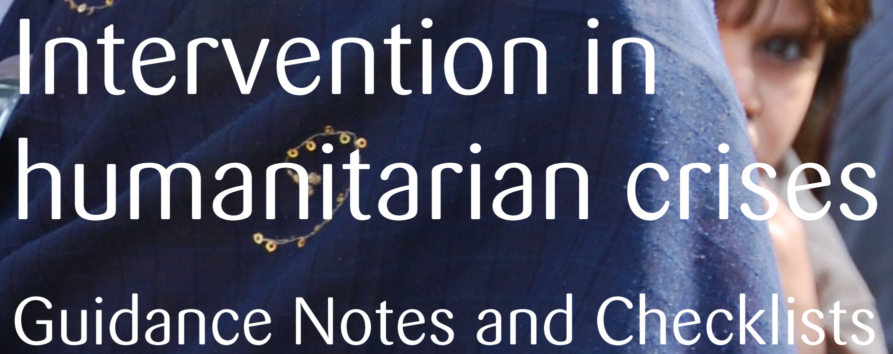

Intervention in humanitarian crises

Guidance Notes and Checklists

Imprint

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Intervention in humanitarian crises

Guidance Notes and Checklists

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1 Protection

Protection – Guidance Notes

Protection is the responsibility of the state, which is obliged under international law to protect civilians within its borders. According to the Sphere Project, there are four basic principles of protection that apply to all humanitarian actions:

1. **Avoid exposing people to further harm as a result of your actions**
   People involved in humanitarian response must do all they can to protect the affected population from further harm.

2. **Ensure people's access to impartial assistance – in proportion to need and without discrimination**
   Humanitarian assistance should be accessible to all those in need, particularly to most vulnerable groups. The denial of access to necessary assistance is a major protection concern.

3. **Protect people from physical and psychological harm arising from violence and coercion**
   People should be protected from violence and/or from being forced or induced to act against their will. Physical and psychological harm, spread of fear and deliberate creation of terror and panic should be prevented.

4. **Assist people to claim their rights, access available remedies and recover from the effects of abuse.**
   Humanitarian organisations should assist the affected population to claim their entitlements and rights for benefits (e.g. compensation or restitution of property, etc.). Affected people could be assisted to overcome the effects of rape and recover from the effects of abuse – physical and psychological, social and economic.

It is necessary that all humanitarian agencies follow protection principles, even if they do not have a protection mandate. There are following specific problem areas:

- ✓ Child protection
- ✓ Gender-based violence
- ✓ Housing, land and property
- ✓ Mine action
- ✓ Rule of law and justice[1]

1 The Sphere Project, 2011, p. 29

Human rights are universal and apply to all people affected by armed conflict or disaster. In addition, there are specific rights for certain groups determined by their vulnerabilities and special needs. The box below describes the fundamental rights people are entitled to, including specific groups and their special needs.

Rights that apply to all persons[2]	✓ The right to life ✓ The right to non-discrimination ✓ Freedom from torture or other cruel, inhuman or degrading treatment or punishment ✓ Freedom from arbitrary arrest and detention ✓ Freedom from enforced disappearance ✓ The right to seek and enjoy asylum ✓ The right to equal recognition of and protection before the law ✓ The right to an effective remedy ✓ Freedom of movement ✓ The right of family life and the principle of family unity ✓ The right to be registered at birth ✓ The right to an adequate standard of living, including adequate food, clothing, and housing ✓ The right to work ✓ The right to the enjoyment of the highest attainable standard of health ✓ The right to education ✓ The right to participation
Rights which are specific to certain groups	✓ The right to special protection for a child deprived of his/her family environment ✓ Freedom from child abduction and trafficking ✓ Freedom from underage recruitment ✓ The prohibition of child labour ✓ The prohibition of refoulement (forced return of a refugee to place of origin) ✓ The right of refugees to and identity document

2 NRC, 2008, p. 240

Groups with special protection needs[3]

Population Categories	Groups with specific needs
Boys and girls	✓ Unaccompanied and separated children ✓ Children formerly associated with armed forces or groups ✓ Child heads of households
Youth	✓ Out-of-school and unemployed youth
Women	✓ Women heads of households, incl. widows ✓ Women without male support ✓ Women formerly associated with armed forces/groups ✓ Women who are survivors of GBV
Elderly	✓ Older persons without family or community support ✓ Grandparents-headed households
Persons affected by sickness, disability or trauma	✓ Sick persons without family or community support ✓ Persons with physical disabilities ✓ Persons with mental disabilities ✓ Persons living with or at risk of HIV/AIDS ✓ Survivors of torture

Protection Risks in a camp settings[4]

- Attacks on civilians by parties to the conflict
- Presence of armed elements in the camp
- Child recruitment
- Gender-based violence (GBV)
- Abuse, neglect and exploitation of children
- Risk deriving from family separation, particularly for children, the oldest or other community members who rely on family support for their survival
- Presence of landmines around the camp
- Common crime
- Inadequate law enforcement
- Conflicts within the camp population and with host communities
- Absent or inadequate birth registration mechanisms
- Obstacles in accessing identity or other documents
- Lack of access to fair and efficient justice systems
- Restrictions to freedom of movement and choice of residence
- Limited participation in camp management by certain portions of the camp population
- Discrimination access to basic provisions and services – water, food, shelter, basic health services particularly for persons with specific needs
- Limited access to livelihood activities

3 NRC, 2008, p. 333
4 NRC, 2008, p. 240

Child Protection – Guidance Notes

Children represent the most vulnerable group in emergency situations. Child protection is defined as ***"the prevention of and response to abuse, neglect, exploitation and violence against children".***[5] Emergencies can have devastating effects on children's lives. They can be killed or injured, orphaned, separated from their families, recruited into armed forces or groups, sexually abused, or being trafficked. **The Minimum Standards on Child Protection in Humanitarian Action** provide standards for relevant child protection needs, such as:

- dangers and injuries
- physical violence and other harmful practices
- sexual violence
- psychosocial distress and mental disorders
- children associated with armed forces or armed groups
- child labour
- unaccompanied and separated children
- justice for children

Child protection risks in emergencies depend on different factors such as the nature of the emergency, the number of children affected, the different types of child protection problems, the level of organisation and stability of the state, the state's capacity to respond, etc.[6]

Following **child protection strategies** can serve different child protection needs:

Case Management

Case management describes the process of helping individual children and families through direct social-work-type support and information management. A child protection case management system could be implemented in following contexts:

- In large sudden onset disasters where governments need support in order to cope with the scale of a disaster.
- In long lasting emergencies and/or developing countries where a government is willing to implement/maintain social welfare structures.
- Where a government does not realise its responsibility of supporting child protection or to implement a related social welfare system.

Case management practices can be used in following contexts:

- family tracing and reunification of separated and unaccompanied children during emergency responses.
- support for the return and reintegration of children from exploitative or abusive circumstances such as hazardous labour or association with armed forces and groups.
- harmful and unnecessary institutional care.[7]

There are **four basic components of case management**:

5 Child Protection Working Group, 2011, p.13
6 Child Protection Working Group, 2011, p.13
7 Save the Children, 2011, p.1

- Identification and assessment (including the opening of a case and start of documentation)
- Individual support planning (planning of response and care)
- Referral and liaison with support services (where required)
- Monitoring and review (including case closure).[8]

These four components form the basis for case management systems in the context of development and emergency programming.

Community-based child protection needs

Communities can provide ways to prevent and respond to child protection needs. A community-based child protection mechanism describes a network or group of people at community level who work in a coordinated manner to address child protection needs. The mechanisms can be internal (traditional and/or existing institutional mechanisms) or external. Community-based mechanisms must include existing local structures and traditional or informal processes in order to be effective and support ownership of processes.[9]

Community-based child protection groups are groups of people, who are working for the well-being of children. Such groups can be present in villages, urban neighbourhoods or other communities, such as refugee camps. Often such groups have different names – e.g. children committee, child welfare committee, child protection committee, child rights committee, etc. Children play a significant role in community-based child protection groups. They can be involved in the work of these groups at following stages:

- Children are talking to adults from these groups, refer cases and report possible risks
- Representatives from children groups are attending meetings of the adult’s groups
- Representatives from the adult groups are visiting children’s groups
- Children and adults are building one group together

Projects addressing child protection should also focus on child participation and accountability (e.g. information, complaint mechanisms for children).

Child friendly spaces

Child Friendly Spaces (CFS) bring together children and adults in order to mobilize communities and build protective community networks. The concept of CFS contributes to the improvement of general child protection by covering basic and special needs of children in emergency situations.

- CFS can be used in emergency situations as a very first response to children’s needs as an entry point for work in affected communities;
- CFS are a possibility to respond to children’s right to protection, psychosocial well-being and non-formal education;
- CFS are used as a temporary solution and serve as a bridge between early recovery and long term support.

The specific objectives of CFS are:

8 Save the Children, 2011, p. 1
9 Child Protection Working Group, 2011, p. 143 ff

- Mobilise communities around the protection and well-being of all children, including vulnerable children;
- Provide opportunities for children to play, acquire relevant skills, and receive social support;
- Offer inter-sector support for all children in the realisation of their rights.

CFS are used as a temporary solution to create a protective environment for children in emergencies. They fill a gap after disaster when the national education system is affected and not functioning. They could be organised in camps or other temporary shelters integrated into communities. Community centres and schools can be used as CFS venues.

Community volunteers are responsible for CFS activities. With regard to exit strategies for CFS, communities can decide what to do with the established structures after the emergency situation.[10] Since CFS should not exist parallel to existing structures, they could be integrated into the local education system (e.g. education/community based structures).

According to UNICEF there are **six main principles** addressed by Child Friendly Spaces:

Principle 1: CFS provide a secure and safe environment for children
Principle 2: CFS provide a stimulating and supportive environment for children
Principle 3: CFS are built on existing structures and capacities within a community
Principle 4: CFS use a participatory approach for the design and implementation
Principle 5: CFS provide or support integrated programmes and service
Principle 6: CFS are inclusive and non-discriminatory

Child Friendly Spaces offer the possibility to address major priority fields of child protection-in-emergencies. Following activities can be offered at CFS:[11]

1. *Right to Protection from Physical Harm*
- Referring urgent medical cases, or other urgent cases and follow-up.
- Disseminating life-saving information to children and community members, such as the risk of harm of mines, unexploded ordnance (UXO), cluster bombs and strategies for risk mitigation.

2. *Right to Protection from Psychosocial Distress*
- Offering semi-structured and structured activities that promote positive cognitive, emotional, and social functioning.
- Creating children's network

3. *Right to Protection from Family Separation*
- Identifying separated children and referral for family tracing
- Disseminating information on family tracing
- Together with parents and caregivers identifying risk of and common reasons of family separation and developing strategies for risk mitigation.

4. *Right to Protection from recruitment into Armed Forces or Armed Groups*
- Educating children on the risk of recruitment
- Offering peer support

10 Bollier, A. „Child friendly spaces and memory work: experiences of terre des hommes Lausanne", p. 8-11
11 Save the Children, 2008 a, p. 9 ff

5. ***Right to Protection from Exploitation and Gender-based Violence***
- Including both genders and ensuring that a gender-sensitive approach is applied at all times
- Supporting of establishing child protection networks

terre des hommes project example

Camp Coordination, Shelter's Services and Child Protection in Darfur, Sudan

Problem description: The military clashes between rebels and the government in 2010 have worsened the humanitarian situation. A total of 4.6 million people in Darfur still need humanitarian aid. About 1.9 million internally displaced people (out of a total of 3.6 million) live in Darfur. The situation in the camps in Darfur remains very difficult for IDPs. They are overcrowded and still face food and water shortages and insecurity.

Project objective: The integrity of conflict affected communities in West Darfur is strengthened by provision of services and child protection assistance

Project description / activities: Child Protection is one of the main components of this project, as children represent an extremely vulnerable group among affected population/IDPs in the camps. Following activities are offered to promote child protection in the area:

1. Provision of quality and effective psychosocial support to vulnerable children
2. Provision of technical and practical skills for youth to favour a socio-economic integration
3. Provision of individual support to vulnerable children through a case management system
4. Capacity building for child protection committees established at the camp level
5. Empowerment of community members leading to active involvement in the running of Child Friendly Spaces and Teenagers' Centres
6. Facilitating of camp-level Child Welfare Referral Groups with partner NGOs and CPCs
7. Organising child protection awareness campaigns within the camps through involvement of community members and specific groups
8. Establishment of a functional partnership between the Ministry of Social Welfare (MoSW) social work team and tdh staff towards sustainability of social work with IDP and host community children
9. Strengthening the referral pathway for special groups of vulnerable children through identification of supportive structures outside the camps
10. Capacity building of the Ministry of Education (MoE) and Ministry of Youth and Sports (MoSY) staff.

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The Sphere Project (2011): Humanitarian Charter and Minimum Standards in Humanitarian Response

Protection / Child Protection – Checklists

Protection (All groups)

	Pre-disaster
1	What was the social environment in the affected area prior to the disaster/conflict?
2	What were traditional means by which people protect themselves before the disaster (e.g. family networks, community self-help initiatives)?
3	What groups were most vulnerable prior to the disaster?
3.1	*children*
3.2	*women*
3.3	*elderly*
3.4	*minorities*
3.5	*other*
4	What was the situation of minorities prior to disaster? Have any cases of rights violations of minority groups been reported before the disaster/conflict?
5	Have any cases of gender-based violence been reported before the disaster/conflict?
6	Have any cases of child abuse been reported before the disaster/conflict?
7	Were there any community groups / local initiatives existing before the disaster (e.g. Child Protection Committees – CPC) to address protection issues of community members or groups?
8	Were there any traditional ways/mechanisms with regard to protection issues (e.g. in conflict resolution)?
9	What was the role of local government with regard to protection? Are there any national protection policies in place?
10	What were major problems concerning protection before the disaster?

Protection (All groups)

	During emergency
1	What are the benefits for the affected population generated by the activities of your organisation?
2	What could be the unintended negative consequences of your activities for people's security and dignity?
3	How could these risks be avoided or minimised?
4	Have possible protection threats that can be caused by your activities been taken into consideration?
5	Do your activities undermine people's own efforts to protection?
6	Do you consider cultural and traditional issues in your activities?
7	Do your activities protect the rights of people who have historically been marginalised or discriminated (e.g. women, minorities)?
8	What will be the impact of this protection on the relationships within and beyond the community?
9	Could your activities cause conflicts within the community or between neighbouring communities?
10	Could your activities be influenced by any armed or political groups or other actors?
11	Could your activities be subject to criminal exploitation?
12	Are there any community initiatives in the affected area with regard to protection issues?
13	Are all groups equally presented in the community structures: women, minorities, people with disabilities?
14	Are there any capacity building activities in protection issues planed (by your or any other organisation) to enable affected people to better protect themselves?
15	Do all affected people have an equal access to humanitarian assistance?
16	What groups among the affected population are mostly in need of protection? What are major gaps?
17	How could these gaps be filled?

Child Protection

	During emergency
1	Are there any local traditional systems of child protection in place?
2	Are there any community-based child protection groups in the affected area?
3	Are parents involved in these groups?
4	Are women and men equally presented in these groups?
5	Are there any children's groups in the community (e.g. children's feedback committees)?
6	Are representatives of children's groups attending meetings of any child protection group?
7	Are representatives of child protection groups visiting children groups?
8	Are children and adults forming one group together?
9	Do people involved in both children and adult groups need special trainings?
10	What issues with regard to child protection are most important to work on?
10.1	*Child trafficking*
10.2.	*Child sexual abuse*
10.3	*Child labour*
10.4	*Child recruitment*
10.5	*Other*
11	Are there any state institutions responsible for child protection?
12	Do any national child protection systems exist? / Which governmental body is responsible for child protection issues?
13	Is there any cooperation between community-based child protection groups and local authorities?
14	If there is any, are community-based groups recognized as a part of the institutional child-protection system?
15	Was any platform established to be used for communication between child protection groups and governmental bodies? (e.g. forum, etc.)?
16	Is there any political will to cooperate with community groups responding to children's interests?
17	What kind of child protection activities are offered in the area?
18	Are there any child related activities/services beyond schooling in the area?
18.1	*What kind of activities are offered?*
18.2	*Are they integrated in the national system (schools, kindergarten), initiated by local initiatives or community-based self-help initiatives?*
19	What are major gaps with regard to child protection?
20	What is needed to fill these gaps?
21	Is external/specialised intervention of other actors required and if yes, what kind of (case management, safe spaces, etc.)
22	Consider a service mapping, support mechanisms and/or available social security provisions to build on existing capacities

2 Mental health and Psychosocial Support (MHPSS)

Mental health and Psychosocial Support (MHPSS) – Guidance Notes

Man-made conflicts and natural disaster cause major psychological and social problems among the population. In a short time they can undermine the long-term mental health and well-being of the affected population. Meeting the psychosocial needs of affected people is as important as addressing the urgent needs for food and non-food, water and hygiene, health and shelter.[12]

Activities related to MHPSS are mostly carried out in the emergency phase and continue in the rehabilitation phase. Both psychosocial care and rehabilitation of the physical infrastructure can contribute to the well-being of those affected. It is important to involve people in distribution processes, reconstruction/construction of shelters, planning of activities, etc. Such activities help affected population to heal their own wounds because they feel that they can help others and get a sense of pride.[13]

According to the intervention pyramid for mental health and psychosocial support in emergencies MHPSS activities can take place at different levels simultaneously. The first three levels are highly relevant to humanitarian operations:

1. Basic services and security
Provision of psychosocial care is closely linked to basic needs/services and security of affected people. When basic needs are covered and people feel safe, their psychological conditions are also improved. Assistance should be provided in a safe, dignified and socio-culturally appropriate manner promote mental health and psycho social well-being.[14]

2. Community and family support
People's mental and psychosocial well-being can be supported through community and family support. Examples of possible activities are: family tracing and reunification, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as women groups or youth clubs.

