UNIT 12 MINIMUM STANDARDS OF RELIEF

Structure

12.0 Learning Outcome

Upon studying this unit, you should be able to

- Appreciate the principles governing humanitarian action and rights of people affected by disasters;
- Have an overview of minimum standards for various sectors;
- Be able to interpret and apply these standards

12.1 Introduction

Disaster management should ensure that development efforts do not increase the vulnerability and the humanitarian response must be equitable. Many times the basic human rights of those affected by disasters are not upheld. To meet the requirement of improving the quality of assistance provided to people affected by disasters and to enhance the humanitarian system in disaster response having a standard for the form of assistance. By a remarkable collaborative initiative aimed at improving the effectiveness and accountability of disaster response, the Sphere Humanitarian Charter and Minimum Standards in Disaster Response sets out what people affected by disasters have a right to expect from humanitarian assistance. It is born out of concern that basic human rights of those affected by disasters are frequently not upheld.

Sphere is founded on two core beliefs that all possible steps should be taken to alleviate human suffering arising out of calamity and conflict, and those affected by disaster have a right to life with dignity and therefore a right to assistance**.** Its aim being to improve the quality of assistance provided to people affected by disasters and to enhance the accountability of the humanitarian system in disaster response. The ability to achieve the Minimum Standards depends on a various factors and some of these may be outside their control like political and security factors. It would also depend on the extent to which agencies have access to the affected population, the consent and cooperation of the authorities

in charge, and whether they can function in conditions of reasonable security. Availability of sufficient financial, human and material resources is essential.

The Charter is concerned with the most basic requirements for sustaining the lives and dignity of those affected by calamity or conflict. The Minimum Standards which follow aim to quantify these requirements with regard to people's need for water, sanitation, nutrition, food, shelter and health care. Taken together, the Humanitarian Charter and the Minimum Standards contribute to an operational framework for accountability in humanitarian assistance efforts. We will be discussing all the issues relating to the minimum standards in this unit. These details discussed in this unit have been adopted from the **Sphere Project – Humanitarian Chapter and Minimum Standards in Disaster Response.**

12.2 Humanitarian Charter

Meeting essential needs and restoring life with dignity are core principles that should form all humanitarian action. The Humanitarian Charter is based on the principles and provisions of international humanitarian law, international human rights law, refugee law, and the *Code of Conduct for the International Red Cross and Red Crescent Movement and (NGOs) in Disaster Relief*, the Charter describes the core principles that govern humanitarian action and asserts the right of populations to protection and assistance. The Humanitarian Charter expresses agencies' commitment to these principles and to achieving the Minimum Standards. This commitment is based on agencies' appreciation of their own ethical obligations, and reflects the rights and duties enshrined in international law in respect of which states and other parties have established obligations.

It recognise that that through their own efforts the basic needs of people affected by disasters are met, and the primary role and responsibility of the state is to provide assistance when people's capacity to cope has been exceeded. International law recognises that those affected are entitled to protection and assistance. It defines legal obligations on states or warring parties to provide such assistance or to allow it to be provided, as well as to prevent and refrain from behaviour that violates fundamental human rights. The primary roles and responsibilities of humanitarian agencies in providing assistance reflects the reality that those with primary responsibility are not always able or willing to perform this role themselves due to lack of capacity or a wilful disregard of fundamental legal and ethical obligations, resulting further human suffering.

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

1. The right to life with dignity: This is reflected in the legal measures concerning the right to life, to an adequate standard of living and to freedom from cruel, inhuman or degrading treatment or punishment. It entails the right to have steps taken to preserve life where it is threatened and a duty not to withhold life-saving assistance.

2. The distinction between combatants and non-combatants: This fundamental principle has been increasingly eroded with increasing proportion of civilian casualties. That internal conflict or 'civil war' must not blind the need to distinguish between those actively engaged in hostilities, and civilians and others (including the sick, wounded and prisoners) who play no direct part. Non-combatants are protected under international humanitarian law and are entitled to immunity from attack.

3. **The principle of non-refoulement**: This is the principle that no refugee shall be sent (back) to a country in which his or her life or freedom would be threatened on account of race, religion, nationality, membership of a particular social group or political opinion; or where there are substantial grounds for believing that s/he would be in danger of being subjected to torture.

In relation to the principles set out this Charter is based on the following instruments:

1. Universal Declaration of Human Rights 1948.
2. International Covenant on Civil and Political Rights 1966.
3. International Covenant on Economic, Social and Cultural Rights 1966.
4. The four Geneva Conventions of 1949 and their two Additional Protocols of 1977.
5. Convention on the Status of Refugees 1951 and the Protocol relating to the Status of Refugees 1967.
6. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984.
7. Convention on the Prevention and Punishment of the Crime of Genocide 1948.
8. Convention on the Rights of the Child 1989.
9. Convention on the Elimination of All Forms of Discrimination Against Women 1979.
10. Guiding Principles on Internal Displacement 1998.

12.3 Minimum Standards

The Minimum Standards do not attempt to deal with the whole spectrum of humanitarian concerns or actions. First, they do not cover all the possible forms of appropriate humanitarian assistance. Second, and more importantly, they do not deal with the larger issues of humanitarian protection. The minimum standards fall into two broad categories: those that relate directly to people's rights; and those that relate to agency processes which help ensure people acquire these rights. Some of the minimum standards combine both of these categories.

