of person(s) to contact in case of injury.

Checkpoints

- Regard all checkpoints with caution. They may be manned by personnel with varying degrees of experience, sometimes nervous or agitated. Do not drive through or leave a checkpoint until you are sure of the intentions of the security personnel.
- When approaching a checkpoint:
    - slow down to a walking pace,
    - open the window slightly,
    - switch off background noise (music, air conditioner, heater, etc.),
    - when approaching the checkpoint at night, switch to parking lights and illuminate the vehicle with the interior light,
    - make sure your hands remain visible,
    - follow the signals of the security personnel,
    - stop if requested to do so.
- When requested to stop:
    - bring the car to a halt,

- do not resist searching of the vehicle or personal belongings or identity checking,
- be relaxed and courteous,
- do not move away unless you receive a clear instruction to do so by someone who appears to have official authority,
- slowly drive away and check that everything is normal by glancing in your mirror,
- If you hear a gunshot, stop at once, remain seated and wait. Remain calm.
- If you face a problem of any kind, do not hesitate to use the car or portable radio to inform the Head of Mission. However, make sure that security personnel manning the checkpoint are fully aware of what you are doing.

➢ *When Directly Threatened by Arms*

- Stay where you are (if in the car, stay in the car).
- Leave your hands clearly visible (in a car – clearly visible on the steering wheel).
- Do not be aggressive, do not try to escape.
- Remain passive, but demonstrate personal composure and calmness.
- Move slowly with precise gestures.
- Speak quietly and distinctly.
- Identify yourself. Say that you are from your Organization.
- Do what you are told.
- Give them what they request or what you have.

Mines, Booby Traps and Unexploded Devices

Any area which has been fought over and where the warring parties established strong defensive positions (in particular where those positions changed hands) will usually be mined. This is especially true of lowlands in front of defensive hill positions. Such areas may

also contain a lot of unused or undetonated explosives and ammunition. All delegations working in such areas must follow particularly strict security rules and preventive measures.

Reporting of Security.

All staff is exposed to security/safety incidents such as accidents, criminality in general and acts resulting from conflict. A systematic and immediate reporting of all incidents affecting the security of the Organization delegations and staff, is essential. Even though it seems to be a minor anomaly, the incident as such may be indicative of mounting tension or a possible future trend of threats, and it is imperative that this be well-documented and available at higher level (Head of Mission, headquaters) for the senior management.

Modified from : Handbook for Delegates 2002 chapt. 8.

PART III

Data Collection:

Data collection is extremely important when working on the field because the information that can be acquired by elaborating raw data can be useful both in pursuing and adapting the project to local needs and in acquiring information on statistical trends and significance to motivate further interventions in the field of interest. For this reason the collection of data must be uniform in kind and method and must never be changed during the course of a mission abroad even in situations of complete or partial staff turn over.

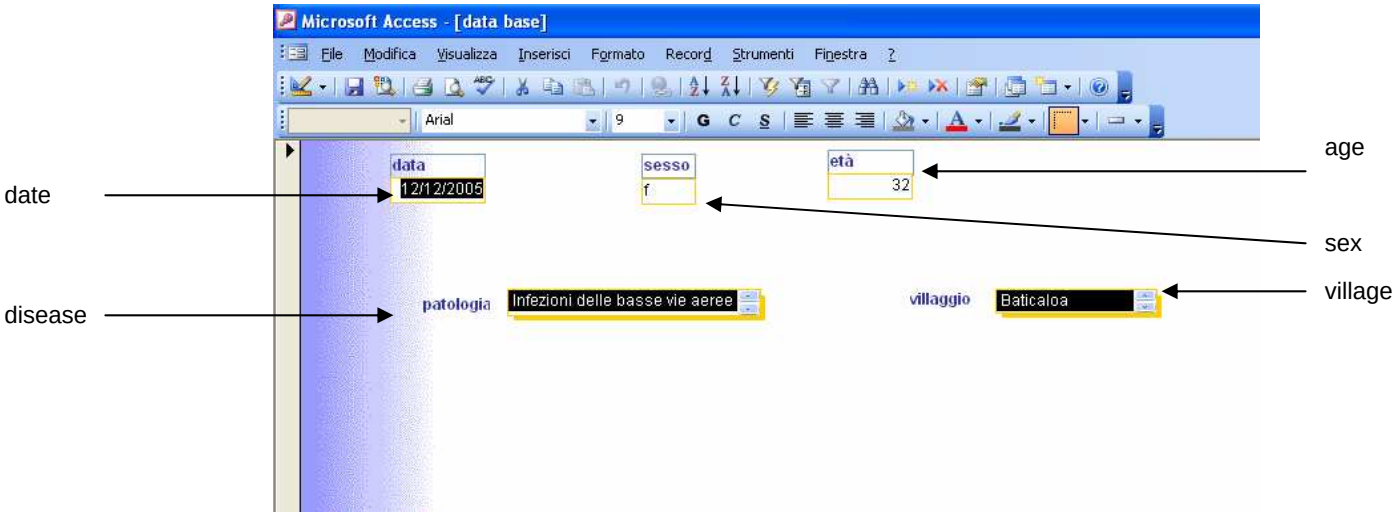
Data base:

Many databases exist in order to collect data and allow to :

1. Create archives according to disease, age, sex, date of access to the health service and distinguishing hospitalized from out patients.
2. Elaborate graphs in order to visualize the most common diseases and the number of medical interventions made in a certain amount of time (a month, a week…)

However a specialized system for epidemiological surveillance of communicable diseasaes is necessary for the study of the territorial distribution of infections and rapid identification of clusters. Communicable diseases are of great importance during the median and late phase of emergencies and educational and medical activities should be adapted to the picture frame drawn with this intrument.