3. Focused, non-specialised support
This level includes activities for a smaller number of people who need more targeted support from trained and supervised workers for example in form of family or group support.

12 ACT Alliance: Community-based psychosocial support in emergencies
13 UNICEF: Conference on Community-based Disaster Risk Reduction, p. 81-82
14 IASC (2008): IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, p. 9-10

For example, survivors of gender-based violence may need a combination of emotional and livelihood support from community workers. Psychological first aid (PFA) and basic mental health care by primary health care workers are also parts of this layer.

4. Specialised services
This layer represents the additional support for people who need of professional psychological, therapeutic or psychiatric intervention.

Child Friendly Spaces (CFS) can be an additional component of psychosocial support in emergencies that contribute not only to the well-being of the children, but also to that of their parents and thus the whole family. It is therefore important to involve parents in CFS activities. The CFS model is based on the principle of community mobilisation. It can be beneficial for the whole community.[15]

Psychosocial support for children – Guidance Notes

Children in emergency situations are most severely affected and very often overlooked. Together with other vulnerable groups, they need special attention and support. In emergencies, children's well-being is at risk because they are very vulnerable to disasters. Special programmes may therefore be needed to improve their psychological and social well-being.

Child-oriented psychosocial support addresses the psychological and social well-being and development of children. When designing psychosocial programmes for this vulnerable group, a culture-specific analysis of the children's situation should be taken into account.

Psychosocial programmes are closely linked to health, education, protection, participation, but also livelihood. All these sectors and related programmes contribute to mental health and psychosocial well-being of affected children.

Stable relationships between children and their parents or other caregivers are a protective factor against psychological disturbance, especially when adults are able to maintain their caring roles.[16]

In emergency settings protective factors for children are interrupted and not in place. Therefore, children are in need of specific support which could be provided through specialized programmes from organisations active in this field.

When children are traumatised they can show both emotional and physical reactions. These reactions are normal reactions to traumatic events. In such cases parents, teachers and other caregivers should look after the children and observe changes in their behaviour.

Typical stress reactions of young children are:

- ✓ crying
- ✓ whimpering
- ✓ screaming

15 Child friendly spaces and memory work in Summary on workshops 23-26.09.2010, p. 8-10
16 WHO (2008): Manual for the health care of children in humanitarian emergencies, p. 79

Non-verbal signs of psychological stress include:

- ✓ Trembling
- ✓ Frightened facial expressions
- ✓ Helplessness and passivity (caused by a fear of being separated from parents)
- ✓ Immobility and/or aimless motion
- ✓ Excessive clinging
- ✓ Total withdrawal
- ✓ Regressive behaviour (thumb-sucking, bed-wetting, fear of darkness)

Children with a need for psychosocial support will show signs of:

- ✓ Helplessness and passivity
- ✓ Generalized fear
- ✓ Cognitive confusion
- ✓ Difficulty identifying what is bothering them
- ✓ Lack of verbalization
- ✓ Sleep disturbances
- ✓ Anxious attachment
- ✓ Regressive symptoms
- ✓ Worsening symptoms
- ✓ Symptoms are highly distressing for the child or its family

Provision of psychosocial support to a child means:

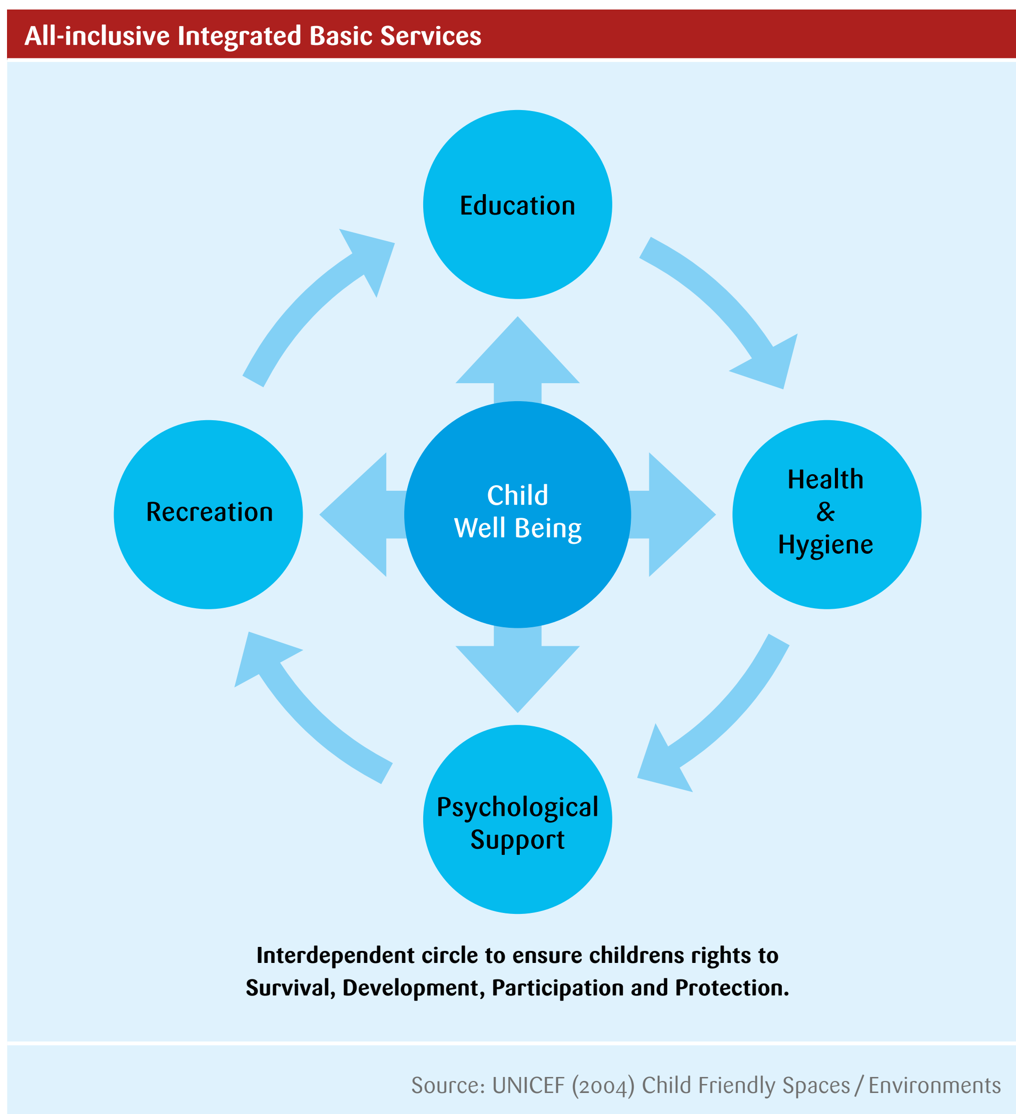
- understanding the child's emotional reactions through observation and monitoring decreasing emotional distress by listening, reassuring, and modelling healthy behaviour for the child
- facilitating recovery by normalizing life routines, providing a safe space for the child to talk about his/her feelings, and providing opportunities for the child to engage in play and other recreational activities.[17]

Child Friendly Spaces (CFS) are a good example of an instrument for the psychosocial support of children in emergency settings. CFS protect children from physical harm and psychosocial distress and create a supportive environment for child development and learning after a disaster.[18] CFS cannot be the solution to all children's problems, but they are effective in reducing a range of distressing impacts of crisis on children.

The two most common objectives of Child Friendly Spaces are:

1. To offer children opportunities to develop, learn, play and build/strengthen resilience after or during an emergency or crisis.
2. To identify and find ways to respond to particular threats to all children and/or specific groups of children, e.g. those with particular vulnerabilities.

17 WHO (2008): Manual for the health care of children in humanitarian emergencies, p. 79-80
18 Save the Children (2008): Child Friendly Spaces in Emergencies. A Handbook for Save the Children Staff, p. 2



Source: UNICEF (2004) Child Friendly Spaces / Environments

Child-Friendly Spaces help to create a familiar environment and routine and thus help to support children to strengthen their natural capacity for resilience. Through CFS, children can continue basic childhood learning tasks and learn positive coping mechanisms through social activities with other children.

Child Friendly Spaces give children space and time to:

- Restore their normal flow of development through normalizing play activities;
- Process and reduce harmful levels of accumulated stress from events;
- Learn and share new positive coping strategies by socializing with other children and adults in supportive environments with adult supervision;
- Learn information about relevant personal safety concerns.

CFS are able to improve the capacities of families to care for their children by helping parents and/or other caregivers learn to interact with their children and talk to them about current experiences, fears and hopes for the future. Child Friendly Spaces reflect five priorities:

1. Right to protection from physical harm;
2. Right to protection from psychosocial distress;
3. Right to protection from family separation;
4. Right to protection from recruitment into armed forces or armed groups;
5. Right to protection from exploitation and gender-based violence.[19]

The following table shows typical reactions of children in different phases in emergency situations and appropriate support in the form of different activities.[20]

Phases	Common reaction found in children	Appropriate and responsive psychosocial support
Phase 1 – acute onset of emergency (first two days)	✓ Shock and confusion are common reactions ✓ The feeling that "this is not real" is common	✓ Giving reassurance and comfort (psychological first aid) ✓ Helping culturally appropriate grieving rituals, etc.
Phase 2 – reaction within the first three to four weeks; lifesaving operations are in place	✓ Intense grief, horror, anger, or mood swings ✓ Need for productive activities and a safe environment to process distressing events ✓ Trying to make sense of what happened	✓ Widely disseminating information on common reactions to abnormal situations (involve social leaders) ✓ Identifying and communicating what caretakers can do to support their children and the importance of returning structure of everyday life that is possible, etc.
Phase 3 – from three to four weeks to the end of the lifetime of Child Friendly Spaces (could be up to three months, or possibly longer in occasional situations)	✓ Losses begin to "sink in" – trying to understand the sequence of events and how it will affect the family future ✓ Some children isolate themselves ✓ Other children have a strong need and are able to participate in concrete activities	✓ Offering recreational and, physical activities ✓ Offering drama, expressive drawing, painting, targeted games ✓ Offering arts and crafts, etc.

19 Save the Children (2007): Child Protection in Emergencies: Priorities, Principles and Practices
20 Save the Children (2008): Child Friendly Spaces in Emergencies. A Handbook for Save the Children Staff, p. 6-7

terre des hommes project example

Psychosocial Support System for Elementary School and Community in Merapi (Indonesia)

Problem description: Due to frequent natural disasters in the region, hundreds of thousands of people were evacuated more than four times. The eruption and mud flood had a negative impact on the economic and social situation of the local population. Some villagers had to stop their agricultural activities and work in sand mines. Economic instability had a negative impact on parents' attitudes towards their children. Due to the economic situation, parents had to work hard spending their time earning money. Therefore, children were neglected and had to take care of themselves and do housework. In school they have to learn hard and face many problems. Adults and children experience a change of attitude that could manifest itself in violence between parents and children, parents and their neighbours, teachers and pupils and among other residents.

Project objective: Establish Psychosocial Support System in school and community at Red Zone area surrounding Mt. Merapi.

Project description / activities: To achieve the project objective following activities take place during the project implementation:

1. Training on psychosocial intervention for teachers
2. Training on psychosocial intervention for students
3. Training for village cadres and core team
4. Regular discussions for teachers, village cadres and core team
5. Round table discussions on psychosocial material and sharing experience among participants.
6. Focus Groups discussions with beneficiaries on the content of the psycho social support modules

terre des hommes project example

Creating Protective Environment for Children through Child Friendly Spaces in Flood Affected Area of Swat (Pakistan)

Problem description: Due to the floods in Pakistan, the affected families were displaced. Under these circumstances, the vulnerability of children had increased. The displaced families and their children needed a safe environment. In this context, 10 Child Friendly Spaces (CFS) were later established in the flood-affected Union Councils of Tehsil Kabal.

Project objective: Create a protective environment for 1.000 flood affected children in selected locations of Swat district to ensure the protection of children's rights through psychosocial support, nutritional and medical care, recreational and play activities.

Project description / activities: One of the project results was the access of affected children to psychosocial support services. The original idea of CFS was to cover psychosocial aspect of the affected children. In order to meet the psychosocial needs of the children and to offer them psychosocial support, following activities were conducted:

A. Creative: painting, drawing, clay, singing, role play, acting performance. Drawing activity contributed positively in relieving children of their stress. In the beginning children drew pictures showing violence. Later on, while visiting CFS, the pictorial depiction of children changed to drawing nature, sceneries and themes, interesting for children.
B. Recreational: sport activities (indoor and outdoor). Sport games and role play competitions contributed to children's well-being and emotional resilience.
C. Non-formal education: As part of this component, the children were taught the alphabet. Stories were read to them and questions asked to determine the extent of their interest.
D. Health-care: children were explained importance of personal hygiene through practical demonstration. Children learnt to wash hands before every meal as well after using toilets.
E. Nutrition: in each CFS biscuits, flavoured milk and juice were distributed to children. Provision of clean water was ensured through installation of water dispenser at each CFS.
F. Focus Group Discussions were held with children to identify existing gaps and find ways to fill these gaps.

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Well-being and resilience after the Tsunami: Evaluation of terre des hommes Psychosocial Programme in Sri Lanka 2005-2007. Final Report

MHPSS – Checklists

Psychosocial care

	Pre-disaster
1	How was the social environment in the affected area prior to the disaster/conflict?
2	What was the poverty level (in %) of the affected population prior to the disaster/conflict?
3	Did poverty have negative impacts in the area / on the affected people?
3.1	*Restricted access to education*
3.2	*Restricted access to basic health-care*
3.3	*Domestic violence*
3.4	*Child sexual abuse*
3.5	*Child trafficking*
3.6	*Child labour / exploitation*
3.7	*Gender-based violence*
3.8	*Political violence*
4	Were any people traumatized prior to the disaster? If yes, do exist any data and what is the background of their trauma?
5	Do current and/or previous political developments have impact on the psychological situation of the local people? If yes, what kind of impacts?
6	What is the traditional role of women in the area?
7	What role does family play in the area?
8	What kind of state / educational institutions are in place in the area (schools, kindergartens, health clinics)?
9	How was the access to education for children and adolescents (esp. girls, disabled) prior to the disaster?
10	How was the access to basic health-care for all vulnerable groups prior to the disaster?
11	How was the access to basic health-care for children prior to the disaster?
12	Did any community groups and/or children committees exist in the area prior to the disaster?
13	Did any data exist on documenting mental health related issues prior to the disaster?
14	Did any referral mechanism exist to address mental health issues, issues of human rights violations, etc.?
15	Did any traditional mechanisms exist to address conflicts within the community (e.g. in case of armed conflicts)
16	What were major problems with regard to psychosocial support prior to the disaster?
17	What efforts were made to solve these problems?

Psychosocial care

	During emergency
1	Have vulnerable groups in need of psycho-social care been identified?
2	Have age and gender issues been considered during the identification process of vulnerable groups?
3	Are there any basic services for the affected people in place?
4	Is the provision of psychosocial aid ensured in safe and dignified ways?
5	Have socio-cultural aspects been taken into consideration?
6	Is the provision of activities regarding community and family support ensured? If yes, what kind of activities are offered (e.g. family tracing, reunification, supporting parenting programmes, etc.)?
7	Are there any focused and/or non-specialised activities in place?
7.1	*A mixture of emotional and livelihood support provided by community workers*
7.2	*Psychological first aid (PFA) and basic mental health care provided by primary health care workers*
8	What other psychosocial activities could be applied in the present emergency?
8.1	*Child friendly spaces*
8.2	*Art therapy*
8.3	*Recreational and educational activities, etc.*
9	Do any local structures exist to work with?
10	Are there any physical spaces available to be used to work with target groups?
11	Are these spaces safe enough to be used for work with the affected population, particularly with children?
12	Are there any resources available to provide psychosocial care (human resources and equipment)?
13	Do people involved in psychosocial activities have relevant skills and abilities to work with vulnerable groups?
14	Are special trainings planned for staff?
15	Do any community groups or children's groups / feedback committees exist?
16	Do members of these groups need relevant trainings? Is it possible to provide such trainings if needed?
17	Do vulnerable people feel secure in their present conditions?
18	Do they have any access to basic needs, as food, water, hygiene, basic health-care?
19	Are special governing systems/institutions in place to ensure well-being of people and the reduction of further psychological risks?
20	What are major gaps with regard to psychosocial support?
21	How could these gaps be filled?