The Minimum Standards: The Sphere Handbook covers five core areas of disaster response, these are:

Chapter 1: Minimum Standards in Water Supply and Sanitation

Chapter 2: Minimum Standards in Nutrition

Chapter 3: Minimum Standards in Food Aid

Chapter 4: Minimum Standards in Shelter and Site Planning

Chapter 5: Minimum Standards in Health Services

The minimum standards specify the minimum levels to be attained in each area. Each chapter is divided into sections covering analysis, various aspects related to the standards and related human resource capacity and training. The Minimum Standards are an attempt to describe the

level of disaster assistance to which all people have a right regardless of political, ethnic and geographical specificity. The standards define the requirements for life with dignity in relatively general terms, while the indicators attach either qualitative or quantitative values to associated standards, together having aspects from assessment to evaluation.

Analysis of the disaster situation and the impact of the technical condition are critical. The agreed standards and indicators provides information to identify needs, design programmes, monitor and evaluate effectiveness, and ensure participation of affected population. Each is analysed on following three standards with key indicators and guidance notes:

1: initial Assessment: Programme decisions are based on a demonstrated understanding of the emergency situation and on a clear analysis of the specific risks and needs relating to the technical area.

2: Monitoring and Evaluation: The performance and effectiveness of the specific technical programme, its in responding to the related problems.

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

After describing the details of these standards, which are discussed in subsequent part of this unit, the Human Resource Capacity standards lays down the following three aspects:

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

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

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

12.4 Minimum Standards in Water Supply and Sanitation

In disaster situation, the people are affected by diseases related to inadequate sanitation and water supply. The aim would be to provide a minimum quantity of clean drinking water and to reduce faeco-oral diseases or exposure to vectors causing disease. Also, the responsibility for procuring water mostly falls on the women and children and safe and easy access to these services are essential. These standards are for water supply, excreta disposal, vector control, solid waste management, drainage and hygiene promotion.

Water Supply Standards

1. Access and Water Quantity: All people have safe access to a sufficient quantity of water for drinking, cooking and personal and domestic hygiene. Public water points are sufficiently close to shelters to allow use of the minimum water requirement. Key indicators being:

* At least 15 litres of water per person per day is collected.
* Flow at each water collection point is at least 0.125 litres per second.
* There is at least 1 water point per 250 people.
* The maximum distance from any shelter to the nearest water point is 500 metres.

2. Water Quality: Water at the point of collection is palatable, and of sufficient quality to be drunk and used for personal and domestic hygiene without causing significant risk to health due to water-borne diseases, or to chemical or radiological contamination from short term use. Key indicators being:
* There are no more than 10 faecal coliforms per 100 ml at the point of delivery for undisinfected supplies.
* Sanitary survey indicates low risk of faecal contamination.
* For piped water supplies to populations over 10,000 people, or for all water supplies at times of risk or presence of diarrhoea epidemic, water is treated with a residual disinfectant to an acceptable standard (e.g. residual free chlorine at the tap is 0.2-0.5 mg per litre and turbidity is below 5 NTU).
* Total dissolved solids are no more than 1,000 mg per litre (approximately 2,000 μs/cm electrical conductivity for simple field measurement), and water is palatable to users.
* No significant negative health effect due to chemical or radiological contamination from short term use, or from the planned duration of use of the water source, is detected (including carry-over of treatment chemicals), and assessment shows no significant probability of such an effect.

3. Water Use Facilities and Goods: People have adequate facilities and supplies to collect, store and use sufficient quantities of water for drinking, cooking and personal hygiene, and to ensure that drinking water remains sufficiently safe until it is consumed. Key indicators being:
* Each household has two water collecting vessels of 10-20 litres, plus water storage vessels of 20 litres. Water collection and storage vessels have narrow necks and/or covers.
* There is 250g of soap available per person per month.
* Where communal bathing facilities are necessary, there are sufficient bathing cubicles for bathing at an acceptable frequency and at an acceptable time, with separated cubicles for men and for women.
* Where communal laundry facilities are necessary, there is 1 washing basin per 100 people; private laundering areas are available for women to wash and dry undergarments and sanitary cloths.

Excreta Disposal Standards

1. Access to, and Number of Toilets: People have sufficient numbers of toilets, sufficiently close to their dwellings to allow them rapid, safe and acceptable access at all times of the day and night. Key indicators being:

* Maximum of 20 people per toilet.
* Use of toilets is arranged by household(s) and/or segregated by sex.
* Toilets are no more than 50 metres from dwellings, or no more than one minute's walk.
* Separate toilets for women and men are available in public places (markets, distribution centres, health centres etc).

2. Design and Construction: People have access to toilets which are designed, constructed and maintained in such a way as to be comfortable, hygienic and safe to use. Key indicators being:

* Technically sound design and construction specifications, approved by the intended users, are used for all forms of household and public toilets.
* Cleaning and maintenance routines for public toilets are in place and function correctly.
* Toilets are designed, built and located to have the following features:
- They are easy to keep clean enough to invite use and not to present a health hazard.
- They are accessible and easy to use by all sections of the population including children, old people, pregnant women and physically and mentally disabled people.
- They are lit at night if necessary for security or convenience.
- Hand washing facilities are close by.
- They minimise fly and mosquito breeding.
- They allow for the disposal of women's sanitary protection, or provide women with the necessary privacy for washing and drying sanitary protection cloths.
- They provide a degree of privacy in line with the norms of the users.
* Latrines and soakaways in most soils are at least 30 metres from any groundwater source and the bottom of any latrine is at least 1.5 metres above the water table. Drainage or spillage from defecation systems does not run towards any surface water source or shallow groundwater source.
* People are provided with tools and materials for constructing, maintaining and cleaning their own toilets if appropriate.