Example of a simple Communicable disease DB:



The Pharmacy can be monitored using the existing archioving system (such a HMS) that allow to define up and download of drugs and to monitor expenses in this field.

Drug info

An up to date software on drugs should be available in order to associate commercial and farmacological names of drugs bought in foreign countries. Moreover it is a useful tool for physicians and farmacists both in prescription and supplying that need to be adaptable to the local market

Paperwork models:

The models for communications and project elaboration should be standardized and common to all missions, in order to supply all requested information.

The following are examples of field reports formats, project proposal formats, Surveillance report format, Demography report format.

Field reports are official documents and as such should be compiled. This means they need to be punctual and must present appropriate style (no exclamation marks, ironic remarks etc.)

Surveillance Report : Surveillance for Communicable diseases by the medical staff deployed on the field is important because it allows us to understand what the situation is and what measures we can take locally, on the other side, and more importantly, it allows interaction with the medical district and local authorities that in case of need may organize public health campaigns, control of water born infections through control of water supplies, vaccination campaigns etc. The method through which cases of infectious diseases can be made known to local health institutions is through “Notification”. A notification is a document produced by local public health systems according to local laws and regulations that indicate the types of diseases to be notified and the amount of time between observation and notification. International notification rules exist and should be in all cases respected when working abroad, usually they do not contrast with local rules. Examples of International Rules for notification:

Notification of Infectious Diseases:

International classes of notification

Class 1 (Urgent) Plague, Cholera, Yellow Fever.
Class I A Louse born typhus fever, relapsing fever, paralytic poliomyelitis, malaria, influenza, esanthematic diseases, TBC, CNS infections, rabies human.

Class 2 (less urgent) typhoid fever, diphtheria, agents of use in bioterrorism (Anthrax, Tularemia, Botulism, suspicion of smallpox), AIDS, fever (more than 7 days duration)
Class 2B Brucella, Leper

Class 3 (in endemic areas) : scrub typhus, hemorrhagic fever arenavirus.
Class 3B bartonellosis, coccidiomycosis
Class 3B (use for statistic and intervention planning on the territory) Schistosomiasis, fasciolopsis…

Class 4 (only if outbreak): Staph food poisoning, keratoconjuntivitis by adenovirus…

Date:

Field Report

From:	
To:	
Period:	

Part I **Overview:**

What is being done?

Who is doing it?

Where?

Are beneficiaries being reached?

How?

Are minimum standards respected?

Part II **Budget**

Project budget at the time of report (weekly and monthly reviews.)

Activities regarding financial activities regarding human resources, goods and services.

Administrative details.

Part III **Logistic team**

Ongoing programs.

Group interactions.

Medical Team

Ongoing programs.

Group interactions.

Part IV: **Other**

Modifications of security measures, local political balance, any other significant changes on the field. Critical attitude: Why is it happening? Have you any idea?

Date:

Medical Report

From:	
To:	
Period:	

Part I **Health ongoing programs**

How may patients are being visited daily?

How many in out patient regime? How many in hospital?

Monthly:

Which are the most frequent affections observed?

Which are the communicable diseases observed?

Epidemiological report:

Part II **Health programs in evolution**

Projects/ meetings / ongoing activities in this sector.

Part III **Budget**

Part IV **Other**

Concept papers and project proposals are the forms required for proposing projects. These forms however should be elaborated in concert with the HQ Desk at all times.

CONCEPT PAPER

Concept Paper No:

Project Sector:	
Project Sub Sector:	
Start Date:	
Place:	
Project Duration	
General Objective:	
Specific Objectives:	
INDICATORS	
Brief Description of Activities:	
Expected Results:	
Target Group(s):	
Number of Participants:	
Number of Beneficiaries:	
Budget:	
Details of Donor:	
Name:	
Address:	
Contact No:	
Contact Person in Sri Lanka:	
Contact No:	
Signature:	
Date:	

PROJECT PROPOSAL

TITLE

WHERE

FROM-TO (PERIOD OF TIME)

Project funded by …..