Psychosocial care

	Child friendly space (CFS)
1	Are there any facilities useable for the arrangement of CFS?
2	Are local people/children participating in the selection of places for CFS and volunteers?
3	Are the facilities safe enough to be used for the work with children?
4	Is it possible to involve adults in the activities with children?
5	Are they sensitized to work with children?
6	Do they need special trainings?
7	Are parents involved in CFS activities?
8	What kinds of activities are provided within the CFS?
8.1	*Recreational: play, drawing, outdoor activities*
8.2	*Art-therapy (also based on traditional art)*
9	Do children feel confident within CFS?
9.1	*Can they relax physically, mentally and emotionally?*
9.2	*Can they express their feelings and thoughts?*
9.3	*Can they develop a feeling of safety?*
9.4	*Can they have fun?*
9.5	*Can they learn social behaviour, rules and values?*
10	How can CFS activities/facilities be integrated into existent rehabilitated structures/ activities (e.g. schooling, any other community activities)?
11	Is it possible to provide psychological first aid (PFA) within CFS by inviting primary health workers?
12	Are children with PTSD identified?
13	Are specialized institutions identified and contacted for referral of PTSD cases?
14	Are CFS facilities used for other community activities, as meetings of community groups/ parent's groups?
15	Are CFS used to provide DRR basics for children and their parents?
16	Are CFS used to train children in basic health-care and personal hygiene?
17	Does an exit-strategy for CFS exist?
18	What is the exit strategy: is it planned to integrate CFS activities in formal education (in schools and kindergartens)?
19	Is there need of any specialised services?
20	What are major gaps in applying CFS in the present emergency setting?
21	How could these gaps be filled?

3 Education

Education[21] - Guidance Notes

Education in Emergencies offers learning opportunities for all age groups. It includes early childhood development, primary, secondary, non-formal, technical, vocational, higher and adult education. In emergency settings education provides physical, psychosocial and cognitive protection that can sustain and save lives.[22]

Immediately after a disaster or conflict, the local education system is disrupted and in many cases it is difficult to restore formal education fast. Therefore alternative forms/phases of education can be applied during/after emergency situations. In three phases, activities can be carried out simultaneously or in combination, depending on the context and situation.

Phase 1: Recreational and Preparatory. The first step in this phase is the creation of „safe spaces" for children for their recreational activities. Activities can be carried out in form of sports, music and various art activities. They help to normalise the children's situation and prepare them for their return to school. The activities can be carried out by refugee teachers, community members or youth and adolescents with leadership and basic teaching skills. If necessary, appropriate training can be provided.

Phase 2: Non-formal Education. The activities in this phase are more flexible in terms of space, time and material, taking into account the unstable emergency situation. The aim of non-formal education is to teach children basic skills in major subjects such as literacy, numeracy and life skills before returning to formal education. The objectives of non-formal education are:

- ✓ supply children with basic reading and writing materials in their language
- ✓ promote recreational and play activities
- ✓ provide teachers with basic teaching instruments and training
- ✓ strengthen community-based schooling initiatives
- ✓ promote the rehabilitation of the educational system, schools and classrooms

Phase 3: Return to Formal Education. This phase includes activities to stabilise education and introduce formal education. The aim is to achieve a normalised teaching situation that includes some of the following characteristics:

21 UNICEF (2006): „Education in Emergencies. A Resource Tool Kit", pp. 13-15
22 INEE (2010): Minimum Standards for Education: Preparedness, Response, Recovery. P. 2

- ✓ schools try to operate based on a normal timetable
- ✓ schools have an organized system of teaching and learning
- ✓ schools incorporate most normal school subjects
- ✓ schools have the capacities to hold examinations
- ✓ textbooks are produced and updated as necessary
- ✓ teachers are trained to cope with the new situation

The existing school curriculum can be improved e.g. in cooperation with the Ministry of Education. Improved curricula can address gender issues, child rights, and conflict resolution or disaster preparedness.

Education in emergencies is beneficial and can at the early stages:

- ✓ help protect children from death or any bodily harm
- ✓ provide lifesaving information on unexploded ordnance, as well as simple messages on health and hygiene
- ✓ make children less vulnerable to being recruited or being trafficked
- ✓ reduce the effects of trauma and give children hope for the future

In longer term education can:

- ✓ provide basic information on child rights
- ✓ be used as an instrument in the reconstruction of post-conflict societies
- ✓ promote conflict resolution, tolerance and respect for human rights
- ✓ increase children's earning potential, enabling them to keep their families healthier and improving their ability to break out of the poverty cycle
- ✓ play a key role in helping reduce the impacts of future natural disasters by including disaster risk reduction (DRR) strategies in the national curriculum.[23]

With regard to education in emergency situations, it is important to use information based on data sources from schools, local government structures, relevant ministries, censuses and other educational institutions.

Cross-sectoral aspects in education programmes:[24]

There are also cross-sectoral links in the education sector. Such links may include health, food, NFI distribution, WASH, etc. In this context, aid agencies should examine to:

Health:

- work with health institutions to provide treatment and health-related information to children in schools.
- hold vaccination campaigns and days at school to ensure maximum coverage.
- see whether school children and teachers can get priority treatment at clinics/camp health centres, when health services cannot be provided at schools
- target health education programmes in schools, so children are able to learn more about healthy ways of living.

23 Save the Children (2009): Education in Emergencies. Policy brief 2009, p. 2
24 NRC (2008): Camp Management Toolkit, p. 543-544

Food and NFI Distribution:

- establish a way of distribution of commodities for teachers that they do not receive their rations during school hours
- establish school-feeding programmes to ensure supplementary feeding for children as well as participation of underserved groups. According to some research studies school feeding programmes persuade parents to enrol girls who would otherwise not attend school at all.

WASH:

- construct water and latrine facilities in emergency or temporary schools: semi-permanent schools should always have good quality latrines.
- promote latrine use through schools.
- incorporate good sanitation practices and establish hygiene education programmes – hand washing after toilet use.
- Promote good sanitation practices such as proper waste disposal and cleaning of compounds and classrooms.

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Education – Checklists

Sector: Education

	Pre-disaster
1	What was the level of school enrolment prior to the disaster?
2	What were/are the causes of the law-schooling quota?
3	What was the level of education in general in the affected area/by refugees (in case of displacement) with regard to:
3.1	*boys*
3.2	*girls*
4	Number of children visiting schools prior to the disaster/crisis?
5	Number of girls visiting schools prior to the disaster/crisis?
6	What are cultural habits with regard to gender issues in education?
7	What kind of educational structures were present in the affected area prior to the disaster/crisis?
8	Was the number of teachers sufficient prior to the disaster?
9	Did disabled children have access to education?
10	Did minority groups have access to education?
11	Have parents been involved in any educational activities/decision-making processes?
12	Were there any structures of participation of parents in the education sector prior to the disaster?
13	Is there any national policy on education?
14	What kind of constrains and risks were there with regard to education prior to the disaster?
15	Are topics with regard to children's rights and disaster risk reduction integrated as a part of school programme (officially/external)?
16	What groups were mostly vulnerable with regard to education? What were their needs?
17	What were major gaps with regard to education?
18	Are there any efforts in place to fill these gaps?

Sector: Education

	During Emergency
1	How many (#/%) schools/other educational facilities are available to be used by the affected population?
2	What kind of facilities could be used for educational activities?
3	How many children (in %) are out of school? Has this number increased because of the emergency?
3.1	*boys*
3.2	*girls*
4	Are there enough teachers available to educate the affected population?
5	Are there any alternative educational activities initiated within the affected population?
6	Are there learning and other recreational materials available?
7	Are there opportunities to organise child friendly spaces in camps or other temporary facilities?
8	Do disabled children have access to educational and recreational activities?
9	Are parents engaged in educational activities? If yes, how are they engaged?
10	Are security and protection issues considered in educational facilities?
11	Do learning facilities/environments address mental and emotional wellbeing of children?
12	Do learning facilities environments address cultural features of the affected people?
13	Are learning facilities used for health and hygiene promotion for children and their parents?
14	Are there well-functioning latrines and hand-washing facilities at school premises?
15	Is supplementary feeding provided at the learning facilities?
16	Are Children's Rights, DRR and HIV/AIDS Prevention included in the current educational programme?
17	Are gender issues considered with regard to women's/girls' access to education?
18	Are gender issues addressed in learning settings, in textbooks, in teacher's behaviour?
19	Are issues of minority groups and other extremely vulnerable individuals considered?
20	What groups are mostly vulnerable with regard to education? What kind of barriers do they have and how can these barriers be minimised?
21	Is there any coordination body with regard to education: Clusters / national or both?
22	Does your organisation attend cluster meetings/any other meetings on education?
23	Does your organisation coordinate your activities with other aid organisations providing educational activities?
24	Does your organisation coordinate your activities with any national structure on education (e.g. Ministry of Education)?
25	Do local organisations experience any barriers with regard to access to international coordination mechanism / cluster system? If yes, why? How can this problem be solved?
26	What gaps do still exist and why?
27	How could these gaps be filled?

Sector: Education

	Recreational and Non-formal education (Phases 1 and 2)
1	How many children are involved in the activities within these phases?
1.1	*girls*
1.2	*boys*
1.3	*children with disabilities / mobility difficulties*
2	What kind of activities are offered?
2.1	*Recreational, sport and play*
2.2	*Psychosocial*
2.3	*Basic literacy, numeracy and life skills*
2.4	*Other*
3	*Are displaced teachers/other community members engaged in the activities within this phase?*
4	Are parents/parents' groups involved in the activities within this phase?
5	Are there any older children and adolescents with leadership qualities and basic teaching capabilities who can lead some activities?
6	Are children provided with adequate learning and recreational materials?
7	Do the teachers need trainings?
8	Do older children and adolescents need trainings in leadership and in basic teaching skills?
9	Has the gender issue been considered with regard to the selection of teachers?
10	Did children participate in the planning of the activities within these two phases?
	Return to formal education (Phase 3)
11	Do the present conditions allow starting with formal education?
12	Are there any changes in emotional, social and cognitive needs of children and their teachers after emergency? Are these needs considered prior to the return to formal education?
13	What are key activities your organisation implements in this phase?
13.1	*Psychosocial rehabilitation*
13.2	*Recreational activities*
13.3	*Infrastructural support (re-construction of schools/classrooms)*
14	Do teachers/volunteers need special trainings?
15	How can you ensure the return of all children to formal education? Do they participate in the planning of educational activities?
16	Is it possible to compare the number of children involved in formal education before and after the disaster?
17	Are educational activities provided in accordance to children's and young people's rights?
18	Are gender issues addressed in the learning settings, in text books, in teacher's behaviour?
19	Does the curriculum contain elements of Children Rights, DRR, conflict resolution?
20	Are there any gaps with regard to education at present?
21	How could these gaps be filled?

Sector: Education and Protection

	Education and protection needs
1	How has the disaster/conflict affected education? Where are children presently learning? Have school operations been affected by the conflict (e.g. by closures, double shifts, home schooling)?
2	Do children urgently need vital information to protect themselves, e.g. on HIV/AIDS, family planning, landmine awareness?
3	Are learning spaces accessible for children? What are possible risks?
4	Are learning spaces accessible for service provider?
5	Do education activities exist? Who does and does not attend them? Why? Language of instruction, lack of enrolment, need to work, discrimination, disability?
6	What kind of activities are offered?
	Educational and protection capacity
7	Is the area safe for learning spaces? Is it cleared of landmines or unexploded ordnance? Does learning occur in a structurally-sound building with sufficient sanitation facilities?
8	Does attendance protect or endanger children? Are children at risk when they are in or travelling to educational activities?
9	Are teachers and facilitators trained? Who monitors their work? Would they be interested in further training?
10	Is the community involved in providing education? What is their role in child protection? What types of cases have they dealt with? How inclusive is the participation? Which sections of the community are involved, and which are not? What groups work with children, aside from those associated with schools? Can activities be linked?
11	What systems are in place to monitor child protection issues, e.g. student attendance and enrolment data? Is this disaggregated by gender? Which inequities are presently being addressed within the community?
12	What is the protection role of the local and national officials from the Ministry of Education?
13	What is the role of the international community in protection and education?
14	Do children have access to opportunities to earn a living through vocational trainings?

4 Water Sanitation and Hygiene (WASH)

Water, Sanitation and Hygiene (WASH) – Guidance Notes

The aim of any WASH programme is to promote good personal and environmental hygiene to protect health. The impact of a WASH programme depends on an exchange of information between the relief organisation and the affected population to identify key hygiene problems and needs and to find culturally appropriate solutions. Optimal use of water supply and sanitation facilities and ensuring safe hygiene have a major impact on public health.

Water Supply

Water is essential for life, health and human dignity. In emergencies, there may not be enough water available to meet basic needs. In most cases, the main health problems are caused by poor hygiene due to lack of water and consumption of contaminated water.[25]

Basic survival needs for water (Sphere) [26]

Survival needs: water intake (drinking and food)	2,5–3 ltr. per day	Depends on the climate and individual physiology
Basic hygiene practices	2–6 ltr. per day	Depends on social and cultural norms
Basic cooking needs	3–6 ltr. per day	Depends on food type and social and cultural norms
Total basic water needs	7,5–15 ltr. per day	

25 Sphere: (2011), WASH, p. 88
26 Sphere: (2011), WASH, p. 98

Maximum number of people per water source (Sphere – WASH) [27]

250 people per tap	based on flow of 7,5 ltr./minute
500 people per hand pump	based on a flow of 17 ltr./minute
400 people per single-user open well	based on a flow of 12,5 ltr./minute

Minimum water quantities for institutions and other uses (Sphere – WASH) [28]

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

27 Ebd., p. 99
28 Ebd., p. 129

Sanitation

With regard to sanitation following aspects should be considered: excreta disposal, vector control / vector-related diseases, solid waste management and drainage.

Possible alternatives for safe excreta disposal [29]

	Safe excreta disposal type	Application remarks
1	Demarcated defecation area (e.g. with sheeted-off segments)	First phase: the first two to three days when a huge number of people need immediate facilities
2	Trench latrines	First phase: up to two months
3	Simple pit latrines	Plan from the start through to long term use
4	Ventilated improved pit (VIP) latrines	Context-based for middle- to long-term response
5	Ecological sanitation (Ecosan) with urine diversion	Context-based: in response to high water table and flood situations, right from the start or middle to long term
6	Septic tanks	Middle- to long-term phase

Latrins are at least 30 m away from any groundwater.
The bottom of any latrine is at least 1,5 m above the water table.

Hygiene Promotion

The aim of hygiene promotion is to protect public health by using the knowledge, practices and resources of the affected population and up-to-date WASH evidence. There are three key factors related to hygiene promotion:

1. A mutual sharing of information and knowledge
2. The mobilisation of affected communities
3. The provision of essential materials and facilities [30]

29 Sphere: (2011), WASH, p. 109
30 Sphere: (2011), WASH, p. 91

List of basic hygiene items[31]

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

Additional hygiene items / per person[32]

- 75 ml / 100 g toothpaste
- One toothbrush
- 250 ml shampoo
- 250 ml lotion for infants and children up to 2 years of age
- One disposable razor
- Underwear for women and girls of menstrual age
- One hairbrush and/or comb
- Nail clippers
- Nappies (diapers) and potties (dependent on household need)

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31 Sphere: (2011), WASH
32 Sphere: (2011), WASH

WASH – Checklists

Sector: Water Supply, Sanitation and hygiene (WASH)

	Pre-disaster
1	How many people are affected by the disaster?
2	Is the data disaggregated by sex, age, disability, etc.?
3	Which were traditional water sources in the affected area?
4	What kind of water supply system was available in the affected area?
5	What alternative water sources did people use in emergency cases?
6	Was water close to people's dwellings?
7	Who was collecting water (men, women, children)?
8	What kind of water storages did people use prior to the disaster?
9	What was the usual water source for livestock?
10	What was the usual water source for irrigation?
11	For what kind of hygiene issues did people use water?
12	Were people aware of hygienic norms with regard to water usage?
13	Were people aware of diseases caused by insufficient hygieec conditions?
14	What kind of sanitation facilities did people use traditionally?
15	What kind of hygiene items were traditionally used in the area (by women, men, elderly and children)?
16	What are risks for possible diseases in the area?
17	What is the practice of solid waste disposal in the area?
18	What were major problems with regard to water, sanitation and personal hygiene prior to the disaster?
19	Did people try to solve these problems? If yes, how did they do it?