Vector Control Standards

1. Individual and Family Protection: People have the means to protect themselves from disease vectors and nuisance pests when they are estimated to be a significant risk to health or well-being. Key indicators being:

* All populations associated with a vector-borne disease risk have access to shelters equipped with insect control.
* Control of human lice is carried out to an agreed standard where louse-borne typhus or relapsing fever are a threat.

2. Physical, Environmental and Chemical Protection Measures: The number of disease-bearing vectors and nuisance animals that pose a risk to people's health and well-being are kept to an acceptable level. Key indicators being: Key indicators being:

* Vulnerable populations are settled outside the malarial zone.
* The population of malaria-bearing mosquitoes is kept low enough to avoid the risk of excessive malaria infection.
* Vector breeding or resting sites are modified where necessary and practicable.
* Rats, flies and other mechanical and nuisance pests are kept within acceptable levels.
* Intensive fly control is carried out in high-density settlements when there is a risk or presence of diarrhoea epidemic.

3. Good Practice In The Use Of Chemical Vector Control Methods: Vector control measures that make use of pesticides are carried out in accordance with agreed international norms to ensure that staffs, the people affected by the disaster and the local environment are adequately protected, and to avoid creating resistance to pesticides. Key indicators being: Key indicators being:

* Personnel are protected by the provision of training, protective clothing, supervision and a restriction on the number of hours handling pesticides.
* The purchase, transport, storage and disposal of pesticides and application equipment follow international norms, and can be accounted for at all times.
* People are informed about the potential risks of pesticides and about the schedule for application. They are protected during and after the application of pesticides according to internationally agreed procedures.
* The choice of pesticide and application method conforms to national and international protocols.
* The quality of pesticide and of treated bed nets conforms to international norms.

Solid Waste Management Standards

1. Solid Waste Collection and Disposal: People have an environment that is acceptably free of solid waste contamination, including medical wastes. Key indicators being:

* Domestic refuse is removed from the settlement or buried on site before it becomes a nuisance or a health risk.
* There are no contaminated or dangerous medical wastes (needles, glass, dressings, drugs etc) at any time in the living area or public spaces.
* There is a correctly designed, constructed and operated incinerator with deep ash pit within the boundaries of each health facility.
* There are refuse pits, bins or specified areas at markets and slaughtering areas, with a daily collection system.
* Final disposal of solid waste is carried out in such a place and in such a way as to avoid creating health and environmental problems.

2. Solid Waste Containers/Pits: People have the means to dispose of their domestic waste conveniently and effectively. Key indicators being:

* No dwelling is more than 15 metres from a refuse container or household refuse pit, or 100 metres from a communal refuse pit.
* One 100 litre refuse container is available per 10 families, where domestic refuse is not buried on site.

Guidance notes

Drainage Standards

1. Drainage Works: People have an environment that is acceptably free from risk of water erosion and from standing water, including storm water, flood water, domestic wastewater and wastewater from medical facilities. Key indicators being:

* There is no standing wastewater around water points or elsewhere in the settlement.
* Storm water flows away.

* Shelters, paths and water and sanitation facilities are not flooded or eroded by water.

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

* Sufficient numbers of appropriately designed tools are provided to people for small drainage works and maintenance where necessary.
* Water point drainage is well planned, built and maintained. This includes drainage from washing and bathing areas as well as water collection points.

Hygiene Promotion Standards

1. Hygiene Behaviour and Use of Facilities: All sections of the affected population are aware of priority hygiene practices that create the greatest risk to health and are able to change them. They have adequate information and resources for the use of water and sanitation facilities to protect their health and dignity. Key indicators being:

1. Water supply
* People use the highest quality of readily available water.
* Public hygiene facilities (showers, laundry basins etc) are used appropriately and equitably.
* Average water use for drinking, cooking and personal hygiene in any household is at least 15 litres per person per day.
* Covers (where provided) are placed on water containers.
* Mean faecal contamination in potable water containers is indicated by less than 50 faecal coliforms per 100 ml.

2. Excreta disposal
* People use the toilets available and children's faeces are disposed of immediately and hygienically.
* People use toilets in the most hygienic way, both for their own health and for the health of others.
* Household toilets are cleaned and maintained in such a way that they are used by all intended users and are hygienic and safe to use.
* Parents and other caregivers demonstrate awareness of the need to dispose of children's faeces safely.
* Families and individuals participate in a family latrine programme by registering with the agency, digging pits or collecting materials.
* People wash their hands after defecation and handling children's stools and before cooking and eating.

3. Vector control
* Bedding and clothing is aired and washed regularly.
* In malaria-endemic areas:
- People with treated mosquito nets keep, use and retreat them correctly.
- People avoid exposure to mosquitoes during biting times using the means available to them.
- Containers which may be mosquito breeding sites are removed, emptied of water regularly or covered.

4. Solid waste management
* Waste is put in containers daily for collection, or buried in a specified refuse pit.
* Parents, other caregivers and children are aware of the danger of touching needles and dressings from medical facilities, in cases where the minimum standard for the disposal of medical waste is not met.
5. Drainage
* Areas around shelters and water points are free of standing wastewater, and local storm water drains are kept clear.
* There is a demand for tools for drainage works.
* People avoid entering water bodies where there is a schistosomiasis risk.
6. Funerals
* People have the resources and information necessary to carry out funerals in a manner which respects their culture and does not create a risk to health.