ORGANIZATION:
PROJECT TITLE:
PAGE NUMBER

1. Executive Summary

1.1 Project title:

1.2 Location:

1.3 Estimated Project Duration: months (FROM- TO.)

1.4 Total Budget: - €/ month

1.5 Number of direct beneficiaries: - people.

1.6 Donor:

1.7 Contact person in location:

2. Project Context

2.1 brief summary of the local situation, assessment of davmage to people and structures

2.2 *Response*

If your Organization has been working in the area describe it's activities

2.3 Co-ordination with ...

If you Cooperate with other Organizations describe it in this section.

3. Project Description

3.1 General Objective

3.2 Specific Objectives

3.3 Beneficiaries

3.4 Description of activities
What are the activities you whant to carry out?

3.5 Working Plan
Example of a **Time flow Chart**

Task / Activities	December	January	February	March	April	June	July-August	September-October	November	December
Health assistance										
Epidemiological surveillance										
Meetings with National Health Authorities										
Meetings with District Health Authorities and Village Heads										
Screening activities										
Evaluation										

3.6 Assumptions

3.7 Risks

3.8 Expected Results
3.9 Indicators

What are the Indicators you chose to evaluate the result of the activities.

3.11 Sustainability

4. Budget

Use an excel chart describing in detail how you would use your budget.

5. Required Resources

5.1 Human Resources
staff

5.2 Material Resources

Surveillance report format

Date
Period of analysis usually 1 month
Location

Total number of visits --- (M ----, F ----)

Communicable diseases observed

INFECTIOUS DISEASES	Total number of cases
GI and Hepato-biliary tract infections	
Skin Infections	
RTI	
FUO	
Otitis	
Conjunctivitis	
Virosis	
Vomit	
UTI	
Various	
Gynaecological infections	
suspect Malaria	

The distribution of all communicable diseases and in particular the trend of the 3 most frequent or epidemiologically significant diseases should be analyzed with excel graphs. Cases of Infectious diseases should be notified according to local laws and certification of this should be included in the report.

Notified cases:

INFECTIOUS DISEASES	Total number of notified cases

Demography report format

Date
Period of analysis
Location

All information available on the following topics should be sent on a 6 month basis to HQ.

- *population density and its variations*
- *age distribution*
- *sex distrubution*
- *ethnic distribution*
- *life expectancy at birth*
- *fertility*
- *occupation rate*
- *education*
- *other*

If possible include graphs and trends, motivate if possible variations observed, quote used reference.

Check list:

When leaving on an international mission you can refer to this check list for personal guidance:

- **Documents.**
  - ID card
  - Passport
  - Vaccination Card (all vaccinations up to date)
  - Photocopies of all the above.
  - Extra passport photos.
  - International driving license if available
- **Personal items.**
  - Consult HQ for information on climate and situation on the field.
- **Professional items.**
  - All professionals should bring books and instruments they consider necessary for their activity on the field. Consultation with HQ desk can be useful to verify what may be already on site.

Before leaving check:

- With the travel agency what is the maximum weight you are allowed for your baggage and if there are any other types of restrictions to be respected.
- Consult your physician regarding the mission, go through a routine check up and required vaccinations.
- Bring all necessary drugs with you because it may not be possible to find them on site.
- Any medical conditions (chronic and acute) must be referred to HQ desk at least 1 month before leaving presenting a medical certificate.
- Information of your insurance may be requested at HQ.

Useful Contacts and websites:

Cholera Cafè	
Web site	www.coleracafe.com
e-mail (web master)	info@coleracafe.com
Red Cross/Red Crescent Movement websites	
Italian Red Cross Website	www.cri.it
International Federation of the Red Cross Red Crescent Movement	www.ifrc.org
ICRC	www.icrc.org
UN Websites:	
WHO: world Health Organization	www.who.int
WHO regional Office for Europe	www.euro.who.int
Health library for Disastres	www.helid.desastres.net
Pan American Health Organization	www.paho.org
Relief Web	www.reliefweb.int
UNAIDS	www.who.unaids.org
UNDP	www.undp.org
UNHCR	www.unhcr.org
UNICEF	www.unicef.org
WFP	www.wfp.org
FAO	www.fao.org
World Bank	www.worldbank.org
Other international organizations and projects	
ECHO (EU Humanitarian Office)	http://europa.eu.int/comm/echo/
International Displacement Monitoring Office	www.internal-displacement.org
IOM (international organization for migration)	www.iom.int

Organization for economic cooperation and development	www.oecd.org
Sphere Project	www.sphereproject.org
Active Learning Network for accountability and performance	www.alnap.org
Important Health Institutions:	
CRED (Centre for research on the epidemiology of disasters)	www.cred.be
CDC (Centre or Disease Control)	www.cdc.gov
Natural Hazards Centre	www.colorado.edu/hazards/
News and Country information	
BBC	www.bbc.co.uk
ANSA	www.ansa.it
Free online encyclopaedia	http://en.wikipedia.org/wiki/Main_Page
CIA	www.cia.gov
Major NGO websites	
CARE	www.care.org
MERLIN	www.merlin.org.uk
MSF	www.msf.org
OXFAM UK	www.oxfam.org.uk
SAVE THE CHILDREN USA	www.savethechildren.org
WORLD VISION	www.wvi.org