Sector: Water Supply, Sanitation and Hygiene (WASH)

	During Emergency
1	Are local water sources damaged or contaminated?
2	Could any alternative water source be used as an emergency source?
3	How much water is available and does it correspond to the basic needs/norms?
4	For how long will it last?
5	Could the available water be used for drinking?
6	Do all people have access to the available water?
7	Is it necessary to provide water treatment?
7.1	*What kind of treatment is necessary?*
7.2	*Is water treatment possible in the existing situation?*
8	Do people have special means to use water with regard to hygienic norms?
9	Do people need to be trained in these norms?
10	What are the key hygienic issues related to water supply?
11	Are there any containers or other possibilities available for a safe transportation and storage of water?
12	Do children, elderly, disabled and people with HIV/AIDS have smaller or specially designed containers for water carrying?
13	How far are water points from people's dwellings now? Is the distance more than 500 metres (Sphere)?
14	Who is normally collecting water (men, women, children)?
15	Are security standards for water collecting considered? Do women and children feel safe while collecting water?
16	Were people (esp. women and children) consulted before arranging water points?
17	Is there any need regarding the construction or reconstruction of a traditional water supply system?
18	If yes, what resources are necessary for it (human resources, equipment, material)?
19	In case of rural displacement: what is the usual water source for livestock?
20	Is there any risk of conflict between the host population and the displaced people because of water usage?
21	What are major gaps with regard to water?
22	How could these gaps be filled?

Sector: Water Supply, Sanitation and Hygiene (WASH)

	During Emergency
	Sanitation
1	What kind of sanitation facilities are available during the emergency: bathing facilities/ latrines?
2	Do they correspond to traditional norms?
3	Are these facilities separately used according to gender to ensure safety, privacy and dignity of girls and women?
4	Do they correspond to minimum standards? If not, how many persons use one latrine/ bathing facility?
5	Is there enough water for bathing and laundry?
6	Were people (esp. women, adolescent girls, people with disabilities) consulted before arranging facilities?
7	When the facilities are communal, is their location central and accessible for all?
8	Is the location of the facilities safe enough for children, adolescent girls and women?
9	What are the practices concerning excreta disposal?
10	Do current defecation practices pose a threat to water supply, living areas and to the environment in general?
11	Are people with disabilities in need of special sanitary facilities?
12	Is there any risk of vector-related diseases due to current excreta disposal?
13	Are people aware of the reasons of vector-related diseases?
14	Are there any preventive methods needed to avoid vector breeding?
15	Do people at risk of these diseases have access to individual protection?
16	Are people in need of any information concerning sanitation norms?
17	What are major gaps with regard to sanitation?
18	How could these gaps be filled?
	Solid Waste Management
19	Is it possible to dispose solid waste on-site or is it necessary to collect it and dispose it off-site?
20	Does the accumulation of solid waste pose a risk to health and what is its effect on the environment?
21	Are there any medical facilities and how do they manage their waste disposal?
22	What are major gaps with regard to waste management?
23	How could these gaps be filled?

During Emergency

	Hygiene
1	What kind of hygiene items are available at present?
2	Are people aware about the use of items? Are they culturally appropriate?
3	Are they accessible and sufficient for all people?
4	Is it possible to purchase these items locally?
5	Are enough water and other hygiene items available for personal hygiene?
6	If soap is not available, what alternative means could be used (ash, clean sand, soda, etc.)?
7	Do women need special hygiene items (e.g. underwear, menstrual pats, etc.)?
8	Do children need specific hygiene items (e.g. diapers, lotions, etc.)
9	Do elderly people and people with disabilities need special hygiene items?
10	What additional hygiene items are needed to improve the current hygienic conditions?
11	Do people wash their hands after defecation and before feeding?
12	Are people in need of hygiene promotion? Are they well informed about hygienic norms?
13	Are there any facilities available for hygiene promotion, as child friendly spaces, community centres, etc.?
14	What are major gaps with regard to personal hygiene?
15	How could these gaps be filled?

5 Health

Health – Guidance Notes

According to the World Health Organisation (WHO) health systems mean: *„all the organisations, institutions and resources that are devoted to producing health actions"*. In emergencies agencies operating in the affected area should comply with national health standards and use treatment protocols and lists for essential medicines. If the system and the above documents are outdated or no longer available, international standards should be used as a reference.

In the best case health systems develop a process of continuity of care. In this case, the establishment of an effective referral system is very important. Ideally, the referral system should function 24 hours a day, seven days a week.[33]

Health promotion: The community health promotion programme should be organised in consultation with local health facilities and community representatives to ensure gender balance. The programme should include information on major health problems and potential risks, the availability and location of health services to protect and promote good health, and harmful practices. Public health messages and materials should be understandable and culturally sensitive. Community centres, schools or child-friendly spaces could serve as places to disseminate health information to reach children and their parents.

Access to health services: Health services should be accessible to all people without discrimination and according to their needs. In order to ensure optimal access and coverage of health services, their location and staff should be organised accordingly. When planning health services, the needs of people at risk (e.g. people with mobility problems, people with HIV/AIDS, the elderly) should be taken into account. Patients have the right to have health facilities and services organised in a way that respects their dignity, privacy and confidentiality.

During the disaster, it may be necessary to organise mobile health services that meet the needs of isolated populations or mobile people with limited access to health care.

In cases where local hospitals are damaged, it is essential to organise field hospitals. Normally, it is more effective to provide existing hospitals with resources than to set up field hospitals. It makes sense to set up field hospitals for urgent cases of traumatic physical

33 The Sphere Project (2011) – Minimum Standards in Health Action, pp. 288-320

injuries within the first 48 hours and secondary care for traumatic injuries (days 3–15) or as a temporary facility until damaged local hospitals are rebuilt. [34]

Essential medicines list: Most countries have an established list for essential medicines. This list should be reviewed and updated with local health authorities where appropriate. If such a list is unavailable, the WHO model lists of essential medicines should be followed. (http://www.who.int/medicines/publications/essentialmedicines/en/).

Drug management: Health agencies should establish an effective drug management system based on the four main elements of the medicines management cycle: selection, procurement, distribution and use. According to Sphere, the aim of such system is to ensure the efficient, cost-effective and rational use of quality medicines, storage and correct disposal of expired medicines.[35]

Health information system (HIS) is a system for the collection and processing of data from various sources. The information is then used for policy making and management of health services. National or country HIS include data collected from civil registration, censuses, population surveys, facility surveys, individual records, etc. A strong HIS is a major component of any health system.[36]

In emergencies HIS faces a double dilemma: the information required to respond to humanitarian situation must be detailed and timely. The given context does not allow collecting the data in an appropriate way.[37]

If possible, a monitoring system should be built upon the existing HIS. In some emergencies, a new or parallel system is required as the data sources are often incomplete and fragmented. In emergency situations, health data should include but not be limited to:

- ✓ Deaths recorded by health facilities including under – 5 deaths
- ✓ Proportional mortality
- ✓ Cause-specific mortality
- ✓ Incidence rates for most common morbidities
- ✓ Proportional morbidity
- ✓ Health facility utilisation rate
- ✓ Number of consultations / clinician / day

Data related to health-care should be disaggregated by sex, age, vulnerability, affected and host population and context (e. g. camp vs. non-camp situation).

34 The Sphere Project (2011) – Minimum Standards in Health Action, p. 299
35 The Sphere Project (2011) – Minimum Standards in Health Action / Guidance Notes 3. Drug Management, p. 303
36 web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTHSD/0,,contentMDK:22239824~menuPK:6335249~pagePK:148956~piPK:216618~theSitePK:376793,00.html
37 Thieren, M.: Health Information Systems in Humanitarian Emergencies, www.who.int/bulletin/volumes/83/8/584.pdf

Health financing: According to World Health Organisation (WHO) a minimum package of essential health services requires expenditures of at least USD 40 per person per year in low income countries. In emergency situations these costs should be higher than in non-emergency situations.[38]

Packages of essential health services are often promoted to improve health service delivery. In low-income countries an essential health package includes limited public health and clinical services provided at primary and/or secondary care level. In rich countries the packages often are described according to what they exclude. Essential Health Packages are generally developed after a combination of cost-benefit analysis and other technical, political and social considerations.

38 The Sphere Project (2011) – Minimum Standards in Health Action, p. 304-306

Child Health – Guidance Notes

In emergencies, children are particularly vulnerable to increased morbidity and mortality rates. Infants and children under the age of 5 are most at risk. With regard to the health of the child in emergency situations, the following points must be taken into account:

1. Prevention of vaccine-preventable diseases

Vaccination is essential in emergency situations, as affected people and especially children are threatened by various diseases. Children between 6 months and 15 years should be vaccinated, especially against measles. Older children who have not been vaccinated and have not yet had measles run the risk of contracting the disease and serve as a source of infection for infants and young children. It is therefore recommended to vaccinate all children up to the age of 15. In resource-poor environments, priority should be given to children aged 6–59 months.[39]

2. Management of new-born and childhood illnesses

Disaster affected populations should have access to information on early care for neonatal diseases (fever, cough, diarrhoea, etc.). This information could be presented as health education messages. In emergency situations there is an Integrated Management of Childhood Diseases (IMCI). This approach focuses on the care of children under 5 years of age at the primary care level. If IMCI exists in the affected country and the clinical guidelines are adapted, these guidelines should be integrated into the standardized protocols. Health personnel should be appropriately trained.[40] ICMI is an integrated approach to children's health that focuses on children's well-being. The aim of ICMC is to reduce child mortality, illness and disability and promote better growth and development in children under five. The ICMC includes both curative and preventive elements implemented in health facilities, families and communities. The ICMC strategy includes the following components:

- Improving case management skills of health workers
- Improving overall health system
- Improving family and community health practices

IMCI is very effective in emergency situations and also in non-emergency situations in developing countries. In these countries, children admitted to hospitals very often suffer from several diseases that make a single diagnosis impossible.

IMCI as an integrated strategy ensures the combined treatment of serious childhood diseases. This includes the prevention of these diseases through immunisation and improved nutrition.[41]

IMCI and referral guidelines can be improved in combination with rapid triage and treatment. Triage is the classification of patients into priority groups according to their medical needs, available resources and chances of survival. Health professionals who care for children should be trained according to the guidelines of Emergency Triage, Assessment

39 The Sphere Project, 2011, p. 320 ff
40 The Sphere Project, 2011, p. 320 ff
41 WHO: Integrated Management of Childhood Illness (IMCI) http://www.who.int/child_adolescent_health/topics/prevention_care/child/imci/en/#

and Treatment (ETAT).[42] According to Triage, all sick children should be divided into the following groups when they first come to hospital:

- Children with EMERGENCY SIGNS who require emergency treatment
- Children with PRIORITY SIGNS who require rapid assessment and treatment without any delay
- Children who have emergency or priority signs and therefore are NON-URGENT cases. These children can wait their turn for assessment and treatment.[43]

Children with diarrhoea should be treated with low osmolarity and given a zinc supplementation. Children with cough should be examined for pneumonia. Children with chest in-drawing, the main symptom of pneumonia should be referred to hospital. Persons with fast and/or difficult breathing are given appropriate medication.

Diphtheria is less common but very dangerous in the population with low diphtheria immunity and especially in overcrowded areas. Vaccination campaigns with three separate doses as a preventive measure should be carried out in the storerooms.[44]

Sources and further reading

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42 ibid
43 WHO (2005): Emergency Triage Assessment and Treatment (ETAT). Manual for participants
44 ibid

Health – Checklists

Sector: Health

	Pre-disaster
1	How was the health system in the affected area organised prior to the disaster?
2	What health facilities were available before the disaster?
2.1	*Clinics*
2.2	*Public health centres*
2.3	*Mobile health services (mobile clinics)*
2.4	*Private health centres*
3	How well were they been equipped?
4	Were these facilities accessible/affordable for everyone?
4.1	*What was the distance / how far was the nearest available health centre (the distance in km)?*
4.2	*Were public health services free? If not, which services were free? How expensive were other services?*
4.3	*How expensive were private health services?*
5	How frequently did people visit local health facilities?
6	Were basic medicines available? Were these affordable for everyone? How expensive were these prior to the disaster?
7	What diseases were common in the area and what was the general treatment?
8	Did people prefer using traditional curative methods instead of medicines and medical assistance?
9	What was the mortality rate (in %) prior to the disaster?
9.1	*men*
9.2	*women*
9.3	*children*
10	What was the morbidity rate (in %) of:
10.1	*men*
10.2	*women*
10.3	*children*
11	What was the frequency of common child diseases prior to the disaster?
12	What was the level of vaccination before the disaster?
12.1	*children*
12.2	*adolescents*

13	At which level was primary health-care provided?
13.1	*household level*
13.2	*community level*
13.3	*peripherical facilities*
13.4	*central facilities*
13.5	*referral hospitals*
14	Were people aware of diseases, as:
14.1	*communicable (e.g. measles, hepatitis A-D, herpes)*
14.2	*vector borne (e.g. malaria, leishmaniosis)*
14.3	*water borne (e.g. diarrhoea, cholera, polio, hepatitis A and E)*
14.4	*respiratory tract infections (e.g. bacterial pneumonia, tuberculosis)*
15	Were there any AIDS cases identified prior to the disaster?
16	What were major gaps/deficits prior to the disaster regarding health care in the region?

Sector: Health

	During emergency
1	What health facilities are existing? How are they functioning?
2	Can they provide 24-hour/seven-day service?
3	Does the equipment at these facilities match the needs of the affected people?
4	Is there enough medical staff? Do they need trainings in emergency skills?
5	Are there any mobile clinics in place?
6	Is there need for more mobile clinics?
7	Have affected people been consulted prior to organising mobile clinics in order to meet traditional and cultural features of the region?
8	Is there any need in organising alternative health facilities, as field hospitals? If yes, where could they be placed?
9	At which level was primary health-care provided?
9.1	*household*
9.2	*community*
9.3	*peripheral facilities*
9.4	*central health facilities*
9.5	*referral hospitals*
10	Is a referral system established?
11	Are medicines available locally? Are they free of charge?
12	If people have to pay for medicines, can they afford it?
13	Is regular vaccination in place?
14	Do all people have access to vaccination? Are they aware of its importance?
15	Is it possible to use schools and child friendly spaces for health promotion?
16	Are preparedness measures taken to outbreak communicable diseases?
17	Are AIDS prevention measures in place?
18	Are measures of reproductive health in place?
19	Most countries have a standard list for essential medicines. Does such a list exist in your country as well? Is it possible to check its appropriateness?
20	How is drug management functioning? Is the system based on four key elements: selection, procurement, distribution and use?
21	How is the health information system (HIS) functioning? Is health data recorded?
22	Has confidentiality been taken into account? (e.g. data related to injury caused by torture or other human rights violations, SGBV, etc.)
23	Is the recorded data disaggregated by age, sex and vulnerability level of the affected population?
24	How is health waste management organised?
25	Are people aware of the danger of poor health waste management?
26	Are dead bodies disposed in a dignified and safe way?
27	Are cultural aspects taken into account?

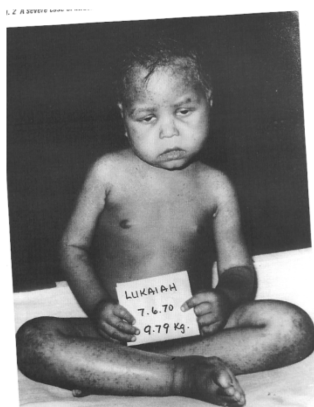
28	What is the mortality rate (in %) after the disaster?
29	What is the morbidity rate (in %) after the disaster?
30	Which agencies are operating in the area?
31	Who is coordinating health activities in the affected area (e.g. Ministry of Health, WHO, other)?
32	Is there a need for specialised services in the area?
33	Have political and/or social characteristics on regional /national level been taken into account for the implementation of health programmes?
34	What are major gaps/deficits?
35	How could these gaps be filled?

6 Food Security

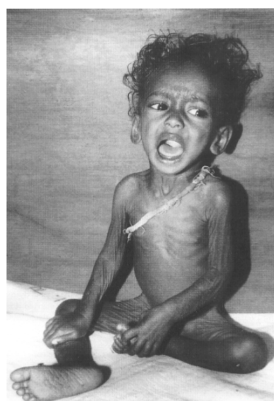
Food Security – Guidance Notes

Malnutrition

Malnutrition is a condition in which health is compromised by the deficiency or imbalance of one or more nutrients. Children are most affected by malnutrition. Body measurements are used as indicators of malnutrition. Weight, height, length and arm circumference are used as indicators in children. Malnutrition in children causes their underdevelopment and stunting. According to SCN (UN Standing Committee on Nutrition) World Nutrition Situation 5 report, more than 147 million pre-school children in developing countries are affected by stunting, making school performance more difficult. Pregnant women diagnosed with malnutrition run the risk to give birth to underweight babies.[45] There are two forms of acute malnutrition that need to be identified: Marasmus and Kwashiorkor.



Marasmus



Kwashiorkor

- **Indications of Marasmus**: expended fat and muscles, thin face, loose skin of the buttocks, prominent ribs.
- **Indications of Kwashiorkor**: oedema starting at legs and feet, hair change, skin lesions, depigmentation. Due to oedema people may look fat and there are no sign of hunger.

45 www.unsystem.org/scn/Publications/AnnualMeeting/SCN31/SCN5Report.pdf

The Mid Upper Arm Circumference (MUAC) – defines wasting in terms of fat and muscle mass in the mid-upper arm. For healthy children aged 1–5 years it should be about 14 cm. MUAC between the age of 5 to 59 months is used as a first screening method in emergencies. Malnourished children are also monitored by "weight for height" measurements. Height cut-offs of 65–110 cm are used when the age of children cannot be determined.