2. Programme Implementation: All facilities and resources provided reflect the vulnerabilities, needs and preferences of all sections of the affected population. Users are involved in the management and maintenance of hygiene facilities where appropriate. Key indicators being:

* Key hygiene risks of public health importance are identified in assessments and in the objectives for hygiene promotion activities.
* The design and implementation process for water supply and sanitation programmes includes and operates a mechanism for representative input from all users.
* All groups within the population have access to the resources or facilities needed to achieve the hygiene practices that are promoted.
* Hygiene promotion activities address key behaviours of importance for public health and they target priority groups.
* Hygiene and behaviour messages, where used, are understood and accepted by the intended audience.
* Users take responsibility for the management and maintenance of water supply and sanitation facilities as appropriate.

Water quantities in addition to the minimum standard for basic domestic consumption are:

1) Public toilets 1-2 litres/user/day for hand washing, 2-8 litres/cubicle/day for cleaning toilet
2) All flushing toilets 20-40 litres/user/day for conventional flushing toilets, 3-5 litres/user/day for pour-flush toilets
3) Anal washing 1-2 litres/person/day
4) Health centres and hospitals 5 litres/outpatient, 40-60 litres/inpatient/day, Additional quantities may be needed for some laundry equipment, flushing toilets etc
5) Cholera centres 60 litres/patient/day, 15 litres/carer/day
6) Therapeutic feeding centres 15 -30 litres/person/day, 15 litres/carer/day
7) Livestock 20-30 litres/large or medium animal/day, 5 litres/small animal/day

12.4 Minimum Standards in Nutrition

General Nutritional Support to the Population Standards

1. Nutrient Supply: The nutritional needs of the population are met. Key indicators:

* Levels of moderate malnutrition are stable at, or declining to, acceptable levels.

* There are no cases of scurvy, pellagra or beriberi.

* Rates of xerophthalmia or iodine deficiency disorders are not of public health significance (see guidance notes below).

* There is access to a range of foods - staple (cereal or tuber), pulses (or animal products), fat sources etc.

* There is access to vitamin C rich or fortified foods or appropriate supplements.1

* There is access to iodised salt for the majority (>90%) of households where iodine deficiency disorders are endemic.

* There is access to vitamin A rich or fortified foods or appropriate supplements.[1]

* There is access to additional sources of niacin (e.g. pulses, nuts, offal) if the staple is maize or sorghum.

* There is access to additional sources of thiamine (e.g. pulses, nuts, eggs) if the staple is polished rice.

* Infants under six months have access to breast milk (or appropriate substitute).

* Children aged from about six months[2] have access to nutritious energy-dense foods.

* There is no indication that the extra nutritional needs of pregnant and breastfeeding women and adolescents are not being met.

2. Food Quality and Safety: Food that is distributed is of sufficient quality and is safely handled so as to be fit for human consumption. Key indicators
* There are no outbreaks of food-borne diseases caused by distributed food.

* There are no unreasonable complaints about the quality of foods distributed - from recipients or programme staff.

* Suppliers of food commodities carry out regular quality control and produce commodities that meet the official government standards or Codex Alimentarius Standards (e.g. with regard to packaging, labelling, shelf life etc).

* All foods supplied are systematically checked by independent quality surveyors.

* All food received in the country of distribution, for the disaster-affected population, has a minimum six-month shelf life (except fresh produce and whole maize meal) and is distributed to the population before the expiry date.

* Adequate storage structures (in line with current recommendations) are in place and proper management of stores is conducted (see Food Aid resource management standard, in chapter 3*).*

* Staff has adequate knowledge about potential health hazards caused by improper handling, storage and distribution of food.

3. **Food Acceptability**: Foods that are provided are appropriate and acceptable to the entire population. Key indicators
* People are consulted on the acceptability and appropriateness of the foods being distributed and results are fed into programme decisions.

* Foods distributed do not conflict with the religious or cultural traditions of the recipient or host populations (this includes any food taboos for pregnant or breastfeeding women).

* The staple food distributed is familiar to the population.
* Complementary foods for young children are palatable and digestible.

* There is no distribution of free or subsidised milk powder to the general population.

* People have access to culturally important condiments (such as sugar or chilli).

4. Food Handling and Safety: Food is stored, prepared and consumed in a safe and appropriate manner, both at household and community level. Key indicators
* There are no outbreaks of food-borne disease linked to a local food distribution site occurring as a consequence of hazardous food preparation.

* The coordinating body has received no reports from representatives of the affected population concerning difficulties in storing, preparing, cooking and consuming the food being distributed.

* Every household has access to at least one cooking pot, enough fuel for food preparation, water containers to store 40 litres; and 250g soap per person per month. (See Shelter and Site Planning, household items standards, in chapter 4; and Water Supply and Sanitation water supply standards, in chapter 1.)

* Where the food basket contains unfamiliar commodities, instructions on preparation are provided to households to maximise acceptance and minimise nutrient loss.

* Individuals who cannot prepare food or cannot feed themselves have access to a carer who can prepare appropriate food in a timely manner and administer feeding where necessary.

* Where food is distributed in cooked form, staff demonstrate knowledge about potential health hazards caused by improper storage, handling and preparation of commodities. (See human resource capacity standard 1.)

* Adequate milling or other processing facilities are available reasonably close to home if required, for example if whole grain is distributed.

Nutritional Support to Those Suffering from Malnutrition

1. Moderate Malnutrition: The public health risks associated with moderate malnutrition are reduced. Key indicators

* There is no increase in levels of severe malnutrition and/or there is no increase in numbers registered for therapeutic care.

* Surveillance systems are established to monitor malnutrition trends.

* Programme objectives reflect understanding of the causes of malnutrition and clear identification of the target group(s).

* All staff who have regular contact with mothers of young children are trained in the principles of infant and young child feeding in the emergency context. (See human resource capacity standards.)

* From the outset feeding programmes have clearly defined and agreed criteria for closure of the programme.