The Body Mass Index (BMI) is used to measure the nutritional status of adults. It calculates body mass by relating body weight to surface area rather than height. It is calculated by dividing the square of the person's height by his or her weight in kilograms. BMI = kg/m^2. Persons with BMI less than 18,5 are considered as „underweight".[46]

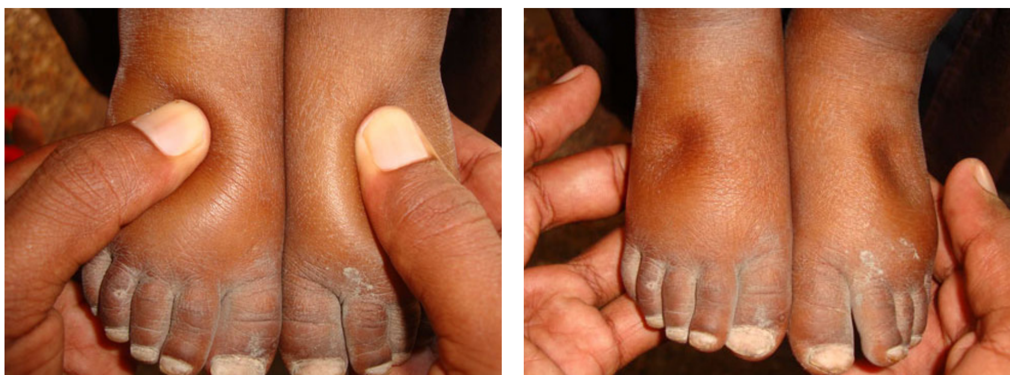
Measuring mid-upper arm circumference

Preventive measures of malnutrition

Direct Food (general rations, supplementary feeding, wet feeding) aims to provide affected people with daily feeding which corresponds to minimum nutritional requirements and contains a daily intake of 2,100 kcal / person / day.

Therapeutic or curative feeding is an acute medical task that uses food as medicine to avoid death.

Malnourished children with oedema indication must be treated at therapeutic feeding centres. Malnourished children with no medical complications or oedema could be treated at home according to a non-centre-based approach.[47]



Indication of oedema

46 The American Red Cross / Federation of the RC/RC, (draft 2/01), p. 11
47 WHO (2004): Guiding Principles for feeding infants and young children during emergencies, p. 45

Per capita energy requirements

According to established humanitarian norms, the average minimum nutritional/food consumption requirement for a typical developing country population undertaking light physical activity in a warm climate is 2,100 kcal / person / day. For a population engaged in heavy physical work, 350 kcal are added to give a total of 2,450 kcal / person / day. In many developing countries, a significant proportion of the population is chronically food insecure, with usual access to less than 2,100 kcal / person / day. Therefore, minimum nutrition requirements are as follows:

Energy	2,100 kcals / person / day
Protein	53 g (10 % of total energy)
Fat	40 g (17 % of total energy)

The following table provides an example of a daily ration providing the required 2,100 kcal of energy:

Ingredients:
- 400 g of cereal flour / rice / bulgur
- 60 g of pulses
- 25 g of oil (vitamin A fortified)
- 50 g of fortified blended foods (Corn Soya Blend)
- 15 g of sugar
- 15 g of iodized salt

Nutrition value:
- Energy 2100 kcal
- Protein 58 g
- Fat 43 g

www.wfp.org/wfp-food-basket

Supplementary feeding

Supplementary food is usually distributed in form of a dry ration containing specific nutrients. **It aims to meet the nutritional needs of vulnerable groups,** such as children under five and pregnant or breast feeding women. Usually, dry supplementary rations for young children provide about 1000–1200 kcal/day and take into account sharing among household members. If the special ration is additionally distributed through on-site cooked meals the usual amount is 500–700 kcal/day per child. Supplementary feeding is a temporary measure when general food rations are inadequate. Once a general ration is sufficient and meets the standards, supplementary feeding can be adjusted or ceased. When supplementary feeding is provided, the affected population/the whole community should be informed about the intention of the programme and encouraged to ensure that food reaches the target groups.[48]

48 WHO (2004): Guiding Principles for feeding infants and young children during emergencies, p. 28-29

Complementary feeding

In addition to breast milk, infants should receive complementary food, which is rich in energy, protein and micronutrients such as iron, calcium, vitamin A, vitamin C and folate. When choosing foods, animal products or fortified food rations containing sufficient amounts of iron, zinc and calcium should be taken into account. Complementary food is usually prepared as soft, easy-to-eat porridge or as nutrient snacks. Simple soft mixtures of general food aid commodities, for example cereals, pulses, fortified food, oil and sugar, together with a variety of vegetables and fruits provide suitably complements to breast milk.

In case of displacement affected people may face difficulties with unfamiliarity of local food. In this case, nutritionists must work with people to advise them on the use of local food. For the displaced population, the advice of local women can be helpful in learning more about local food and how to prepare it. Caregivers need to know:

- to what extent the distributed food commodities meet the nutritional needs of infants and young children
- which locally available food is especially rich in essential nutrients missing in regular food commodities [49]

Distribution of special commodities

Fresh commodities (fruits, vegetables, meat and fish) that can be purchased locally, contain vitamins and minerals and are therefore valuable for young children and older infants. It is important to distribute such foods in order to prevent micronutrient malnutrition. Some products, as milk, pose a serious risk to children. Therefore, their distribution should be strictly monitored. Any milk that is distributed in an emergency could interfere with breastfeeding. Breast-feeding women should be informed before distribution so that they do not use it as a substitute for breast milk. Milk powder should not be distributed alone, but always as part of a dry ration or during supervised on-site feeding. Unmodified animal milk should not be given to children under six months of age.[50]

Food Procurement and Distribution

Prior to the procurement and distribution of food rations, it is important to communicate with the target groups about the size and composition of the rations. The type of ration size and content depends on how people transport their food to their place of residence and whether they have good enough storage facilities.[51]

The distribution point should be a safe place for target groups/receivers and not far from their homes. Recipients should not walk more than 10 km (no more than an hour's walk) to the distribution point. They should be informed by the relief organisation of any possible changes in ration size, distribution time, place, etc. The information about the rations should be displayed at the distribution points (written in the local language, drawn visually or as oral communication to be accessible and understandable to all). Alternative ways of

49 Ebd, p.21-22
50 WHO (2004): Guiding Principles for feeding infants and young children during emergencies, p. 28-29
51 Sphere Handbook (2011): Food Security, p. 175

distributing food should be created for people with mobility difficulties.[52]People with special needs require special provisions:

- Separate fast track queues – prioritise persons with specific needs and those at risk, such as larger families, separated children or older people. These criteria should be communicate in the information process, and be well known to the population.
- Transportation of heavy items from the distribution site back to people's homes with wheel barrows, donkey carts, or community support groups.
- Sun and rain-protected places to rest reserved particularly for older people and small children, those with impaired mobility or breastfeeding mothers.[53]

School feeding programmes

School feeding programmes have both a nutritional objective – to improve the nutritional status of schoolchildren – and an educational objective – promoting school enrolment and attendance as well as improving school performance and cognitive development.

School feeding programs operate with different modalities, ranging from the distribution of a small morning snack to complete hot-lunch programs that provide a relatively large proportion of the daily calorie, protein and other nutritional needs. Such programs typically require the use of teachers and school staff to procure, prepare and distribute food and plan menus. Parents are often encouraged to participate in the development and implementation of school nutrition programs.

The positive impact of school nutrition programs is not limited to improving nutritional status and educational performance. They also sometimes serve to introduce healthy eating habits and basic food hygiene practices. Certain activities such as school gardening, nutrition education and food conservation practices can be linked to the school nutrition programme.

The benefits of these programmes can be increased by using local knowledge – particularly that of mothers – to develop locally acceptable recipes, methods of cooking and size of individual portions, and to identify local foods that can be added to the distributed food.

Below are some of the specific concerns related to the school feeding programmes:

- The phasing out of such programmes is typically associated with a high drop-out rate from school, indicating the low sustainability of programme effects.
- Participation in the programme depends on school attendance, and the most at-risk children, such as girls in rural areas and street children who do not attend school, are not reached.
- School feeding programmes often depend on foreign food assistance, making it difficult for governments to continue the programmes with their own resources.[54]

52 Sphere Handbook (2011): Food Security, p. 194-195
53 NRC (2008): Camp Management Toolkit, p. 400-401
54 FAO: Types of Targeted Food and Nutrition Programmes, www.fao.org/3/y1329e/y1329e05.htm

terre des hommes project example

Help for the victims of hunger in the Horn of Africa (Kenya)

Problem description: Due to the drought and famine in the Horn of Africa, more than 12 million people are facing food shortage. Two million children are severely affected by the health and malnutrition crisis. In Somalia, the situation is aggravated by the ongoing armed conflict. Hundreds of thousands of Somalis are fleeing to Kenya for protection. The Kenyan population is affected by the massive influx of Somali refugees into areas that were already in a precarious state. Kenyans are also suffering from the food crisis, but have not yet received the same level of support as refugees. In the refugee camps, the local population has little access to medical infrastructure. Between 17 % and 20 % of children under 10 and women suffer from acute malnutrition.

Project objective: By the end of 2013, vulnerable children and their families, in 2 divisions of Lagdera District, have access to strengthened community services, thereby improving their health status and protection as well as their coping mechanisms and resilience.

Project description / activities: Through this project terre des hommes intends to improve health and nutrition of about 8,000 children under six and 350 expectant and lactating mothers. The project activities take place in the villages around the refugee camp Dadaab. Target groups represent communities hit by famine not benefiting from the humanitarian aid and health-care services given to the refugees. Children and expectant/lactating mothers with signs of malnutrition are identified by health workers to be treated in out-patient programmes. Terre des hommes supports the Kenyan Ministry of Health in running local health centres. Women and children with complicated cases of malnutrition are referred to these health centres for nutritional stabilization.

Sources for these guidance notes and further reading

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Food Security – Checklists

Sector: Food security

	Pre-disaster
1	What is the total number of population in the target area?
1.1	*Children (all categories)*
1.2	*Pregnant and breastfeeding women*
1.3	*People with disabilities*
1.4	*Other EVIs*
2	What is the number of people who need food aid?
3	Have people received food aid in previous years? If yes, why and what kind of aid?
4	What are main income sources of the target population?
5	What are basic food products used in the area?
6	What are traditional food habits of the affected people?
7	How many meals per day did local people usually eat?
8	How much money did people spend on food: per day/week?
9	Where does the food normally come from?
9.1	*Local land/self production*
9.2	*Local market*
9.3	*Other sources*
10	Who is responsible for meeting food needs in a household?
11	What is the role of women regarding food security?
12	Did pregnant and breastfeeding women use different/complementary food?
13	Did children use different food than others?
14	What kind of complementary feeding did people have?
15	Were people aware of minimum nutritional requirements?
16	Were people aware of the importance of complementary feeding particularly for children and breastfeeding women?
17	Have cases of malnutrition/underfeeding been identified prior to the disaster?
18	How do people usually fight malnutrition?
19	Are there any local initiatives in the area to work with?
19.1	*Village committees?*
19.2	*Self-help groups*
19.3	*Women groups*
20	What coping strategies did affected people have prior to the disaster? Could these be strengthened during the emergency?

Sector: Food security

	During the emergency
1	Information on the local market:
1.1	*Availability of essential food products*
1.2	*Local food prices (any inflation after the disaster?)*
1.3	*Are food products affordable for the affected population?*
2	Are people able to cook by themselves?
2.1	*What are traditional utensils they usually use for cooking?*
2.2	*Do they need any kitchen utensils: cookers, pots, fuel, etc.?*
2.3	*How is the access to potable water?*
3	Do hygiene conditions allow people to cook by themselves?
4	Are people in need of cooked food / community kitchens?
5	Do people have enough space for food storage?
6	What groups are extremely vulnerable to food shortage?
7	Have any cases of malnutrition/underfeeding been identified within the affected population?
8	What are main causes of malnutrition/underfeeding?
9	Do people have access to supplementary/complementary feeding?
10	Who is extremely in need of such food?
10.1	*children/infants*
10.2	*breastfeeding women*
10.3	*elderly people*
10.4	*sick people*
11	What are coping strategies of the affected people with regard to food at present?
12	How long can they last?
13	What are the short- and medium-term effects of people's coping strategies on the actual situation?
14	What are major gaps with regard to food aid?
15	How could these gaps be filled?

Sector: Food security

	Children aged (0–5 years)
1	How was the infant/child feeding arranged prior to the emergency?
2	What is the percentage (#/%) of breastfeeding mothers of children under 2 years?
3	How did the majority of people feed their infants under six months prior to the emergency?
3.1	*Breast milk*
3.2	*Infant formula**
3.3	*Other*
4	Is infant formula available in the area? Is it financially affordable for everyone?
5	What was the main food of children above 6 months?
5.1	*Did mothers use breast milk only because of other food shortages?*
5.2	*What complementary food is used normally?*
	Children aged (5–18 years)
6	What was the main food of children prior to the emergency?
7	Did they have some complementary food?
7.1	*School meals*
7.2	*Others*
	Pregnant and breastfeeding women
8	How was the food of this group prior to the emergency?
9	Did they use complementary food to get milk for breastfeeding?
10	Did the emergency influence this habit?
11	How do they compensate it/do they use some traditional methods?
12	Do they need any vitamins?
	Complementary feeding
13	What kind of local food can complement the general, daily rations?
14	Do the affected people have access to this food?
15	Are (displaced) people aware of local food?
16	Are the affected people aware of the importance of complementary feeding?
17	Do people need any instructions from nutritionists or the local population on the preparation of local food?
18	Are there possibilities to exchange recipes of complementary food preparation within the (displaced) community?

* Infant formula is a manufactured food designed and marketed for feeding to babies and infants under 12 months usually prepared for bottle-feeding from powder (mixed with water or milk) or liquid (with or without additional water).

Sector: Food security

	Procurement
1	What is the access to the local market?
2	Is it possible to procure all food items locally?
3	What food items could be procured locally?
4	How is the quality of local food?
5	What are the prices of local food? Are these prices higher than prior to the emergency?
6	Is it possible to procure complementary food?
6.1	*Infant formula**
6.2	*Other*
	Composition of rations / food baskets
7	Does the food basket correspond to the basic needs?
8	Have traditional/cultural habits of target groups been taken into account?
9	How large is one ration per person (weekly, bi-weekly, one-month ration)?
	Pre-distribution
10	Are the affected people already registered?
11	Did people get ration cards?
12	Are people informed about the distribution date, time and point?
13	Are other agencies working in the same area informed about your distribution?
14	Are people informed about the quantity and type of rations?
15	Is the distribution point a save place?
16	Is it easily accessible for the target groups?
17	Are gender issues addressed while arranging the distribution place?
18	Do you need to organize any alternative distribution for other vulnerable groups, e.g. disabled, elderly?
	Distribution process
19	Is the distribution point protected during the distribution?
20	Are there enough aid workers/volunteers involved in the distribution process?
21	Are requirements of people with special needs considered?
	Food aid risks
22	Poor control during the purchase of food items
23	Poor control at storage/warehouse
24	Poor control during the distribution
25	Risks during the transportation of goods
26	Poor control of lists and distribution cards
27	Lack of information/participation of target groups
28	What are major problems/gaps with regard to food distribution?
29	How could these gaps be filled?

* Infant formula is manufactured food designed for feeding infants and babies under 12 months of age. It is usually prepared for bottle-feeding from powder (mixed with water or milk) or liquid (with or without additional water).

Sector: Food security

	During emergency
1	Do affected people of all ages have access to adequate nutritious food?
2	Is there any difference in ages regarding the access to adequate feeding?
3	Do vulnerable groups as children and breastfeeding women have access to adequate complementary feeding?
4	Do affected people have access to potable water?
5	Are people aware of these foods? If not, do they need any instruction on how to use/ prepare it?
6	Have minimum nutritional requirements for the planning of general rations been met?
7	Can the affected people acquire 500 kcal / person / day from their own efforts/resources?
8	Have any cases of malnutrition among the affected population been identified?
9	What groups are mostly affected by malnutrition?
10	Do malnourished people have access to adequate feeding and health-care?
11	Do malnourished people need therapeutic feeding as a medical measure?
12	Are caregivers, community health workers and others aware of the riskr of malnutrition?
13	Are they able to recognize early signs of malnutrition?
14	Do they know any methods on how to recognize malnutrition?
15	Are they equipped with useful information on this topic?
16	What are major gaps with regard to malnutrition/underfeeding?
17	How could these gaps be filled?

7 Non-Food Items (NFIs)

Non-Food Items (NFIs) – Guidance Notes

NFIs are provided to support personal hygiene and health conditions, food storage and preparation, clothing and bedding and shelter support for individual as well as communal use. A market analysis should be done as part of an assessment to find out to what extent required goods can be purchased locally.

NFIs are often distributed in form of individual and/or family packages. The quantity and specification of NFI in a household package should be considered with reference to the number of people in a typical household, their age, sex and the presence of people with special needs. In order to meet the needs of all people affected, it is important to consult with them. For example, it is important to consult with women to identify which types of feminine hygiene items are most suitable for them and which types of NFIs children need most.[55]

Individual and general household items should be familiar to the affected population for use without additional guidance. However, technical guidance and instructions should be provided to complement the provision of shelter supplies such as building materials, tools and fixings.

Personal hygiene and health

Discussions with affected men and women should form the basis for the selection of hygiene items and although it may not be possible to consult with all people in an acute emergency, there is always space for dialogue with the affected population. Existing cultural practices and familiar products should be assessed in specifying the items supplied. Care should be taken to avoid specifying products that would not be used – due to lack of familiarity – or that could be misused. It is critical to combine the distribution of hygiene items with hygiene promotion activities in order to sensitise for hygiene related issues and the use of distributed items. The specific needs of women and children must be taken into account (e.g. through distribution of dignity kits for women).

Clothing and bedding

It is necessary to identify separate needs of affected population for clothing: women, men, girls and boys in appropriate sizes. All women, girls, men and boys have at least two sets of clothing in the correct size according to the culture, season and climate. People should

55 IASC, 2006, p.1

have access to adequate clothing to ensure their thermal comfort, dignity, health and well-being. Children up to 2 years should have a blanket in addition to clothing. Cultural/traditional characteristics with regard to clothing should also be taken into account.[56]

Cooking and eating

The choice of cooking and kitchen utensils should be culturally appropriate and safe to use (especially indoors). All plastic items (buckets, bowls, jerry cans, etc.) should be made of food-grade plastic. All metallic goods (cutlery, bowls, plates, etc.) should be made of stainless steel or enamelled. The affected population, particularly women and girls, should be consulted about the location and means of collecting fuel for cooking and heating in order to address personal safety. The need for fuel for female-headed households, chronically ill people and people with mobility problems should be met.[57]

Tools and fixings

Tools and fixings for reconstruction, removal of debris and/or maintenance should be familiar to affected population and appropriate to the local context. Where possible, tools for livelihood activities (e.g. shovels, hoes, fishing nets, etc.) should be provided. The use of tools should be monitored in order to avoid negative effects on the environment. Training and awareness-raising measures for the safe and easy handling and maintenance of tools should be available.[58]

Example of composition of a package of household and hygiene items

Household items (per family)	Hygiene items (per person / month)
• 1 small and 1 big cooking pot with cover	• 75 ml / 100 g tooth paste
• 2 ladles	• 250 ml shampoo
• 1 knife	• 250 g bathing soap
• 1 washing pan	• 200 g washing powder
• 10–20 liter water containers with cover	• 1 razor blade (per family)
• Further water containers	• Sanitary napkins
• 1 plate (per person)	• Cotton diapers
• 1 spoon (per person)	• 1 comb/hairbrush
• 1 cup (per person)	• 1–2 towels

www.wfp.org/nutrition/WFP-foodbasket

56 The Sphere Project, 2011, p. 271 ff
57 The Sphere Project, 2011, p. 273 ff
58 The Sphere Project, 2011, p. 276 ff

The **modalities for distribution** should be planned in consultation with the affected population, taking into account following points:

- criteria for selecting most needy beneficiaries,
- information about distribution process and items to be distributed to the affected population,
- walking distance to distribution points,
- means of transportation (to and from the distribution point),
- security and protection matters (during and after distribution) and
- climate conditions.

Monitoring of the distribution process and the use of the NFIs provided should be carried out to assess the adequacy and suitability of both the process and the items themselves.[59]

Sources for these guidance notes and further reading

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59 The Sphere Project, 2011, p. 268 ff

NFIs – Checklist

Sector: Non Food Items (NFI)

	Pre-disaster
1	What kind of household items / cooking utensils do people use traditionally?
2	What kind of stove and fuel are traditionally used?
3	What kind of lighting did people use in the area?
4	What types of clothing/blankets did people use traditionally?
5	What are common basic hygiene items in the area?
6	Did women use special hygiene items (e.g. hygiene pads, etc.)
7	Did people use diapers/lotions for their children?
8	Did elderly people and people with disabilities use special hygiene items?
9	What kind of basic tools did people use for repairing and maintenance works in their households before the disaster?
10	What kind of tools did people use for livelihood activities?
11	What kind of fuel for cooking did people use?
12	Where was/is the next market to purchase NFIs? / Is access to such markets warranted?
13	What were prices for NFI before the disaster?
14	Did people produce some NFI themselves? If yes, what kind of NFI?
15	What kind of coping strategies are known in the area in case of difficulties with regard to NFI?
16	What were major gaps with regard to NFI before the disaster?
17	Did people try to fill them and how?

Sector: Non Food Items (NFI)

	During Emergency
	Household items / Cooking
1	How many households are in need of necessary cooking utensils and other household items?
2	What kind of utensils do people need?
3	How many households are in need of cooking fuel/stoves?
4	What kind of stoves and fuel do people need?
5	What groups are most in need?
6	Do people need lighting?
	Clothing and bedding
7	How many people are in need of clothing?
7.1	*women*
7.2	*men*
7.3	*children / infants*
7.4	*elderly*
8	How many people are in need of bedding?
8.1	*How many children infants?*
9	What kind of bedding do people need urgently?
9.1	*clothing / warm clothing*
9.2	*blankets / warm blankets*
9.3	*mattresses*
9.4	*other bedding or clothes*
10	What groups are most in need of clothing / bedding / other NFIs?
11	Is it possible to procure clothing and bedding locally?
12	What other kind of items are mostly needed?
	Personal hygiene
13	What kind of basic hygiene items do people need to address urgent personal hygiene?
14	What kind of hygiene items are commonly used in the area? Which items are accepted among the population?
15	Are women in need of special hygiene items?
16	Are children in need of diapers / other hygiene items?
17	Are elderly or disabled people in need of diapers / other hygiene items?
18	What additonal items could be needed to improve health conditions and dignity of target groups (e.g. mosquito / bed nets, etc.)
19	What groups are mostly in need of hygiene items?

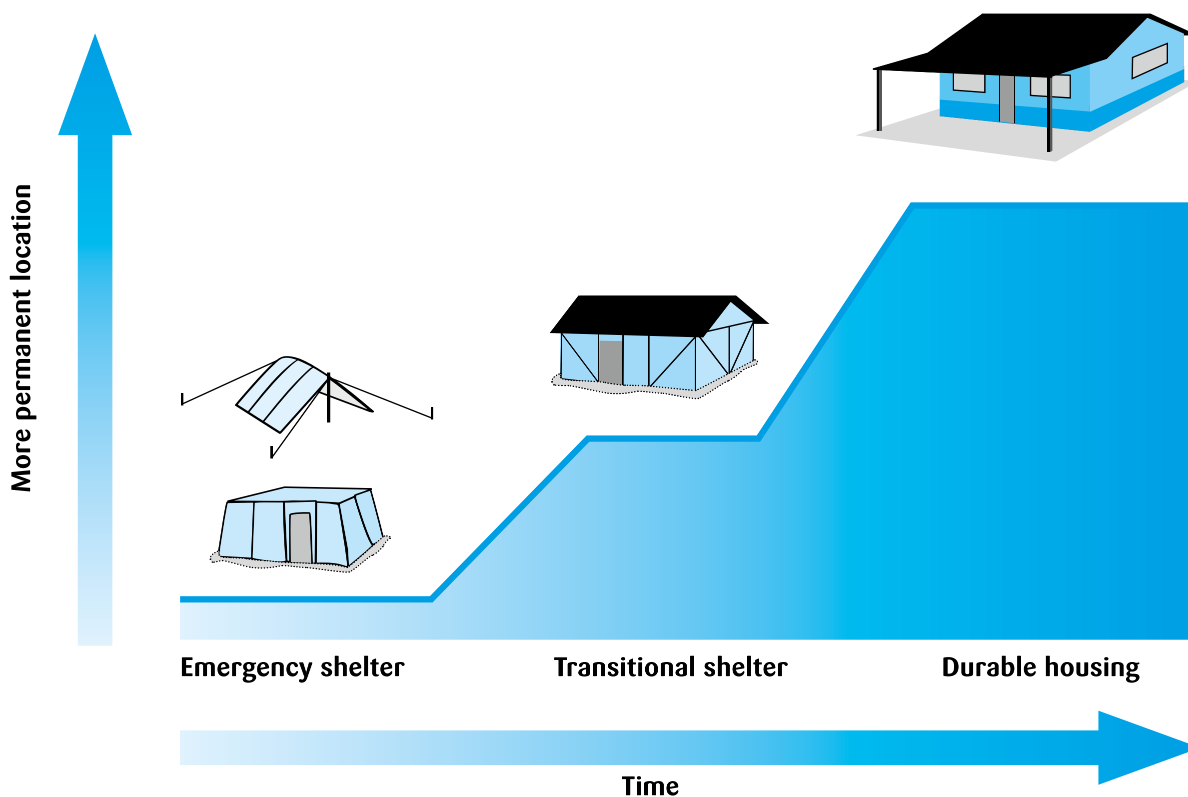
	Tools and equipment
20	What kind of basic tools do people need for repairing, construction or maintaining works in their households?
21	What kind of tools do people need for their livelihood activities?
22	What groups are mostly in need of these tools?
23	Do people need to be trained in using distributed tools and equipment?
	General
24	Are people discriminated or do they have restricted access to distribution of NFIs because of age, sex or disabilities?
25	Are distribution areas safe places and accessible for all, especially for women, unaccompanied girls and boys and people with disabilities?
26	Are any special distributions organised for people with mobility difficulties?
27	Are women, girls, boys, people with disabilities and other vulnerable individuals consulted on NFI issues in order to address protection issues?
28	Are women and girls consulted on location and means of collecting fuel (e.g. firewood) for cooking and heating?
29	Can people apply their coping strategies in the present emergency setting?
30	What are major gaps with regard to NFIs generally?
31	How these gaps could be filled?

8 Shelter

Shelter – Guidance Notes

With regard to shelter in emergencies there are several types of housing to be offered to the affected population. These are: temporary and transitional shelter as accommodation in refugee camps or in communal settlements. When the situation improves people can start rebuilding their damaged houses and socially oriented buildings or build new ones. The types of buildings in this phase are permanent shelter.

Shelter types



Shelter types, IFRC, 2011, p. 8

Emergency shelter / Camp-type settlements

A minimum area of 45 square metres per person should be provided for emergency settlements. The area should have safe roads and footpaths and have space for communal external cooking, educational and recreational facilities. There also should be space for camp administration, food and water storage, distribution areas and small kitchen gardens for individual households.

Where communal services can be provided by existing or additional facilities outside the planned settlement area, the minimum usable surface area should be 30 m^2 per person. Immediately after the disaster, especially in extreme climatic conditions where sufficient shelter materials are not yet available the minimum covered area per person should be 3,5 m^2. This standard also applies to urban areas, where household activities take place within the covered area and where there is less adjacent outdoor space which could be used by the affected people. The covered area should provide space for the following activities: sleeping, washing and dressing; care of infants, children, ill or infirm; storage of food, water, household possessions and other key assets; cooking and eating indoors when required; and the common gathering of the household members. The design of the covered area should maximise the use of indoor space and any adjacent outdoor areas.

Cultural and traditional practices as well as climatic conditions of the target region should be taken into account. Response plans agreed with local authorities or other bodies should ensure that temporary or transitional shelters do not become permanent housing.

Standards for Emergency Shelter (Emergency Shelter Cluster – IASC)

Indicators	Standards (UNHCR/Sphere)
Average camp area per person	45 sq. metres
Average floor area of a shelter per person in camps	3,5 sq. metres In warm climates (cooking outside)
	4,5 sq. metres In cold climates (incl. area for in-house services, e.g. bathing facilities or toilets, depending on socio-cultural habits)

IASC – Gender and Shelter in Emergencies

6 settlement forms of people displaced by disaster

Settlement form	Definition
Host families	local families shelter the displaced population within their households or on their properties
Urban self-settlement	urban unclaimed properties, or land unaffected by the disaster, are used informally by displaced populations
Rural self-settlement	displaced populations create a settlement on collectively owned rural land
Collective centres settlement	existing, large structures such as transit facilities can serve as collective shelters
Self-settled camps	independent from government or international organisation support, camps are formed by the displaced population
Planned camps	government or aid organisations plan camps, including infrastructure, to house displaced populations
	The World Bank – Safer Homes, Stronger Communities

In most cases, after a disaster, people start building their own shelter to protect themselves. In Haiti, after the 2010 earthquake, hundreds of thousands of people gathered in self-made camps in different parts of the Port-au-Prince metropolitan area. Especially in urban areas it becomes a challenge to meet minimum standards for shelter, hygiene, water and sanitation, and health which may require reorganisation or resettlement. The reorganisation/resettlement of slef-made camps should include several considerations

- Depending on the context, the reorganisation or relocation of self-made camps may not be as urgent as the immediate delivery of goods and services.
- If site planning takes place and people are reluctant to relocate to a new site or within the site, find out the reasons. For example, people might have divided the area by ethnic origin. Therefore, consult the people concerned instead of forcing them to move according to top-down planning.
- The relocation, reorganisation or upgrading of a self-made camp requires additional capacity and expertise, which must take place in parallel with the supply of goods and services.
- Reorganisation can make management easier, more efficient, more participatory and safer
- Resettlement or reorganisation must be urgently considered if the population is in immediate danger due to their settlement location or if groups/persons face protection problems.
- The reorganisation of an existing camp may also happen due to new arrivals, communities are evicted from collective centres, or when existing camps are consolidated during phase-out.[60]

60 NRC (2008): Camp Management Toolkit, p. 191

The planned establishment of temporary camps requires a variety of aspects to be taken into account which can best be addressed through joint and coordinated efforts of aid agencies. Below is a summary of the most important aspects to consider:

- The site should be free of major water-related hazards, e.g. malaria, river blindness, bilharzia and sleeping sickness. Provide personal protection against mosquitoes, blackflies, tsetse flies, etc.
- The topography of the land should permit easy drainage and the site should be located above flood level.
- Whenever possible, the area should be naturally protected from adverse weather conditions.
- Open space close to blocks or rows of shelters should be identified for sanitation and waste management. The residential area of the camp should be exposed to the prevailing wind to avoid odours from latrines.
- There should be enough space for people to be sheltered and for all necessary public facilities such as roads, firebreaks (areas without buildings and with little or no flammable vegetation) and service areas.
- Food distribution areas should be organised in such a way as to create safe conditions for those who collect food and those who distribute it.
- Drainage ditches should be dug around tents or other shelters and along roads, especially where there is a risk of flooding. Care should be taken to lead water away from shelters, latrines, health centres, and stores.
- Persistent areas of stagnant water that are difficult to drain can be backfilled or covered. Water points should have adequate drainage to avoid mud.
- For security reasons and to reduce the risk of the site being cut off it should be provided with at least two access roads.
- Shelters should be arranged in rows or in clusters of 10–12 on both sides of a road at least 10 metres wide.
- Built-up areas should be divided by 30 metres wide firebreaks, approx. every 300 metres.
- Shelters should be spaced 8 metres apart so that people can pass freely between them without being obstructed by pegs and ropes. This space also helps to prevent the spread of fire. If this is not possible due to a lack of space, the distance between shelters should preferably be at least twice the overall height of each shelter, and should never be less than 2 metres.
- There should be a minimum of 3.5 sq. metres of space per person inside the shelter in warm climates where cooking is done outside, and 4.5–5.5 sq. metres per person in cold climates where cooking is done inside the shelter.
- Shelters may be tents or prefabricated units, or may be built out of plastic sheeting together with timber, stone and thatch. Where plastic sheeting is used, it is common to provide one piece, 4 metres by 6–7 metres, per household.
- Small shelters with few occupants are preferable to large shelters with many occupants. In cold weather, kerosene stoves or other heating appliances should be provided and people instructed in their use; all precautions must be taken to prevent fires.
- In the absence of electric lighting, wind-proof kerosene or oil lamps, or battery operated lanterns, should be provided for lighting shelters, toilets and roads.
- Natural ventilation should be adequate for temporary shelters such as tents.