2. Severe Malnutrition; Mortality, morbidity and suffering associated with severe malnutrition are reduced. Key indicators

* Proportion of exits from a therapeutic feeding programme who have died is <10%.

* Proportion of exits from therapeutic feeding programme recovered is >75%.

* Proportion of exits from therapeutic feeding programme defaulted <15%.

* There is a mean weight gain of ≥8g per kg per person per day.

* Nutritional and medical care is provided to people who are severely malnourished, according to clinically proven therapeutic care protocols.

* Discharge criteria include non-anthropometric indices such as: good appetite; no diarrhoea, fever, parasitic infestation or other untreated illness; and no micronutrient deficiencies.

* Nutrition worker to patient ratio is at least 1:10.

* All carers of severely malnourished individuals are able to feed and care for them.

3. Micronutrient Deficiencies: Micronutrient deficiencies are corrected. Key indicators

* There are no cases of scurvy, pellagra or beriberi.

* Rates of xerophthalmia are not of public health significance (see general nutritional support standard 1).

* Rates of iodine deficiency disorders are not of public health significance (see general nutritional support standard 1).

* Appropriate WHO micronutrient supplementation protocols are implemented for individuals admitted to feeding programmes.

* All clinical cases of deficiency diseases presenting at health centres are treated using WHO micronutrient supplementation protocols.

* All children under five years old presenting at health centres with diarrhoeal disease receive Vitamin A supplements. (See Health Services measles control standards, in chapter 5.)

* All children under five years old presenting at health centres with hookworm, and who are not severely malnourished, receive iron supplements in conjunction with treatment for disease.

* Procedures to respond efficiently to micronutrient deficiency to which the population may be vulnerable are established. These might include active searching for cases, tracing and campaigning to raise public awareness.

12.5 Minimum Standards in Food Aid

Food aid requirements may be established for:

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

A complementary ration: to provide one or two food commodities to complement existing foods available and accessible to the affected population (for example, pulses and oil might be provided to complement locally accessible cereals).

A supplementary ration: to provide specific foods as a supplement to the general ration, in order to cover the needs of particular groups. Typically such groups would include malnourished individuals, young children and/or pregnant or nursing mothers.

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

* Requirements are based on the following WHO initial planning estimates:

    - 2,100 kcals per person per day.

    - 10-12% of total energy is provided by protein.

    - 17% of total energy is provided from fat.

- Adequate micronutrient intake through fresh or fortified foods.

* Estimates of people's food and income sources include consideration of:

- Market and income opportunities.

- Foraging and wild food potential.

- Agricultural seasons and access to productive assets.

- Sources of income and coping strategies.

* Ration scales include consideration of:

General nutritional requirements.

Specific needs of vulnerable groups.

Access to alternative sources of food and/or income.

* Commodity selection includes consideration of:

Local availability and market impact.

Local acceptability and preparation.

Fitness and nutritional composition.

Fuel requirements for cooking.

Targeting Standard: Recipients of food aid are selected on the basis of food need and/or vulnerability to food insecurity. Key indicators:

* Targeting objectives are agreed between the coordinating authorities, female and male representatives of the affected population and implementing agencies.

* Targeting criteria are clearly documented, whether in terms of population group(s) or geographical location.

* The distribution system is monitored to ensure that the targeting criteria are respected.

Resource Management Standard: Food aid commodities and programme funds are managed, tracked, and accounted for using a transparent and auditable system. Key indicators

* Safe stewardship practices are maintained to ensure that all commodities are safeguarded until distribution to recipient households:

    - Storage is safe and clean, and protects food commodities from damage and loss.

    - Third party service providers assume total liability for food commodities in their care and agree to reimburse any losses.

    - Food commodities are inspected and unfit commodities are certified and disposed of in accordance with standard procedures.

    - Damaged commodities are inspected and salvaged to the best possible extent.

    - Physical inventory counts are periodically reconciled with stock balances.

* Contracting for goods and services is transparent and fair.

* Inventory accounting and reporting systems are established:

    - Waybills document commodity transactions.

    - Stock ledgers provide summaries of receipts, issues and balances.

    - All losses are identified and accounted for.

    - Summary inventory reports are compiled and made available.

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

* The supply chain is established and includes procurement, documentation, transport, storage and handling from point(s) of origin to final destination(s) or distribution site(s).

* Local purchases of food commodities and contracting for logistics resources and services are coordinated; impact on the local market is taken into consideration.

* Information on food aid stock levels, expected arrivals, distributions and any other information relevant to planning, forecasting and managing the flow and availability of food aid is shared between agencies.

* Special staff are assigned responsibility for logistics management (e.g. planning and control, importation and clearance, primary and secondary logistics, warehouse and inventory management, transport planning and management, contract management and supervision).

* Delays in distribution arising from a commodity shortfall are no longer than two weeks.

Distribution Standard: The method of food distribution is equitable, and appropriate to local conditions. Recipients are informed of their ration entitlement its rationale.
Key indicators
* People are aware of the quantity and type of ration to be distributed for each distribution cycle, and reasons for any differences from established norms are provided.

* People receive the quantities and types of commodities planned.

* The method of distribution is readily accessible and scheduled at convenient times to minimise disruption to everyday activity.

* Recipients are involved in deciding the most efficient and equitable method of distribution; women are consulted and have an equal input into decision-making.
* When deciding the frequency of distributions (monthly or more frequently) there is consideration of:

- The cost of transporting commodities from the distribution centre.

- The time spent travelling to and from the distribution centre.

- The security of recipients and commodities once distributed.

12.6 Minimum Standards in Shelter and Site Planning

Housing (shelter) Standard

1. Living Quarters: People have sufficient covered space to provide protection from adverse effects of the climate. They have sufficient warmth, fresh air, security and privacy to ensure their dignity, health and well-being. Key indicators being:

* The covered area available per person averages 3.5-4.5m².

* In warm, humid climates, shelters allow optimal ventilation and provide protection from direct sunlight.

* In hot, dry climates, shelter material is heavy enough to ensure high thermal capacity. If only plastic sheeting or tents are available, provision of a double-skinned roof or an insulating layer is considered.

* In cold climates, shelter material and construction ensures optimal insulation. A temperature that is comfortable to the occupants is achieved by means of insulated shelter combined with sufficient clothing, blankets, bedding, space heating and calorific intake.

* If plastic sheeting is provided for shelter, it meets the specifications defined by UNHCR.

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

* People have access to sufficient blankets.

* Children up to 2 years old have at least one full set of clothing and hygiene materials appropriate to the culture, season and climate.

* Women, girls, men and boys have at least one full set of clothing in roughly the correct size, appropriate to the culture, season and climate. In addition, women and girls have a regular supply of sanitary protection.

* Culturally appropriate burial cloth is available as required.

Household Items Standard

1. Items for Households and Livelihood Support: Families have access to household utensils, soap for personal hygiene and tools for their dignity and well-being. Key indicators being:

* People have appropriate household items: 1 cooking pot with well-fitting lid, 1 basin, 1 kitchen knife, 2 wooden spoons; and 2 water collection vessels of 1-20 litres plus water storage vessels of 20 litres.

* Each person has: 1 eating plate, 1 metal spoon and 1 mug.

* Each person has access to 250g of soap per month.

* There is planning for durable items to be replacedwhen necessary.

* As soon as possible, each household has access to appropriate tools and materials to support livelihood activity.

* Tools and materials supplied are appropriate and familiar to the population, and are of a similar technological level to that which people were used to before the disaster. Items are appropriate to the conditions in which they are to be used.

* Those affected are aware of their entitlements under assistance programmes.

2. Environmental Concerns: Fuel economic cooking implements and stoves are made available, and their use is promoted. Key indicators being:

* People have access to, and make use of, fuel-economic and low smoke wood stoves (produced locally if possible), gas or kerosene stoves and cooking pots with well-fitting lids.

* The use and benefit of fuel-economic devices is promoted through community education programmes, if needed, and their production is planned as early as possible.

* People are aware of the benefits of using fuel-economic devices.

* Women are consulted about the location and means of collecting fuel for cooking and heating.

Site Selection Standard

1: Site Selection: The site is suitable to host the number of people involved. Key indicators being:

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

* The appropriate population size of a temporary settlement is defined following socio-economic assessments of both displaced and host populations, and assessments of the carrying capacity of the region and site.

* The appropriate type of temporary settlement required is determined: reception or transit centre; self-settled camp; planned temporary settlement or extension to a temporary settlement.

* Requirements for the form the settlement is to take are determined with reference to:

- Information generated by the physical assessment.

- Actual or potential threats to the security of the affected population. This is particularly important for refugee populations and is always critical for single women, widows and unaccompanied adolescent girls.

- The maximum estimated duration of the settlement.

- The preferred population density of the settlement.

- The level of integration of the displaced population with the host population.

* The requirements for the form of the settlement are tested against the physical constraints of each potential site. The site meets the following requirements, regardless of seasonal variations:

- It is located at a safe distance from possible external threats to physical security, usually not less than 50km.

- It is accessible by heavy trucks from an all-weather road. If it is necessary to construct a road, the soil type and terrain should support this activity. Communal facilities are accessible by light vehicles..

- It is near to existing social and economic facilities where appropriate.

- There are adequate quantities of water (for drinking, cooking, hygiene and sanitation).

- It is not less than 3 meters above the anticipated water table in the rainy season.

- Water rights, and the right to use other natural resources such as wood, stone, sand are arranged before, or at the same time as, the site is selected.

- Land rights are established prior to occupation and permitted use is negotiated as necessary.

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

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

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

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

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

* The site provides 45m² space for each person. This includes infrastructure (eg roads, sanitation, schools, offices, water systems, security/fire breaks, markets, storage facilities, shelter locations), but excludes land for agriculture (crops and livestock).

* Clusters of living areas or village groups are established.

* Empty land for possible future expansion is identified.

* There is provision for social facilities such as markets, places of worship, graveyards, health facilities, solid waste disposal, water points, community and nutrition centres, workshops, wood lots and recreational areas.

* There is provision for facilities required by humanitarian agencies such as administrative offices, warehousing and staff accommodation.

* There are adequate firebreaks of at least: 2 metres between dwellings, 6 metres between clusters of dwellings, and 15 metres between blocks of clusters.

* There is a graveyard for each population group and graveyards are appropriately located.

* Quarantine camps are established, or sites are identified and prepared, in isolation from general residential areas, in order to minimise the spread of an epidemic.

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

3: Security: Site selection and planning ensures sufficient personal liberty and security for the entire affected population. Key indicators being:

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

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

* Social, health, sanitation and other essential facilities are safely accessible for everyone, and are lit at night if necessary.

* Cluster planning is used in order to support self-policing by the displaced population.

* The overall size of the settlement population does not exceed a level that makes internal and external security and protection measures ineffective.

* Internal and external security and protection activities are carried out by the host authorities and/or the relevant UN agency.

* The agency assigned responsibility for overall coordination assists with internal security for groups at risk.

* Systems to prevent and manage the consequences of sexual and gender-based violence are in place.