- The chosen site should be located at an appropriate distance from a sufficient source of good water and ideally close to a highland from which water can be distributed by gravity; water sources should be gradually improved and protected as basic needs are met. No one should have to walk more than 500 metres to a water point, and there should be at least one water point for every 250 people.
- Where there is no piped water, water tanks should be installed.
- Refuse bins should be provided.
- Latrines or other facilities for excreta disposal should be provided (at least one toilet per 20 people), and gradually improved as time and resources allow. The risks of indiscriminate defecation should be emphasized in health education. Maintenance of toilets must be given priority in health education and camp organisation.
- Bathing, laundry and disinfection facilities should be provided, health education should emphasize the importance of frequent hand-washing.
- The camp site should be cleaned regularly according to a prearranged schedule.
- Separate accommodation is required for unaccompanied children, with the possibility for adults (social workers and/or community volunteers) to stay with them; there should be at least one adult per shelter or room. These children can be very disoriented and frightened and may also have special nutritional needs.
- In conflict- and famine-related disasters, many people may be suffering from malnutrition and exhaustion upon arrival, requiring special services such as intensive or therapeutic feeding. Intensive feeding or nutrition rehabilitation units should be provided with up to 15–30 litres of potable water per bed per day. Latrines and other disposal facilities used by parents, children and staff must be treated with particular care. Means for hand-washing by all staff and parents concerned with child feeding are also important.[61]

Transitional Shelter

Transitional shelter is the provision of longer-term structures until permanent shelter can be provided. Transitional shelters should be able to accommodate people for a period of up to several years, during the period of reconstruction and securing of land tenure. They are designed to facilitate the transition of the affected population to more durable shelter. Established in the longer term, this type of housing requires space and materials of its own. In the planning and construction of transitional shelters, the greatest possible participation of the community should be sought. There are five main characteristics of transitional shelters:

4. upgraded into part of a permanent house;
5. reused for another purpose;
6. relocated from a temporary site to a permanent location;
7. resold, to generate income to aid with recovery; and
8. recycled for reconstruction.[62]

61 WHO (2003): Environmental Health in Emergencies and Disasters, p. 87f
62 IOM (2012): Transitional Shelter Guidelines, https://www.iom.int/files/live/sites/iom/files/What-We-Do/docs/Transitional-Shelter-Guidelines.pdf

Permanent Shelter / Construction

The affected population should be consulted before setting up their shelter. Local people with appropriate construction expertise should be involved in construction planning to meet local needs and traditional practices. The people should be involved in the construction as far as possible. Owner-driven housing reconstruction can be an appropriate solution. In this way, people become actors and owners of the process. Construction guidelines and standards should be agreed with the relevant national authorities to meet safety and performance requirements.

The design and materials used should enable individual households to maintain and adapt or improve housing with locally available tools and materials to meet their longer term needs.

The rehabilitation and construction of permanent shelter and in particular public buildings such as schools, kindergartens and health clinics should apply to disaster preparedness standards and be disaster resistant.

Sources and further reading

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Shelter – Checklists

Sector: Shelter

	Pre-disaster
1	How are households organised?
1.1	*family*
1.2	*groups/clans*
1.3	*unaccompanied children*
2	How many persons belong to one household on average?
3	How many individuals within the disaster-affected population are not members of any household?
3.1	*women*
3.2	*men*
3.3	*unaccompanied children*
3.4	*elderly*
4	What are typical/traditional types of shelter in the area?
5	What kind of building materials did people use prior to the disaster?
6	What kind of household / livelihood activities did people practice prior to the disaster?
7	What basic services were available?
7.1	*Water (potable and for personal hygiene)*
7.2	*Other sanitation and household needs?*
8	What kind of social facilities were available?
8.1	*health clinics*
8.2	*schools/kindergartens*
8.3	*community centres*

Sector: Shelter

	During emergency – temporary shelter
1	How many buildings/houses are destroyed?
1.1	*personal housing*
1.2	*public buildings (schools, kindergartens, clinics, etc.)*
2	How many households lost their housing?
3	How many individuals lost their housing?
4	Which groups of the affected population need assistance in organising their shelter (women, unaccompanied children, elderly, people with disabilities)?
5	How many affected individuals are in need of adequate shelter?
5.1	*women*
5.2	*men*
5.3	*unaccompanied children*
5.4	*elderly and people with disabilities*
6	How many affected households can be assisted at their original living places?
7	How many households are displaced?
8	Where did those displaced find their shelter?
8.1	*(tents) camps*
8.2	*host families*
8.3	*communal facilities (schools, KG, clinics)*
8.4	*prefabricated buildings, etc.*
9	Have minimum norms for temporary shelter been taken into account (e.g. 3,5 m^2 per person)?
10	If not, has the impact of dignity, health and privacy been met?
11	Have local climate conditions been taken into account with regard to arrangement of temporary housing?
12	Have cultural specifics with regard to use of living space been considered?
12.1	*sleeping arrangements*
12.2	*accommodation of extended family members*
13	Have the affected people been consulted before their shelter has been arranged?
14	Has gender issue been taken into account?
15	What kind of household / livelihood activities can take place adjacent to the shelter?
16	Are basic services available at temporary shelters?
16.1	*Water (potable and for personal hygiene)*
16.2	*Other sanitation and household needs*
17	Are social facilities in place?
17.1	*schools*
17.2	*kindergartens*
17.3	*community centres*

18	To what extent have social facilities/infrastructure been destroyed? What kind of social facilities/ infrastructure have been mostly destroyed?
18.1	*Schools and kindergartens*
18.2	*Health clinics*
18.3	*Streets and bridges*
19	What are major gaps in addressing shelter needs?
20	How could these gaps be filled?

Sector: Shelter

	(Re) construction
1	Do the present conditions allow reconstruction activities?
2	Did affected people participate in the planning of reconstruction?
3	Are people able to participate in the reconstruction / of their shelter? If yes, how (e.g. man-power, material, money, etc.)?
4	Do women/girls participate in reconstruction activities? If yes, how do they participate?
5	Do people need any support in reconstruction? If yes, what kind of support?
5.1	*Training before starting the reconstruction*
5.2	*Resources*
5.3	*Assistance by professionals during the process of reconstruction*
6	What other groups are in need of additional help?
6.1	*unaccompanied children*
6.2	*single elderly*
6.3	*people with disabilities and/or with HIV/AIDS*
6.4	*female-headed households*
7	Has DRR been integrated in rehabilitation/construction activities (e.g. earthquake/flood resistant housing)?
8	What local resources/materials are available and could be used for reconstruction?
9	Do affected people have access to building materials/tools?
10	Could temporary shelter be upgraded and/or expanded?
11	Are there local HR/construction specialists available to be involved in reconstruction activities?
12	Is any land available? If yes, to whom does this land belong?
13	Is the land prone to any natural disaster?
14	What are opportunities and constrains with regard to land usage?
15	Have environmental impacts been taken into account?
16	Is there any coordination body with regard to reconstruction: international or national?
17	Does the local government have any national strategy/programme with regard to reconstruction and what is the role of the local government?
18	Do you coordinate your activities with other stakeholders involved in this phase: national or international (Cluster)?
19	What are current national and international standards applied with regard to construction?
20	What are major gaps with regard to (re)construction?
21	How could these gaps be filled?

9 Livelihoods

Livelihoods – Guidance Note

After disaster priority should be given to the preservation, recovery and development of resources for food security and future livelihoods. Political instability, insecurity and conflict/disaster risks can limit livelihood activities and access to local markets. According to the Sphere Minimum Standards there are three standards for primary production, income generation, employment and market access.

Primary production: New technologies could only be introduced to the affected population if they have been tested beforehand. They should also be accepted by the beneficiaries. After their introduction, relevant consultations, training and other appropriate support should be offered to the target groups. Production support should assess possible nutritional impacts, including access to nutritious food through own production or through cash generated by such production.

The feasibility of transferring funds to households to enable access to production should be linked to the availability of local goods, safe and affordable transfer mechanisms and access to local markets. Examples of inputs could include seeds, tools, fertilisers, livestock, fishing and hunting equipment, loans and credit facilities, market information and means of transport. An alternative to benefits in kind is cash or vouchers that enable people to buy products themselves. The provision of agricultural inputs and veterinary services should be planned in accordance with the respective seasons of agriculture and animal husbandry.

Seeds: Priority should be given to seeds from crops already used locally so that farmers can apply their own criteria in determining quality.

Impact on rural livelihood: Primary food production may not be viable if there is a lack of vital natural resources or if certain groups as landless people have no access. Provision of resources in-kind or cash could initiate tensions in the affected population.

In order to support local market / local private sector, inputs and services for food production should be purchased locally.

Market and vulnerability analysis: All affected people should have opportunity to access markets. To identify people with limited access to markets and livelihood activities, a market and vulnerability analysis can be carried out to assess existing markets, access to markets, gaps and opportunities for market development (see below).

Cash and voucher based assistance (CVA): CVA has often been seen as an alternative, in particular to food aid, but other types of interventions can also be supported in this way. Cash and vouchers need to be considered as alternatives for all types of commodity-based distributions. This would include:

- Food aid
- Shelter
- Non-food items
- Seeds, tools and other agricultural commodities such as fertiliser

Cash can theoretically act as a substitute for any area of need for which there is a private market, so cash or vouchers could also be seen as alternatives to the public provision of health, education and veterinary services. There are different types of cash interventions:

Cash transfers[63]

Cash transfers provide poor and vulnerable households with the resources required to address their basic needs and invest in productive activities. Cash transfers can be unconditional or conditional:

- Unconditional cash transfers: Cash is disbursed to beneficiaries without the need to fulfil any particular condition.
- Conditional cash transfers: Cash is disbursed to beneficiaries with the condition of having to carry out certain actions or meet specific requirements, such as attending a training, adopting good agricultural practices, etc.

Cash (+)

To maximize their impact and sustainability, the provision of unconditional cash transfers to beneficiaries is complemented with productive inputs, assets and/or technical training. The cash provided to beneficiaries enables them to address their immediate food and other basic needs while the "plus" component promotes their engagement in productive activities. For example:

Possible Cash (+) components (FAO)

63 FAO: www.fao.org/emergencies/fao-in-action/cash-and-vouchers/en/

Cash for Work

Short-term employment opportunities are provided to poor, vulnerable men and women, with the objectives of:

- Providing income support to poor, vulnerable households through short-term, intensive and unskilled labour, and
- Building or rehabilitating community productive assets (e.g. irrigation canals, water harvesting systems, etc.) and restore agricultural activities through reforestation, land rehabilitation, etc.

Cash for Work can contribute to (1) address basic needs, (2) prevent negative coping mechanisms and (3) stimulate local economies

Vouchers programmes

Beneficiaries receive vouchers that can be redeemed for goods and services (e.g. seeds, fertilizers, tools, livestock, animal feed and veterinary supplies and services) at selected shops.

Input trade fares

Input trade fairs are temporary one-day markets where farmers and pastoralists can purchase agricultural inputs and access services through the exchange of vouchers.

Possible advantages of cash [64]	Possible disadvantages of cash
Cost efficient – distributing cash is likely to be cheaper than commodity-based alternatives because transport and logistics costs are lower	Inflationary risks – if an injection of cash causes prices for key goods to rise, then recipients will get less for their money and non-recipients will be worse off
Choice – cash allows recipients to decide what they should spend the money on. This enables people to choose what they most need, and allows for this to vary from person to person	Anti-social use – cash can be used to buy anything. Some may be used for anti-social purposes
Empowerment – Cash empowers men and women by allowing them to prioritize and address their own needs	Security risks – Moving cash around may create particular security risks for staff implementing cash programmes, and for the recipients of them
Multiplier effects – distributing cash can have knock-on economic benefits for local markets and trade if the money is spent locally, and it may stimulate agricultural production and other areas of livelihoods	More difficult to target – because cash is attractive to everybody it may be more difficult to target, as even the wealthy will want to be included
Avoids disincentive effects – unlike commodities (food, shelter) cash is unlikely to discourage local trade or production	More prone to diversion – cash may be more attractive than alternatives and so particularly prone to being captured by elites, to diversion particularly where corruption is high and to seizure by armed groups in conflicts
Fewer costs for recipients – food often costs recipients a significant amount to transport from the distribution site to their home. Cash avoids this	Disadvantages women – women may be less able to keep control of cash than alternatives such as food
Dignity – cash can be better at maintaining the dignity of recipients. It may, for instance, be possible to avoid long, degrading queues	Less available from donors – donor governments may be more willing to provide commodities than cash
Risk management – Cash-based programmes can reduce the risk of resorting to negative coping mechanisms during crises and mitigate the impacts of shocks	Consumption/nutrition – if a transfer has particular food consumption or nutrition objectives, then food may be more effective. For instance, food can be fortified to address micronutrient deficiencies

64 Harvey, P. (2005): Cash and vouchers in emergencies, p.2; FAO: www.fao.org/emergencies/fao-in-action/cash-and-vouchers/en/

Market survey

Cash and Voucher Assistance (CVA) can only be effective if people affected by crises can easily access cash and purchase the goods they need at local markets. When designing an intervention and deciding whether to use CVA, a market analysis should be part of the overall response analysis. That can include interventions that use the market (such as cash transfers to affected populations), as well as interventions that directly support markets (such as conditional grants to traders to get their market back up and running).Market analysis tools can range from initial mappings and trader surveys to more comprehensive tools. The two major ones are:

- EMMA – Emergency Market Mapping Analysis[65]
- MIFIRA – Market Information and Food Insecurity Response Analysis[66]

The minimum standards for market analysis (MISAM) are a companion standard to the Sphere standards.[67]

Remuneration: Remuneration could be given in cash or in food or as a combination of both. The aim is to enable food insecure households to meet their basic needs. The type and level of remuneration should be decided on case-by-case basis considering the availability of cash and food as well as possible impacts on local labour markets.[68]

65 EMMA Toolkit: www.emma-toolkit.org

66 Lentz et al (2009): Market Information and Food Insecurity Response Analysis, www.cashlearning.org/downloads/resources/documents/mifira-test-report.pdf

67 Sphere: https://spherestandards.org/resources/minimum-standard-for-market-analysis-misma/

68 The Sphere Project: (2011), Food security – Livelihoods, pp. 203-213

terre des hommes project example

India – Rehabilitation after the Tsunami

Problem description: After the Tsunami the conditions of people living in the region of Andra Pradesh became worse. Those who were poor before the tsunami became even poorer. The livelihoods of poor fisher men were completely destroyed.

Project objective: Improvement of the living conditions and future perspectives of 9.954 children and youth in 50 Tsunami affected villages in Nellore and Prakasam districts through providing access to improved primary education, psychosocial services and livelihood support to youth and women (livelihood component)

Project description / activities: After the Tsunami the conditions of people living in the region of Andra Pradesh became worse. Those who were poor before the tsunami became even poorer. The livelihoods of poor fisher men were completely destroyed. The aim of the tdh project funded by VW Company was to establish income-generating backgrounds for poor families in order to ensure sustainable income using already existed local sources. Following activities were offered for project beneficiaries:

a) Small loan programmes – In the frame of this activity 842 families in total have been supported. Moreover women and young people received loans for small businesses in fishery, textile production, livestock breeding, agriculture and repairing works (e.g. fisher boats, bicycles, cars, etc.)

b) Self-help groups – In the frame of small-loan-programmes 726 self-help groups have been established in order to independently manage the finances and their granting. Those groups were mainly organized by women. In this regard trainings for 1 184 women were conducted. The work with women raised their self-assurance and therefore future chances. The women in this project could prove that with relevant support they were able to implement small economic projects.

c) Crop banks – In 15 communities of Yanadi, a group of original inhabitants of the region, so called crop banks have been established. With project subsidy community members could purchase rise, storage it locally in order to sell it afterwards to local people. Community members could then have small loans which were raised from rise selling. Local people shouldn't ask brokers for loans anymore and therefore were not in a danger to get into the burden of debts. The results of the project were very positive. The purchased rise was of a very good quality and for an adequate price. Local people could not only get loans through the rise selling but also ensure the provision of rice in bad times.

d) Diesel-subsidy programme – Most of fisher men use diesel for their boats, which could be normally purchased only in distant big towns. The local government set up a program of provision of diesel for registered fisher boats. Youth groups in eight fisher villages purchase diesel in big amounts and sell it at a good price in their villages. It was intended to build up a cooperative with young people in order to purchase diesel directly from the government and not through distributors. Because of disinterest from the side of the government it was not possible to realise the idea.

Sources and further reading

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Terre des homes-Germany (Sept. 2010): Final report of the project funded by VW Company Council “India – Rehabilitation after the floods (tsunami)”

EMMA Toolkit: www.emma-toolkit.org

MISMA: https://spherestandards.org/resources/minimum-standard-for-market-analysis-misma/

Livelihoods – Checklist

Livelihood

	Pre-disaster
1	What were traditional livelihood activities in the area prior to the disaster?
2	Did people form groups with regard to different livelihood activities/strategies, as:
2.1	*food production/sources*
2.2	*livestock holdings*
2.3	*cash savings*
2.4	*other*
3	What were basic income sources for affected people?
4	Did women contribute to their households? If yes, how?
5	What role did children play with regard to livelihood?
6	What kind of assets, savings or other reserves are owned by the affected people?
6.1	*food stocks*
6.2	*cash savings*
6.3	*livestocks holdings*
6.4	*other*
7	How was the access to the labour market?
8	How was the access to local markets?
9	What were the prices for food and other essential/basic goods?
10	Were there any community groups active in the field of livelihood prior to the disaster?
11	What was the role of these community groups?