* Women and adolescents know about the availability of health services for victims of sexual violence.

* Reasonable steps are taken to ensure that staff are not at risk. In insecure areas an evacuation plan is agreed between agencies.

4: Environmental Concerns: The site is planned and managed in such as way as to minimise damage to the environment. Key indicators being:

* Planning of temporary settlements takes into consideration density and dispersal of the displaced population:

- In fragile environments, the displaced population is concentrated in order to contain non-sustainable demand on the environment.

- In more robust environments, the displaced population is dispersed into a number of small settlements since these are less likely to cause environmental damage than large settlements.

* During site planning, trees and other vegetation are spared as far as possible. Roads and drainage patterns are planned in such a way as to make use of natural contours in order to avoid erosion and flooding.

12.7 Minimum Standards in Health Services

Measles Control Standard

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

2: Vaccination of Newcomers: Newcomers to displaced settlements are vaccinated systematically. All children 6 months to 12 years old receive a dose of measles vaccine and an appropriate dose of vitamin A. Key indicators being:

* Coordination with local health authorities (Expanded Programme on Immunisations - EPI) and involved agencies is established and ongoing.

* More than 95% of all children in the target group (including newcomers) are vaccinated. (See Appendix 5 for sample measles vaccination form.)

* On-site supply of measles vaccine equals 140% of the target group including 15% for wastage and a 25% reserve stock; projections of vaccine needs for subsequent newcomers are made and vaccine is procured if not already available.

* Only vaccines and autodestruct syringes meeting WHO specifications are used.

* The cold chain is continuously maintained and monitored from vaccine manufacture to vaccination site.

* On-site supply of autodestruct syringes equals 125% of expected target groups including a 25% reserve stock. Sufficient 5ml syringes for diluting multiple dose vials are available. One syringe is required for each vial diluted.

* Sufficient WHO-recommended ‘safety boxes' are used to store autodestruct and dilution syringes before their disposal. Boxes are disposed of according to WHO recommendations.

* On-site supply of vitamin A equals 125% of the target group including a 25% reserve stock if vitamin A is to be provided as part of a mass vaccination campaign.

* The date of measles vaccination is entered in each child's health record. Health records for recording vaccinations are provided if possible.

* Infants vaccinated prior to 9 months require re-vaccination upon reaching that age.

* Health facilities have the capacity to ensure routine ongoing measles vaccination of new arrivals if this is a displaced situation, and to identify infants needing to be re-vaccinated at 9 months.

* Relevant messages in the local language are provided to groups of waiting mothers or caregivers on the benefits of measles vaccination, possible side effects, when to return if re-vaccination is indicated and the importance of retaining the health record.

* A public information campaign is conducted by community workers before conducting a mass vaccination campaign.

3: Outbreak Control: A systematic response is mounted for each outbreak of measles within the disaster-affected population and the host community population. Key indicators being:

* A single case (suspected or confirmed) warrants immediate on-site investigation which includes looking at the age and vaccination status of the suspect or confirmed case.

* Control measures include the vaccination of all children 6 months to 12 years of age (or higher if older ages are affected) and the provision of an appropriate dose of vitamin A.

4: Case Management: All children who contract measles receive adequate care in order to avoid serious sequellae or death. Key indicators being:

* A community-wide system for active case detection using the standard case definition and referral of suspected or confirmed measles cases is operational.

* Each measles case receives vitamin A and appropriate treatment for complications such as pneumonia, diarrhoea, severe malnutrition and meningoencephalitis, which cause the most mortality.

* The nutritional status of children with measles is monitored, and if necessary children are enrolled in a supplementary feeding programme.

Control of Communicable Diseases Standard

1: Monitoring: The occurrence of communicable diseases is monitored. Key indicators being:

* The responsible surveillance and disease control unit or agency is clearly identified and all participants in the emergency know where to send reports of suspect or confirmed communicable diseases.

* Staff experienced in epidemiology and disease control is part of the surveillance and disease control unit or agency.

* Surveillance is maintained at all times to rapidly detect communicable diseases and to trigger outbreak response.

2: Investigation and Control: Diseases of epidemic potential are investigated and controlled according to internationally accepted norms and standards. Key indicators being:

* Diseases of epidemic potential are identified by the initial assessment; standard protocols for prevention, diagnosis and treatment are in place and appropriately shared with health facilities and community health workers/home visitors.

* Case reports and rumours of disease occurrence are investigated by qualified staff.

* There is confirmation of the diagnosis.

* Outbreak control measures are instituted and include:

- Attacking the source, by reducing the sources of infection to prevent the disease spreading to other members of the community. Depending on the disease, this may involve the prompt diagnosis and treatment of cases (eg cholera), isolation of cases (eg viral haemorrhagic fevers, ebola) and controlling animal reservoirs (eg plague).

- Protecting susceptible groups in order to reduce the risk of infection: immunisation (eg meningitis and measles); better nutrition and, in some situations, chemoprophylaxis for high risk groups (eg malaria prophylaxis may be suggested for pregnant women in outbreaks); safe blood supply and condoms for prevention of sexually transmitted infections and HIV.

- Interrupting transmission in order to minimise the spread of the disease by improvements in environmental and personal hygiene (for all faeco-orally transmitted diseases), health education, vector control (eg yellow fever and dengue), and disinfection and sterilisation (eg hepatitis B, ebola).

* Qualified outreach personnel (community health workers, home visitors) participate in the control measures at community level by providing both prevention messages and proper case management (provision of ORT and drugs, compliance with prescribed treatment, follow-up at home etc) following agreed guidelines.

* Public information and health promotion messages on disease prevention are part of control activities.