Livelihood

	During emergency
1	What is the level of damages caused by the disaster with regard to:
1.1	*buildings (houses, schools and other social oriented buildings)*
1.2	*infrastructure (streets, bridges, water supply systems, etc.)*
1.3	*cultivable land*
1.4	*livestock*
2	Who is most affected: women, men, children, elderly, disabled?
3	What is the impact of the disaster on the sources of income and food?
4	Can people practice their usual livelihood activities in the present emergency setting?
5	What alternative livelihood activities could be practiced?
5.1	*In agriculture*
5.2	*In livestock breeding*
5.3	*Other*
6	Do these alternative activities vary with regard to men, women?
7	Are there any employment/labour opportunities (access to labour market)?
8	Are there any income generating activities in place?
9	Are there any other alternative activities to address livelihood needs?
10	How sustainable are these alternative activities?
11	Do these activities correspond to cultural/regional specifics?
12	Are there any risks of practicing those alternative activities (e.g. negative impact on the environment)?
13	Do people need any external assistance?
13.1	*Seeds*
13.2	*Animal food*
13.3	*Training/consultation*
14	Are people involved in the planning of livelihood activities?
15	What kind of coping strategies could be applied in the present emergency setting?
16	What are the short- and medium-term, positive and negative effects of people's coping strategies?
17	What deficits could be covered by coping strategies? What kind of resources could be used for it?
18	To what extent do these activities have positive or negative impacts on the affected people's situation?
19	Are there any governmental programmes with regard to compensations?
20	Are people aware of these programmes and how accessible are these programmes?
21	What are the modalities of these compensations? Do they correspond to real needs of the affected people?
22	Is the amount of the compensation fair enough to cover needs of the affected population?
23	What are major gaps with regard to livelihood?
24	How could these gaps be filled?

Cash Checklist

	Programme design
1	Provide targeted cash-based-assistance and includes specific considerations
2	Who within the household should receive cash-based assistance? Have risks and protection concerns been taken into account?
3	Identify safe, accessible and effective mechanisms to deliver cash assistance based on context as well as recipients' financial literacy and preferences
4	Calculate the transfer amount based on the needs to be covered and the cost of meeting these needs
5	Set the transfer frequency and duration based on needs, seasonality, the financial service provider's capacity and protection risks
6	Define key issues and related indicators to monitor process, activity, output and outcome levels.
	Implementation
7	Include context-specific considerations and any other relevant dimensions in financial service provider tenders and establish clear criteria for selection
8	Consider using existing familiar delivery mechanisms already in place for social protection
9	Set up recipient registration and identification systems that are appropriate to the delivery mechanism
10	Ensure that registration and identification cover data required by the financial service provider.
11	Apply and document data protection measures
12	Set up mechanisms for digital data in collaboration with different organisations to the extent possible
13	Clearly define the procedures, roles and responsibilities for the cash delivery process, as well as risk management mechanisms.
14	Ensure that the process of delivering cash-based assistance is accessible and effective.
15	Make sure all affected groups can access the chosen delivery mechanism throughout the project's lifespan.
16	Ensure recipients have information on programme objectives and the duration of cash-based assistance, so they can make informed spending decisions
17	Ensure financial service providers are accountable to recipients through contractual management and monitoring

	Monitoring, evaluation and learning
18	Monitor cash-based-assistance-related processes, activities, outputs and risks, including post-distribution monitoring
19	Monitor whether the cash or vouchers were received by the right person, safely, on time and in the correct amount.
20	Monitor markets and their supply chains consistently, beyond price monitoring
21	Monitor household expenditure and triangulate with market monitoring data to assess whether needs can be met through cash-based assistance and negative coping strategies reduced.
22	Monitor potential risks of cash-based assistance, including protection risks and negative impact on natural resources
23	Regularly evaluate whether the choice of cash-based assistance is effective in meeting changing needs, adapt the programme accordingly and support continuous learning for future programmes
24	Evaluate outcomes related to cash-based assistance

10 Participation

Participation – Guidance Notes

„Participation is the process of involving the affected people in one or more phases of a humanitarian programme or project: assessment, design, implementation, monitoring or evaluation. Participation is a dialogue with people affected by a crisis or disaster and helps to find answers not only to the question what is needed but also how it might be provided in the best way. This dialogue can help to strengthen the relationship between the aid organisation and the population. Participation is based on good communication, transparency and respect for local culture and traditional beliefs of the affected population. **There are two forms of participation:**

Direct participation means individual involvement of the affected people in various phases of an aid programme/project through focus groups, participation in project implementation or suggesting ideas for interventions.

Indirect participation (or participation by representation) means representation of the affected groups by local structures such as community-based organisations (CBOs) and village committees.

Both forms of participation can be facilitated by various types of partnership: between international and local NGOs, governmental organisations and NGOs or development and humanitarian organisations. There are several **types of participation:**

1. ***Passive participation*** – the affected population is informed about ongoing activities
2. ***Participation through the supply of information*** – the affected population receives information, but cannot influence the process.
3. ***Participation by consultation*** – the affected population is asked for its perspective on a given subject, but has no decision-making power. There is no guarantee that their perspectives will be taken into account.
4. ***Participation through material incentives*** – the affected population supplies labour or materials for some operations, in exchange for payment in cash or „in-kind" from the aid organisation
5. ***Participation through the supply of materials, cash or labour*** – The affected population provides part of the materials, cash and/or labour needed for intervention. This also includes cost recovery mechanisms.
6. ***Interactive participation*** – the affected population participates in needs assessments and in programme planning, and has a decision-making power

7. ***Local initiatives*** – the affected population takes the initiative, acting independently. Projects are conceived and run by the community. The aid organisation participates in people's projects.[69]

Ideally, **participation in emergency situations** begins with the assessment phase, in which those affected play a leading role in identifying their needs. In most cases, relief organisations are not able to meet all their needs. They should therefore work with those affected to identify priorities that need to be taken into account. Representation, participation and involvement can take many forms and use a variety of tools and methods.

- Community groups
- Focus groups
- Advocacy groups
- Interest groups
- Working or project groups
- (Camp) communities for technical sectors (and sub-committees)
- (Camp) committees for cross-cutting issues
- Employing (camp) residents as volunteers or paid employees[70]

It is not always possible to take a participatory approach immediately after a disaster. During the initial emergency response, people may have other priorities such as finding their relatives, ensuring survival of their family or they are in shock. In those cases where the affected people cannot fully participate, it is important to at least inform them about planned and ongoing activities.

Children's Participation

Children are very often overlooked as important stakeholders, even if they are the direct target group of the project. This is especially true in crisis situations. But at the same time, children are very important in terms of information and knowledge that can be provided in the community.

Child participation is a process that involves the participation of all children, including the most marginalised children, children of different ages, gender, ethnic groups, religion and abilities. They are directly or indirectly involved in participation. The participation of children is a cross-cutting issue that is relevant in the context of all sectors. It is also used at all levels: family, community, local, regional, national and international.

Child participation means that those children who are capable should participate in the project processes. Therefore, it is recommended to reach children at their sites. Children's participation is more effective when parents and other supporters and/or caretaker are directly involved. They should support the children; understand the need for children's role in participative processes and the importance of the impact of their decisions.

When participating in meetings and discussions, the children need to feel comzfortable and understand the topics of the meetings. Therefore, the language used for such meet-

69 ALNAP/U.R.D., 2009, p. 32-41
70 NRC, 2008, p.82

ings should be easy for children to understand and without technical terminology. There are 7 standards for children's participation.[71]

Standard 1 – An ethical approach: transparency, honesty and accountability
Children are able to freely express their opinions. The purpose of children's participation is clear and children understand how much impact they can have on decision-making. The roles and responsibilities of all involved (children and adults) are clearly defined and agreed upon. Organisations and workers are accountable to children for their commitments.

Standard 2 – Children's participation is relevant and voluntary
Children's participation is voluntary; they have time to participate and are involved in activities appropriate to their capacities, age group and interest. Social, economic, cultural and traditional practices are taken into consideration.

Standard 3 – A child-friendly, enabling environment
Methods of children's participation are developed in partnership with children. Adults (including children's parents) understand the importance of children's participation and are enabled to play a supportive role in these processes. Child meeting places should be friendly and safe, where both girls and boys feel comfortable and relaxed. In all discussions with children non-technical language is used.

Standard 4 – Equality of opportunity
All children participate equally and are not discriminated against because of their religion, race, age, sex, language, ethnic or social origin, disability, political opinion or other status.

Standard 5 – Staff are effective and confident
All staff members understand the organisational commitment to children's participation. Staff is provided with relevant trainings and other opportunities which enables an effective and confidential work with children of different ages and abilities.

Standard 6 – Participation promotes the safety and protection of children
Children involved in participation activities are aware of their rights to be safe and know where to get help if needed. Professional staff is responsible for child protection during participatory processes.

Standard 7 – Ensuring follow-up and evaluation
Follow-up and participation are integral part of any participatory initiative. Children are enabled to take part in follow-up and evaluation. They are encouraged to share their experience with peer groups, local communities and organisations.

Children's participation in the project cycle

Children should be involved as stakeholders in the project cycle by giving opinions, suggestions, information and by participating in the implementation and evaluation of the project. Children could be encouraged to take the lead in defining their needs, designing the project and gathering the information needed.[72]

71 Save the Children, 2005 a, p. 4
72 Tearfund, 2004, p. 29 ff

Needs assessment

In order to work effectively with children during needs assessment several tools can be adopted. In order to use these techniques successfully, employee training in communication with children, child development as well as age and gender issues are important.

Listening to children – It is important to give children the opportunity to talk about their experiences and views.

Dream trees – The dream tree is analogous to the problem tree. After some practical examples, children write or draw problems that represent their actual situation on the trunk of the tree. In the upper part of the tree they draw flowers or fruits that represent the ideal situation they want to reach.

Theatre for development – For some children it could be easier to express important issues through drama. Theatre or role plays can be sued to:

- ✓ Identify important issues with children
- ✓ Develop a drama based on these issues
- ✓ Perform the drama to an audience and discuss issues with the audience after the performance

Transect walks – Adults can learn a lot about the community as they walk around with the children of that community. During this walk children can point out:

- ✓ What is important to them/why
- ✓ What they are afraid of/why
- ✓ What they would like to change
- ✓ What they like and what they do not like about the community
- ✓ Where vulnerable children live (e.g. children with disabilities)

Mapping – Children enjoy mapping. Maps can be drawn directly on the ground using various materials available. Papers and pens can also be used. Adults should not give much orientation on how to draw the map. They just ask the question and children answer through the mapping.

Ranking – Ranking is used to show priorities. It can be used in combination with other exercises e.g. to map positive and negative aspects in the community.

Child-to-child interviews – This instrument can support the collection of baseline information. Participating children could be involved in analysing this information. First children need to be trained in basic interviewing techniques.

Daily activities chart – This exercise can be used to see how much time children use for different activities and how they organise their day. In rural areas children can draw a chart with seasonal activities in order to see the difference. Questions could be:

- ✓ What do they do in a typical day?
- ✓ How many hours they spent on each task?

Songs – In some cultures songs play a significant role for people to describe their problems and concerns. Songs performed by children could be used to express their views, concerns, priorities and wishes. For example, children can use rap songs.

Focus groups – For many children it is easier to talk in a group than during an interview. Focus group discussions can be a good way to talk to children.

Consultations – Consultation is an effective method to generate ideas among children. They bring together children groups with similar concerns and can create an environment in which adults listen to them. Example: Children displaced by conflict in Colombia gathered to develop recommendations for the country representatives participating in the UN General Assembly Special Session for Children.

Project design

Further information should be collected during the project design to identify children's problems. The following tools can be used in the project cycle:

Stakeholder analysis – Children are very important stakeholders in projects particularly designed for them. Therefore, they should be involved as primary stakeholders. Depending on the topic it is important to select groups of children. For example, if the focus is on child labour, child labourers, trafficked children and their parents could participate.

Research witch children – Research is an important part of a well designed project. Children's participation in research is important.

- ✓ While participating in project research the sense of ownership by children is increased
- ✓ Children can express themselves, be heard and listened to
- ✓ They become confident and feel independent

Implementation and evaluation

Once the children have been involved in the project design, they should also be involved in its implementation and evaluation.

Children take a role in project's organising – Children can participate in regular discussions of project decisions (e.g. on location and decoration of youth centres, hiring staff and budgeting)

Children take a role in representing the project – Children can represent the project towards local decision makers or at workshops, meetings and conferences. Their role and task during this representation should be agreed with the children.

Children are involved in project monitoring – To carry out this activity children's groups should be established. They make sure that the monitoring takes place and the project is running. Monthly meetings can be held to ensure that activities are carried out according to plan.

Children are involved in the evaluation of the project – Usually the project evaluation is conducted at the end of the project to assess the impacts. If children participate in this process, the methods chosen should take into account the age and experience of the participating children.[73]

73 Tearfund, 2004, p.29ff

terre des hommes project example

India – Rehabilitation after the Tsunami

Problem description: As a result of Tsunami in December 2004 about 500 fisher villages in India were destroyed. More then 650 000 people were internally displaced. The poverty that prevailed before the disaster worsened. Children were the main victims of the disaster.

Project objective: Improvement of the living conditions and future perspectives of 9.954 children and youth in 50 Tsunami affected villages in Nellore and Prakasam districts through providing access to improved primary education, psychosocial services and livelihood support to youth and women (child protection / participation component)

Project description / activities: A joint project of 4 local partner organisations was initiated to support the reconstruction of 24 fisher villages in Andhra Pradesh. One component was the protection, support and participation of children. As part of the project, around 100 children's clubs with a total of 1,356 members were established.

The partner organisations rehabilitated the educational infrastructure, mainstreamed the children into school, trained the children in the DRR and founded Bal Panchayats (Children's Council) at village level, which were represented by eight children elected by the children of the village themselves. Children between the ages of six and 18 can be members of the Bal Panchayats. They participate in the meetings of the traditional village committees to discuss child-related issues, are observers of children's rights and are consulted in decision-making processes. Children highlighted issues such as child labour and child health. Together with women's groups, the children's councils are working against early childhood marriages. They now observe that girls in their villages do not marry until turning 18 years and attend school instead.

Sources and further reading

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Participation – Checklist

Participation (All groups)

	Pre-disaster
1	What was the access to information by the affected population before the disaster?
2	Are people aware of their rights (e.g. basic human rights, rights for compensations, etc.)?
3	Did people participate in community activities?
4	Did women and girls participate in community activities?
5	Did minorities, people with disabilities and other vulnerable group participate in community activities?
6	How far did traditional and cultural habits influence community life (negative/positive)?
7	What local initiatives and capacity exist before the disaster?
7.1	*CBOs or other community groups*
7.2	*Women groups*
7.3	*Youth clubs/initiatives*
8	What was the role of local initiatives to ensure access to information and participation within the community?
9	Did the affected people have previous experience in working with aid organisations (local/international)?
10	What was the role of local governmental structures in community life? Were there any governmental programmes to strengthen local initiatives?
11	Did people participate in these programmes?
12	What were major gaps with regard to participation before the disaster?

Participation (All groups)

	During emergency
1	Do people have an access to information?
2	Do women and girls have an equal access to appropriate information?
3	Do minority groups and people with disabilities have an equal access to information?
4	How are people organized after the disaster? What local initiatives and capacities are there at present?
5	Is it possible to involve people in various project phases through existing groups?
6	Is it necessary to build new groups in order to ensure participation?
7	Do affected people need any trainings to learn about participation / their rights?
8	What forms of participation could be applicable in the given context?
8.1	*direct*
8.2	*indirect*
8.3	*both*
9	What types of participation could be used by your organisation to involve affected people?
9.1	*passive participation*
9.2	*participation through the supply of information*
9.3	*participation by consultation*
9.4	*participation through material incentives*
9.5	*participation through the supply of materials, cash or labour*
9.6	*interactive participation*
9.7	*local initiatives*
10	What can be done to make sure that people have an interest in investing their time in a participatory processes?
11	What can be the role of local government structures in participation processes?
12	Are there any governmental programmes in place to support local groups in participatory processes?
13	Are there any risks for affected people with regard to participation and how could these risks be minimized?
14	Can participation enable people to raise protection issues through identification and development of their rights to assistance, repair, recovery and safety?
15	Are there any cultural barriers to be taken into consideration during participation?
16	Do local political dynamics have any impact on participatory processes?
17	What are major gapd with regard to participation?
18	How these gaps could be filled?

Participation (Child-related)

	During emergency
1	Do children have access to relevant information?
2	Are children asked about information they need?
3	Do children understand their role and the impact of their participation?
4	Do girls and boys equally participate in the processes? Are there any traditional/cultural features to be taken into account?
5	Do children with disabilities have access to participatory processes?
6	Is the participation of children from minority groups ensured in participatory processes?
7	Are there children's groups/committees established?
8	Does the staff working with children have relevant skills, attitude and experience?
9	Does the staff need additional trainings on topics related to children's participation?
10	Is the environment for children's participation safe enough?
11	Is the participation of children voluntary?
12	Are age and abilities of participating children taken into account?
13	Are children involved in participatory processes during the initial emergency phase?
14	Are topics of the processes relevant and appropriate to children's interest and capacities?
15	Do families and other supporters of children understand the importance of children's participation?
16	Were methods of participation elaborated in cooperation with children?
17	Are there child-friendly spaces available to be used as meeting places?
18	Are children's rights protected during the participatory processes?
19	Are children involved in follow-up and evaluation processes?
20	What are opportunities in children's participation?
21	What are main constrains/gaps in children's participation?
22	How these gaps could be filled?

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