* Community leaders and community health workers/home visitors facilitate access to population groups and disseminate key prevention messages.

* Only drugs from WHO's *Essential Drugs List* are used.

Health Care Services Standard

1: Appropriate Medical Care: Emergency health care for disaster-affected populations is based on an initial assessment and data from an ongoing health information system, and serves to reduce excess mortality and morbidity through appropriate medical care**.** Key indicators being:

* Interventions are designed to be responsive to the identified major causes of excess death, disease and injuries.

* If possible, the local health authorities lead the health care effort and local health facilities are used and strengthened by participating humanitarian agencies. If this is not possible, an external agency leads the effort, works with existing facilities which may require substantial support and coordinates efforts of participating agencies.

* All participating humanitarian agencies agree to coordinate with the lead health care authority which is designated at the time of the initial assessment.

* The health care system is able to cope with a high level of demand.

* The health care system is flexible enough to adapt to changes identified by the health information system.

2: Reduction of Morbidity and Mortality: Health care in emergencies follows primary health care (PHC) principles and targets health problems that cause excess morbidity and mortality**.** Key indicators being:

* Emergency health care interventions are implemented through the existing PHC system if available. The PHC system includes the following levels of care:

- Household level.

- Community level including community health workers and home visitors.

- Peripheral health facilities (dispensary, health post or health clinic).

- Central health facilities (health centre).

- Referral hospital.

* Health care interventions are implemented at the appropriate level of the PHC system. Not every emergency will need all levels of care and the initial assessment can make this determination. If a local health care system does not exist, only those levels needed to prevent excess mortality and morbidity are introduced.

* Emergency health care, including treatment of disease and injuries, is provided to the population largely at community level. Some treatment occurs at health facilities and a smaller number of serious cases is sent to referral centres.

* Staffing at each level of the PHC system is appropriate to meet the needs of the population and only those levels required to reduce excess mortality and morbidity are used or introduced.

* Health professionals from the disaster-affected population are integrated into the health services as much as possible. Outreach workers are selected from the community and reflect the gender and cultural profile of the population as determined during the initial assessment.

* All health care providers agree on the common use of standardised procedures for diagnostic techniques and the treatment of the major priority diseases causing excess mortality and morbidity.

* The New Emergency Health Kits (1/10,000 population) are used to start the intervention but subsequent drug needs are ordered and follow the WHO recommended Essential Drug List.

* The Minimum Initial Service Packages is used from the start of the intervention to respond to the reproductive health needs of the population.

* Unsolicited donations of drugs that do not follow guidelines for drug donations are not used and are disposed of safely.

* Universal precautions to prevent and limit the spread of infections are taught and practised.

* Suitable transportation is organised for patients to reach the referral facilities.

12.8 Conclusion

Minimum standards of relief laid out by the SPHERE project are a valuable effort and need to be reviewed and adapted for applicability to the Indian context. Minimum standard of relief not only addresses the food requirements of the victimised but also provides for the health and immediate first aid facilities, looks at the water and sanitation needs, shelter requirements, and providing food that confines with the nutritional standards as laid down by the WHO and other such agencies. When addressing the relief requirements of the disaster victims, focus should be placed on the special needs of the vulnerable population that is, children, women, aged and the disabled. At the same time equity of relief distribution amongst beneficiary groups must be maintained.

The Sphere Humanitarian Charter and Minimum Standards in Disaster Response can be used in disaster response for the following:

1) In Project Cycle for assessment where indicators can be used as questions and their reference ensures that key issues are not over looked, formulation of objectives in programme planning and for monitoring and evaluation.
2) In disaster preparedness planning by identifying objectives for training and raising awareness, producing inventories of material resources required, and clarifying processes and roles.
3) Advocacy tool to generate resources or access to disaster affected population.
4) For coordination among agencies.

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

12.9 Key Concepts

Accountability: The responsibility to demonstrate to stakeholders, foremost of whom are disaster-affected people, that humanitarian assistance complies with agreed standards.

Humanitarian agency: A local or international non-governmental organisation, UN body or donor institution whose activities support the provision of humanitarian assistance.

Impartial assistance: Assistance is that given on the basis of need alone and makes no distinction as to race, creed, nationality, sex, age, physical or mental disability.

Indicator: 'Signals' that show whether a standard has been attained. They provide a way of measuring and communicating both the impact, or result, of programmes as well as the process, or methods, used. The indicators may be qualitative or quantitative.

The humanitarian principle: Prevention and alleviation of suffering, protection of life and health and respect for human dignity.

Transparency: Openness and accessibility of humanitarian agencies, their systems and information

Groups at risk: The needs of groups that are at risk of additional harm such as women, adolescents, unaccompanied minors, children, elderly people and people with disabilities must be considered. Gender roles within the social system need to be identified.

Equity: The participation of disaster-affected people in decision-making, programme design and implementation helps to ensure that programmes are equitable and effective. Special effort should be made to ensure the participation of women and balanced male and female representation within the assistance programme.

12.10 References and Further Reading

McConnan, Isobel (ed.) The Sphere Project – Humanitarian Charter and Minimum Standards in Disaster Response. New Delhi: Maya Publishers, 2000.

Government of India, *High Powered Committee on Disaster Management Report*, New Delhi: Department of Agriculture and Cooperation, Ministry of Agriculture, 2002.

http://www.sphereproject.org

12.11 Activities

1) What do you understand by the fundamental importance of the humanitarian charter?

2) What are the minimum standards in water supply and sanitation?

3) Sometimes these standards may be difficult to achieve in disaster situation. In such cases how can this be of relevance?